

**Affordability Standards:
Proposed Framework for Select Recommendations**

Standard 1 (Primary Care Spend)

The Council voted to adopt the following Bailit Recommendations

1. Update benchmarking study to determine whether the target needs adjusting
2. Continue to increase the percent of funding directed to non-FFS activities
3. Expand types of non-FFS spending to items that:
 - allow risk-bearing entities to better manage their patients (e.g., develop analytic capacity)
 - promote behavioral health/primary care integration
 - share support among small and independent practices to become medical homes
 - promote evidence-based, community-based care initiatives
4. Require insurers to reallocate unearned quality incentive funds to other primary care providers that did meet quality standards, targets or requirements.

These recommendations reinforce OHIC’s commitment to a primary-care-led health care system and tailors this standard to emerging market conditions. The updated benchmark study and expanded types of non-FFS spending encourage payers to fund initiatives that promote value-based care in an evolving delivery system.

Further, the proposal encourages strategic spending of primary care dollars by offering additional incentives for pioneering and high-quality providers that meet insurers’ quality targets.

Standard 2 (Medical Home)

The Council voted to adopt the following Bailit Recommendations

- (1) Retain current program structure and quickly expand both CSI and proprietary PCMHs
- (2) Transform CSI into a parameter-setting entity with aggressive expansion targets
- (3) End proprietary PCMH and require insurers to expand CSI
- (4) End CSI and require insurers to quickly expand their specific medical home programs.

Proposed Framework for Recommendations:

(A) Proposal

Accept proposal #1 and develop operational definition for “quickly expand”.

Enhance the status quo by establishing voluntary best practices moving towards standardized operations for PCMHs and other collaborative, multi-stakeholder value-based payment designs, including:

- o Contracting techniques
- o Collaborative culture and governance
- o Reporting requirements (quality, utilization, cost)
- o Data collection and review of identified results

(B) Rationale

The above proposal streamlines, from a payer and provider point of view, the administration of patient-centered medical homes without stifling the organic and innovative growth of payer-led efforts. The standards begin as voluntary best practices rather than regulatory requirements and will move towards institutionalized standards. They can be applied to PCMHs and future value-based arrangements, such as ACOs. This arrangement communicates OHIC’s desire to coordinate and spread the lessons of a strong, successful all-payer PCMH while maintaining operational flexibility.

Standard 3 (Currentcare)

The Council voted to adopt the following Bailit Recommendations:

1. Retain the standard as is and continually monitor to determine whether HIE benefit has been realized
2. Based on future assessment, consider whether Currentcare should qualify as Primary Care Spend
3. Limit the percentage of non-FFS spending that may be directed to CurrentCare to avoid undercutting direct PCP support.

Proposed Framework for Recommendations:

(A) Proposal:

- a. Accept Recommendations #1, 2 and 3
- b. To increase Currentcare enrollment and use at point of service, require payers to fund programs such as the following (programs will be subject to OHIC guidelines and informed by stakeholder input):
 - i. Integrate Currentcare into the physician's workflow and train physicians on how to best "use" Currentcare **and**
 - ii. Encourage Currentcare sign-up at the time of enrollment with a standard form, sign-up process, or other direct-to-member incentives to enroll.
- c. Allow payers to use primary care spending to achieve the above objectives. Data, reporting and a future assessment would be required to validate such expenses.
- d. Encourage the use, by OHIC and payers, of community resource organizations and state agencies such as HSRI and RIPIN/RIREACH, CVS Minute Clinics, Medicaid, Dept. of Elderly Affairs to explain process and enroll consumers
- e. Re-visit the ease and efficiency of the sign-up process to determine if adjustments are needed to program protocols

A. Rationale

Given the convergence of a number of different electronic medical record systems, it is critical that there exists a common point of provider access to a patient's health information. Currentcare provides such access to all patients and providers willing to "sign on." Though important to increase the enrollment into the Currentcare system, equally important is facilitating the use of this program. As institutional and professional providers build Currentcare into their work flow, the value of a portal for health information exchange not only becomes evident but will feed enrollment as well. This proposal will enhance participation, facilitate provider use, improve coordination of care.

Standard 4 (Payment Reform Standard)

Bailit Recommendations:

- (1) Require insurers to contract with providers on a population basis for a specified percentage of covered lives (*increasing each year*)
- (2) Require insurers to include downside risk in population-based contracts for a specified percentage of covered lives (*increasing each year*)
- (3) For population-based contracts, replace the annual, price-based revenue limit with a comparable, population-based revenue limit. Retain the price cap as-is for FFS-based contracts.
- (4) Establish governance standards for risk-bearing providers that promote primary care, and care coordination from a medical home.
- (5) Require payments to include a quality component
- (6) Collect outcome measures to determine if desired results for this Standard are realized.

Proposed Framework for Recommendations:

(A) Proposal

Accept the above recommendations and modify #2 in the following way.

Encourage, but do not require, insurers and providers to engage in downside risk arrangement to satisfy the annual price cap.

For Recommendation #1, OHIC shall work with insurers and providers to determine targets, appropriate populations and, if relevant, minimum standards for assuming downside risk. The targets should take into account the State Innovation Model (SIM) structure, which encourages the formation of Accountable Care Organizations and ACO-like groups.

For the third recommendation, develop a revenue limit for annual increases in population-based contracts that serves the same affordability function as the Medicare price index limit in current Standard No. 4. Determine the appropriate outcome

measures that would validate the effectiveness of the Standards and, before requiring additional data submissions from payers, review whether current or planned data collection efforts (for instance, APCD) could satisfy the data collection need.

(B) Rationale

These recommendations compliment the structure that SIM lays out: movement towards ACO and ACO-like entities with integrated services and some downside risk. It also recognizes the uniquely transformative power of downside risk for organizations that are financially and operationally prepared while not requiring the immediate implementation of such programs.

The third recommendation was designed for a fee-for-service payment system and to work with the standard's limit on annual hospital rate increases (Medicare price index + 1%). As payment reform encourages contracts to move away from fee-for-service methods, a population-based revenue limit is needed in those situations where providers have significant market power. With respect to the fourth, fifth and sixth Bailit recommendations, additional research and stakeholder consultation is needed to develop appropriate governance and measurement standards.

Cross-Standard Recommendation

A. Bailit Recommendations:

- (1) Premiums paid and charged incurred by fully insured and ASO (administrative services only) accounts should accurately and equitably reflect the proportionate cost of the system reform programs that benefit all covered lives.

B. Implementation Proposal:

OHIC can identify those Affordability Standard programs that benefit all covered lives (insured and self-insured), and ascertain the PMPM cost of those programs. During the rate review process, OHIC can collect and analyze how carriers' allocation of system benefit costs so that the allocation is accurate and equitable.

C. Rationale

As the percentage of covered lives enrolled in self-insured plans increases, OHIC should develop a mechanism to ensure that carriers and other third party administrators pay their fair share of the cost of system reform Affordability Standard programs that benefit the entire population.