OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Proposed Revisions to the Affordability Standards

HIAC Meeting
Draft as of October 21, 2014

Goal: Increase the Affordability of Health Insurance and Improve Efficacy of the Delivery System

SIM Interagency Alignment

Objectives	Strategies	Revised Affordability Standards
Integrated Population-Based Care Strong Primary Care Infrastructure Efficient Care Delivery	PCMHs ACOs Community Health Teams Nurse Care Managers	80% of Providers in PCMHs/APCPs by 2019 PCMH/APCP Convening: Care Transformation Plan
Data Access and Analytics	Price Transparency Quality/Cost Data HIT/CurrentCare Patient Data Registries	Primary Care Spend: Hold at 2014 % Levels for Direct Spend and Indirect Spend
Payment Reform Cost Growth Containment	Shared Savings (Upside and 2-way Risk Sharing) Bundled Payments Capitation/Global	Population-Based Contracting Targets Reduce Use of Fee-for-Service Payments Hospital Rate Increase and ACO Total Budget Growth Limitations Hospital Contracting Conditions

Review Proposed Changes to Affordability Standards

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1. Primary Care Spend
2. PCMH Expansion
3. CurrentCare
4. Payment Reform
   - Promote use of population-based contracts
   - Promote use of alternative payment methodologies
   - Control cost increases
   - Improve hospital quality
5. Data Collection and Evaluation

1. Primary Care (PC) Spend

- Current Requirement: Health insurers must increase the percentage of total medical payments that are made to primary care clinicians by 1% per year.
- New Requirements: Three integrated requirements for health insurers:
  1. Direct at least 10.7% of total medical payments towards primary care spend
  2. Direct at least 9.7% of total medical payments to "Direct Primary Care Spend."
  3. Direct at least 1% of total medical payments to "Indirect Primary Care Spend."
     - **Insurers may not fall below current (CY14) levels of support**

1. Primary Care (PC) Spend

"Direct Primary Care Spend" is defined as payment that directly benefits primary care practices for:

- providing health care services;
- achieving quality or cost performance goals;
- infrastructure development *within* the primary care practice to enable the practice to transform into PCMH or enter ACO agreements;
- improving primary care – behavioral health integration;
- sharing services among small independent practices that directly enhance a PCP's ability to support population health and effect PCMH transformation;
- sharing community-based services to enable practices to function as PCMHs, and
- increasing the number of primary care clinicians (e.g., through loan repayment programs).

1. Primary Care Spend (cont'd)

"Indirect Primary Care Spend" is defined as payment that strengthens the capacity of PC practices to function as PCMHs and to prepare to manage care under risk-bearing contracts, but does not qualify as Direct Primary Care spending.

- Required support includes CSI-RI administrative expenses and CurrentCare.
- Examples of other types of support include practice coaches, learning collaboratives, and a central call line for PCPs to consult with a psychiatrist on care management.

1. Primary Care Spend (cont'd)

- Rationale
  - OHIC unable to get sufficient benchmark data to justify continuing to increase percentage of PC spend by 1% annually.
    - *OHIC to conduct an in-depth benchmarking study to more comprehensively understand primary care spend across the country, including data from highly-performing systems*
  - 10.7% represents the aggregate projected 2014 PC spend, so requirement will hold in place gains made to date under existing Affordability Standards.
  - Creating direct and indirect PC requirements assures that PC spending goes towards supporting primary care and developing capacity to manage care under payment reform models.

1. Primary Care Spend (cont'd)

- Current Requirement: Health insurers must increase funding directed to non-FFS activities by 5% percentage points per year.
- New Requirement: See Standard 4: Payment Reform

2. PCMH Expansion

- Current Requirement: Health insurers are required to support the current level of CSI-RI activity, but have no PCMH expansion requirement.
- New Requirements:
  - OHIC is adopting the term "Advance Primary Care Practice" (APCP) to afford insurers flexibility in promoting primary care transformation.
  - Health insurers must take actions such that by 12/31/19 80% of contracted primary care practices are classified as PCMHs or APCPs.
  - Health insurers shall provide contractual incentives and disincentives for practices to transform into PCMHs or APCPs.

