Assessment of the OHIC Affordability Standards: *Recommendations for Standards 1 - 3*

Rhode Island Health Insurance Advisory Council
September 24, 2013

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Agenda

1. Plan for Review and Discussion of Recommendations
2. Overview of Findings and Recommendations
3. Reminder of Key Findings for Each Standard
4. Recommendations for Each Standard
5. Discussion

Calendar

- **September 24**: Present and discuss recommendations for:
  - Affordability Standard 1 (primary care spend)
  - Affordability Standard 2 (medical home support)
  - Affordability Standard 3 (support Current*Care*)
- **October 15**: Present and discuss recommendations for Affordability Standard 4 (payment reform)
- **November 19**: HIAC consideration of Affordability Standards recommendations and possible HIAC recommendations to OHIC

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Quick Refresher: The Affordability Standards

1. **Primary Care Spending**: Expand the percentage of total medical payments made to primary care by 1% per year from 2010 to 2014; increase funding directed to non-fee-for-service activities by 5 percentage points per year

2. **Medical Home Support**: Spread the adoption of the patient-centered medical home

3. **Support Current*Care***: Financially support Current*Care*, Rhode Island's health information exchange

4. **Reform hospital payment arrangements** via six hospital contracting conditions

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Bailit's Overall Assessment

1. The Standards have broad-based support and promote good public policy to lower costs and promote primary care services.
2. The State's activities created momentum for real change.
3. Having the state as a partner was essential to making change happen "on the ground."
4. Standards appear to have been effective in:
   a. promoting Medical Home transformation, and
   b. slowing rate of hospital cost increases.
5. The Standards have been successful in changing payer-hospital contracting dynamics and in advancing outcome-oriented quality programs in hospitals.

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Overall Recommendation

- Extend the Affordability Standards through 2018 with modifications that address specific concerns identified during the assessment of the Affordability Standards and the realities of the changing marketplace.

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Affordability Standard #1

1. **Primary Care Spending: Expand the percentage of total medical payments made to primary care by 1% per year from 2010 to 2014; increase funding directed to non-fee-for-service activities by 5 percentage points per year**

2. Medical Home Support: Spread the adoption of the patient-centered medical home

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Bailit's Assessment of Standard 1 (primary care spend)

- Through 2012, payers have met the requirement to increase primary care spend by 1% annually and to direct a specified proportion to non-FFS payments.
- Primary care spend funds have been a vital source of funding to build primary care practice infrastructure to support practice transformation.
- Benefits have gone to a targeted group of primary care providers participating in CSI and payer-specific medical home initiatives, so impact has been limited.
- Impact on cost and utilization will not likely be realized until more primary care practices have transformed into medical homes.

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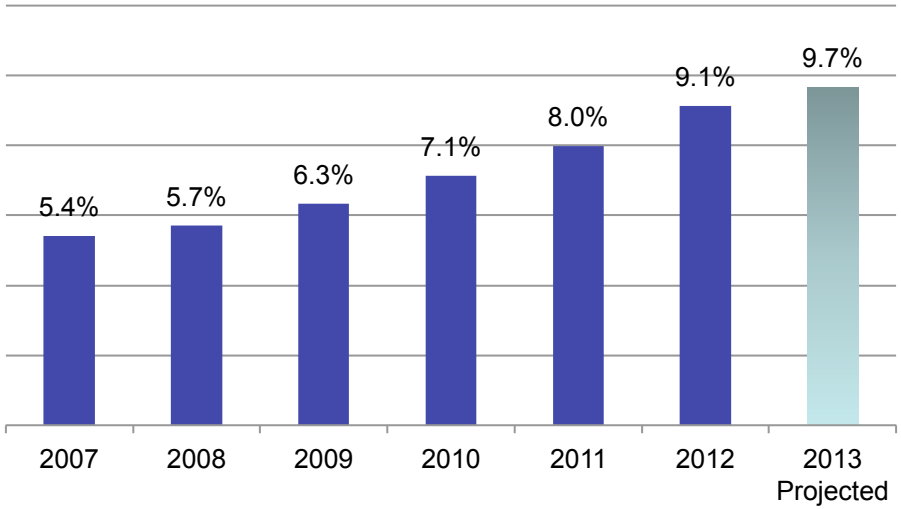
Standard 1:
Primary Care Spend Target in Aggregate

- **Findings:** achievement of 1% Primary Care Spend target
  - Increases in primary care spending started prior to the standard's implementation in 2010, with greatest increases in 2011 and 2012
  - Share of spending on primary care increased from 5.4% in 2007 to 9.1% in 2012 - an increase of 69%

Primary Care Spending as Percent of Total Medical Spending, 2007 - 2013



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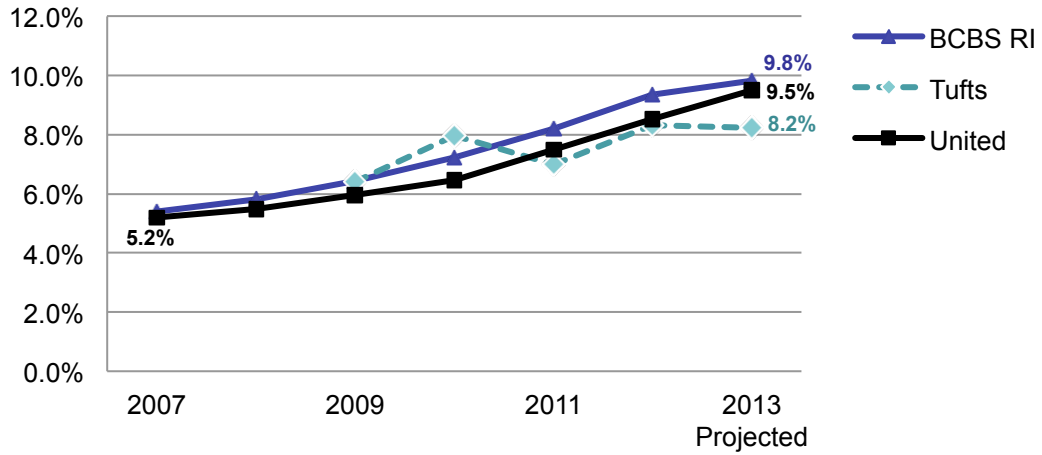
Standard 1:
Primary Care Spend Target by Insurer

- BCBSRI met requirements in 2011 (1%), 2012 (1.2%); projected for 2013 (0.4%)
- United met requirement all three years, but 2013 projection is based on a decline in medical spending

Primary Care Spending as Percent of Total Health Spending by Company,
2007-2012 (Actual) and 2013 (Projected)



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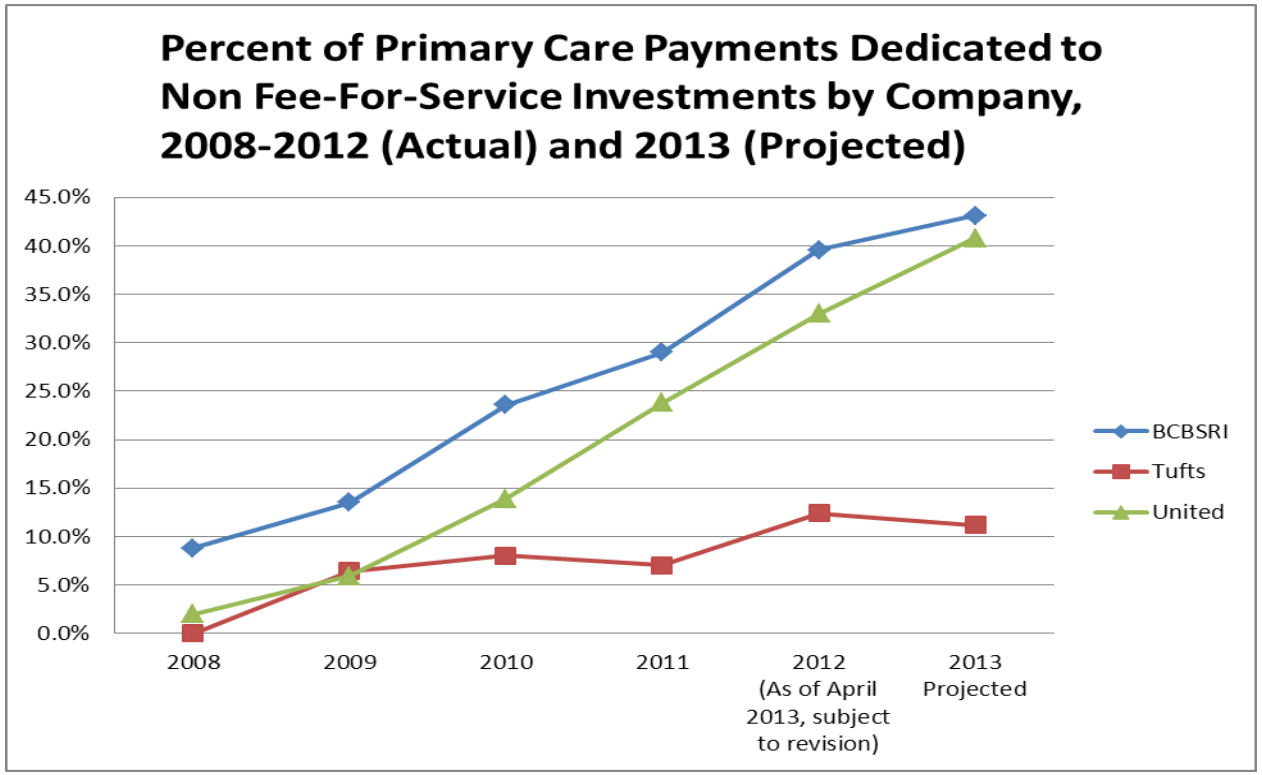
Standard 1: Achievement of 30% Spending on Other-Than-FFS Requirement