2. PCMH Expansion (cont'd)

- New Requirements (cont'd)
  - Commissioner shall convene a Care Transformation Advisory Committee by January 1 of each year, composed of employers, consumers, providers and health insurers.
  - The Committee will be charged with developing and submitting to the Commissioner by May 1 annually a transformation plan to achieve the 80% goal, including:
    - Annual targets
    - Activities and financial support by insurers to achieve the targets
    - Alignment on performance measurement, reporting and data exchange between providers and health insurers

2. PCMH Expansion (cont'd)

- New Requirements (cont'd)
  - If stakeholders are unable to agree on a plan, the Commissioner may adopt a plan during the annual rate review process.
  - Health insurers are to support the transformation plan. Fully insured lives may not be unfairly burdened.

2. PCMH Expansion (cont'd)

- Rationale
  - There is a need to bring smaller, independent practices into PCMH/APCP programs.
  - There are distinct challenges engaging and supporting the many small independent primary care practices that are not yet PCMHs/APCPs.
  - Multi-stakeholder approaches are needed to address PCMH/APCP expansion in Rhode Island. For example:
    - Non-aligned payer performance measures creates administrative burden and lost focus for providers.
    - Common approaches to provision of data to PCMHs/APCPs will support practice analysis and application of data to clinical management.
  - Opportunity to work collaboratively with SIM initiatives, if RI wins the grant.

3. CurrentCare

- Current Requirement: Health insurers must support CurrentCare.
- New Requirement: Health insurers must support CurrentCare as part of their obligation to direct at least 1% of total medical care spending to Indirect Primary Care Spend.
- Rationale
  - Creating a state-wide HIE should facilitate cross-provider sharing of clinical information.
  - CurrentCare needs provider support to take hold in RI.

4. Payment Reform

- <u>Current Requirements</u>: Health insurers are required to:
  - Limit the annual hospital rate increases to a CMS benchmark.
  - Promote adoption of non-FFS payment methodologies, e.g., DRG, APC, case rates, etc.
  - Include quality performance measures as a component of the payment methodology.
  - Include terms that define the parties' mutual obligations for greater administrative efficiencies.
  - Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO).
  - Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

4. Payment Reform: Promote Population-based Contracts

- New Requirements: Health insurers are required to expand payment reform efforts to:
  - Promote population-based contracting by meeting the following percentage targets for covered lives covered by population-based contracts:
    - By end of 2015: 30% with upside risk
    - By end of 2016: 45% with upside risk; 10% with upside and down-side risk
    - By end of 2017: 60% with upside risk; 20% with upside and down-side risk

4. Population-based Contracting (cont'd)

- Rationale for Population-Based Contracting Targets
  - ACOs are emerging in RI within large health care systems, but currently only provide care to approximately 20% of covered lives.
  - To derive benefit of population-based contracting more covered lives need to be covered.
  - Setting reasonable targets provides impetus for expanding ACO formation.
  - Experience elsewhere consistently indicates that significant transformation does not occur until entities accept downside risk, *but entities must be ready*.

4. Payment Reform: Alternative Payment Methodologies

- New Requirements: Health insurers are required to annually increase use of alternative payment methodologies that mitigate FFS volume incentives for hospital services, medical and surgical specialty services, and primary care services.
- Rationale
  - Reducing FFS as a payment methodology will mitigate volume incentives which increase the overall cost of care.
  - Replacing FFS payments with alternative payment methodologies will provide incentives for higher quality and more efficient health care services and improved population health.

Alternative Payment Methodologies (cont'd)

- New Requirements: Commissioner will convene an Alternative Payment Advisory Committee by January 1, 2015.
  - Charged with submitting a schedule for increasing percentage of hospital, primary care and other medical/surgical expenses paid by non-FFS methodologies
- Rationale
  - OHIC wants to continue collaborating with key stakeholders to promote delivery system transformation.

4. Payment Reform: Limiting Cost Increases

- Requirement: Health insurers must promote affordability by:
  - Limiting hospital annual rate increases, including quality incentive payments, to the U.S. CPI-Urban less Food and Energy for the NE Region and assuring that at least 50% of annual increases are linked to performance incentives.

4. Payment Reform: Limiting Cost Increases (cont'd)

- New Requirement (cont'd)
  - Limiting increases to the ACO's annual risk-adjusted budget for total medical expenses to the U.S. CPI-Urban less Food and Energy for the NE Region **plus** 1%
  - Requiring ACO and hospital contracts to include transparency provisions

4. Limiting Cost Increases (cont'd)

- Rationale for cost increase limits based on U.S. CPI-Urban
  - OHIC seeks a credible benchmark appropriate for both hospital rate increases and ACO budget increases
  - U.S. CPI-Urban Less Food and Energy is the most commonly use indicator of consumer cost-of-living change and is a stable benchmark with limited fluctuation
  - It can readily be used to create a differential between hospital- and ACO-allowed increases to create a possible incentive for hospitals to participate in ACOs

4. Payment Reform: Limiting Cost Increases

- New Requirement: On or before January 1 of each year the Commissioner will solicit comments from stakeholders concerning whether the population-based contract budget limit and transformation targets should be adjusted to:
  - Maintain the appropriate spread between ACO and hospital benchmarks to provide effective incentives for hospitals/providers to participate in ACOs
  - Adjust the annual ACO budget increase limits to account for unanticipated, profound macroeconomic events or significant changes in utilization/cost compromising the integrity of the budget increase limit
  - Create more appropriate transformation targets

4. Limiting Cost Increases (cont'd)

- Rationale:
  - Provides opportunity to adjust incentives for providers to join ACOs in the event that the "facts on the ground" indicate a need to do so
  - Provides "safety valve" in the event of unanticipated events that significantly alter expected health care utilization and costs (either up *or* down)
  - Provides an opportunity to adjust transformation targets based on pace of evolution of providers

4. Payment Reform: Continuing Requirements

- Health insurers are required to promote quality incentive programs that include:
  - Measures from the CMS Hospital Value-based Purchasing Program for Medicare
  - Measures regarding management of chronic conditions and high-risk patients
  - Measures of the effectiveness of the transitions of care program developed by the Medicare QIO
  - No advanced payment of quality payments
- Hospital contracts must also define mutual obligations for greater administrative efficiencies, and require active participation in OHIC's Administrative Simplification Work Group.

4. Continuing Requirements (cont'd)

- Rationale
  - Existing requirements have generally been effective.
  - Hospitals continue to have opportunities to improve quality.
  - Administrative simplification is an on-going challenge that needs to be further addressed.

5. Data Collection and Evaluation

- Health insurers will be required to submit the following quarterly reports:
  - Primary Care Spend Report
  - Care Transformation Report
  - Payment Reform Report
- OHIC shall report to HIAC as follows:
  - Annual monitoring report describing the status of progress in implementing the Affordability Standards
  - On or before October 1, 2018 an evaluation of the Affordability Standards plus options for improving their effectiveness

Data Collection and Evaluation (cont'd)

- Rationale
  - Data are needed to track implementation, understand effectiveness and indicate areas of needed change.
  - Insurers have access to needed data and are capable of collecting and reporting requested data.

Planned Schedule

- October 21: Receive HIAC feedback
- Week of October 27: Publish proposed regulation
- Week of November 10: Hold public hearing
- December 1: Close public comment period
- December 10: Revise regulations, as appropriate
- December 19: Issue final regulations