- **Findings:** BCBSRI and United have achieved the goal of at least 30% of primary care spend on other than FFS. Tufts, not subject to the standard, has not.



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Standard 1: Recommendations

1. Retain the requirement that plans meet the primary care spend target, which is currently set at 1% increase annually.
   - Target helps sustain gains
   - To determine if the 1% target should be adjusted, update the initial benchmark study
2. Continue to increase the percentage of required funding for non-FFS activities, which is 40% in 2013 and will be 45% in 2014. Assess % increase in benchmark study.

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Standard 1: Recommendations (cont'd)

3. Expand the definition of non-FFS activities to recognize changing marketplace to allow support for:
   - Programs that build risk-bearing entity infrastructure to successfully assume population-based risk, such as developing data informatics capabilities
   - Programs that promote behavioral health – physical health integration within the primary care practice, such as funding development of universal care plan or software that promotes BH provider – PCP communications
   - Building shared support resources among small, independent practices, such as shared care managers, pharmacists, data analysts
   - Development of evidence-based community-based care initiatives, such as transitions-of-care programs that involve a cross-continuum group of providers

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Affordability Standard #2

1. Primary Care Spending: Expand the percentage of total medical payments made to primary care by 1% per year from 2010 to 2014; increase funding directed to non-fee-for-service activities by 5 percentage points per year

2. **Medical Home Support: Spread the adoption of the patient-centered medical home**

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Bailit's Assessment of Standard 2 (Medical Homes)

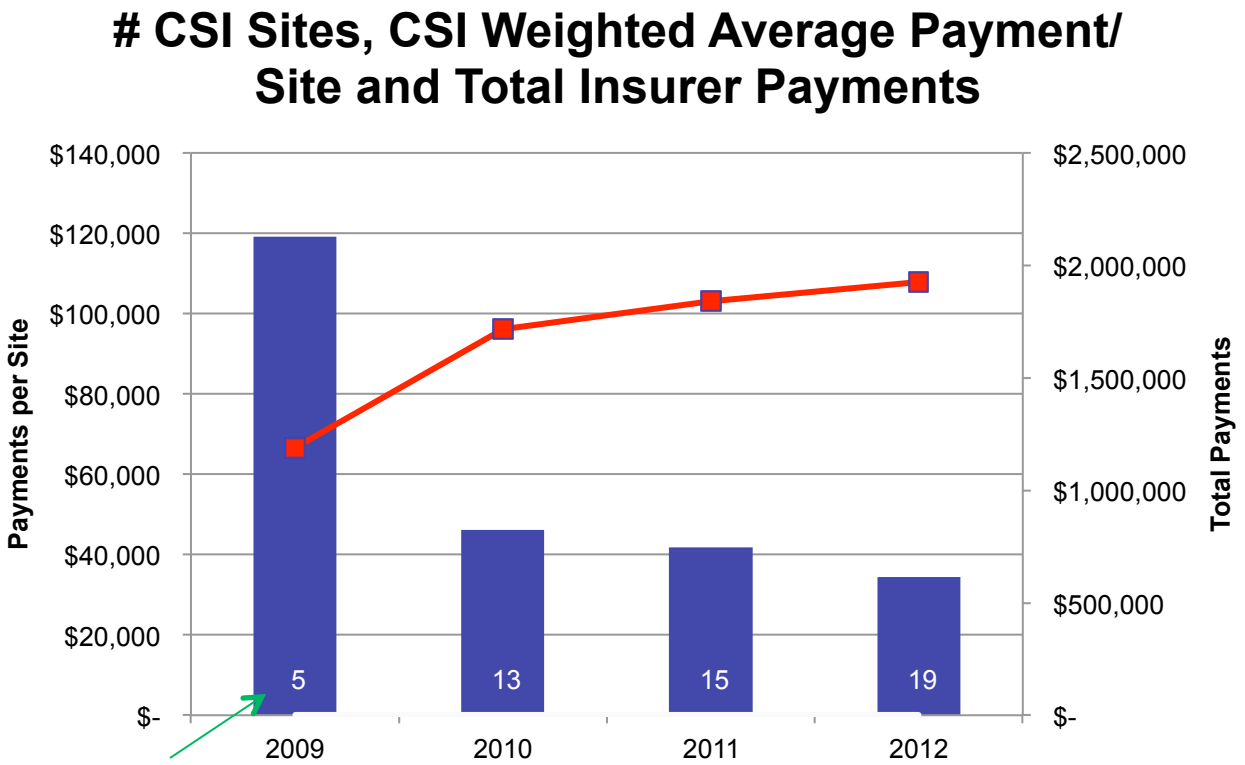
- Standard 2 is considered by all stakeholders to be a "game changer" in RI.
  - Created a common structure that unified program for providers
  - BCBSRI and United have their own medical home initiatives that follow CSI structure and are available to non-CSI practices
  - Allowed Tufts as a new payer to quickly integrate into the program
- To reach the "tipping point" and achieve desired transformation throughout RI, support for medical homes must be significantly expanded to additional practices.

Standard 2 Assessment (cont'd)

- Based on data submitted by payers, it is estimated that 40% of PCPs in Rhode Island are associated with practices in some state of medical home transformation.
- Significant change in practice dynamics may become evident in plan-wide utilization and cost data when a sufficient number of practices have transformed.

Standard 2: Promote Medical Homes

- **Findings**: Three major payers have provided on-going support to CSI practices and the number of sites has grown.



Standard 2: Recommendation

- Retain standard and consider three options to bring PCMH to scale quickly:
  - Retain current program structure and quickly expand both CSI and insurer-specific programs
  - End CSI and require insurers to quickly expand their specific PCMH programs
  - Transform CSI into a parameter-setting entity with contracting and program implementation done by the insurers. Set aggressive expansion targets

Affordability Standard #3

1. Primary Care Spending: Expand the percentage of total medical payments made to primary care by 1% per year from 2010 to 2014; increase funding directed to non-fee-for-service activities by 5 percentage points per year

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Bailit's Assessment of Standard 3 (Current*Care*)

- OHIC changed the standard from requiring payers to provide EMR incentives to requiring payers to support the state's health information exchange (Current*Care*).
- Current*Care* is a statewide Health Information Exchange that will enable participants to share clinical data among providers and with patients.
- Although payer support for Current*Care* does not directly benefit primary care, having an HIE should ultimately improve quality of care by sharing clinical information among affiliated providers.

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Standard 3: Recommendation

1. Retain the current requirement and in the future assess whether an HIE benefit has been realized.
2. Limit the percentage of non-FFS spending that may be directed to Current*Care* to avoid diminishment of direct PCP support.

Conclusion

- The Affordability Standards have had a profound impact on health care in Rhode Island by:
  - promoting primary care transformation
  - changing the dynamics between payers and hospitals to increasingly emphasize quality and efficiency
  - creating a sense of mutual benefit and cooperation among payers and between payers and providers
- The state can address consumer affordability interests and help promote and sustain broad-scale change to that end.
- Recommendations for Affordability Standards 1-3 focus on updating requirements to assure continued beneficial impact.

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Discussion Questions

- Do you agree with the direction of the recommendations?
- What changes to them or alternatives, if any, do you think OHIC should consider?