

System Affordability Standards for Health Insurers in Rhode Island

Carrier Investment Plans

Draft Summary, for discussion with HIAC, PCPAC

Tuesday, October 20th, 2009



OHIC Affordability Priorities and Standards

Standards apply to Commercial Insurers in RI (Developed by HIAC in 2008/2009)

System Affordability Priorities:

“Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care...”

1. Expand and improve the primary care infrastructure in the state -- with limitations on ability to pass costs to premiums
2. Spread Adoption of the “Chronic Care Model” Medical Home
3. Standardize electronic medical record (EMR) incentives
4. Work toward comprehensive payment reform across the delivery system

System Affordability Standards:

1. Health plans **will increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years.** This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.
2. As part of the increased primary care spend, **health plans will promote the expansion of the CSI-Rhode Island project or an alternative all payer medical home model with a chronic care focus** by at least *25 physicians in the coming year¹* and
3. Health plans will promote EMR incentive programs that meet or exceed a minimum value.
4. Health plans commit to **participation in a broader payment reform initiative** as convened by public officials in the future.

(1) Italicized language was refined in September 09, # new participating docs increased from 15 to 25

Standard #1

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Target

Increase to 10.9% the average commercial medical spend in RI for primary care; add 5 points to the percentage of total medical spending that goes to primary care statewide by 2014. Estimated value of new standard: cumulative \$120 Million over **five years.** *The target assumes there will be the ability of primary care practices to make necessary changes for the investments.(1)*

Goals

- ❖ Increased primary care satisfaction
- ❖ Increased primary care supply – overall and as a percentage of RI physicians
- ❖ Reduced incidence of ambulatory care sensitive hospitalizations and ER visits
- ❖ Bending the curve: reduced overall Rhode Island medical trend

Implementation Guidance

Each insurer must submit a plan to OHIC that demonstrates how the increase will be achieved, and that it will be accomplished in a manner that does not contribute to the increase of premiums, with an emphasis on innovative contracting and payment and primary care system investment, not merely fee schedule manipulation. *OHIC will submit the plans to public input and review.*

(1) Italicized language is OHIC addition in September 09.

Standard #1: What we have done

- ❖ Developed initial investment budgets, overall and by carrier
- ❖ Planning with Department of Health on Evaluation Measures
- ❖ Shared draft carrier investment plans with Department of Health's Primary Care Physician Advisory Council (Leadership group of primary care clinicians) for advice and feedback to OHIC
- ❖ Finalized carrier investment plans – how they intended to meet the targeted investment

By the Numbers

\$928 Million

5.8%

Total Rhode Island Fully Insured Medical Spend, 2008
Primary Care “share”

\$53 Million

Current RI Primary Care Spend³ (Fully Insured Comm’l only)

Incremental Primary Care Spend²

\$11 Million

Yr 1 (2010)

\$24 Million

Yr 2 (2011)

\$39 Million

Yr 3 (2012)

Average Incremental Spend per PCP FTE¹ (vs. baseline year 2008)

\$15,000

Yr 1 (2010)

\$32,000

Yr 2 (2011)

\$52,000

Yr 3 (2012)

1. For illustration only. Based on 750 PCP FTEs in RI and 1035 total FTEs. Assumes no changes in PCP count, spend is 100% allocated to primary care providers, investment is distributed evenly and payment reform to accommodate is possible – *none of these is likely.*

2. Based on final 2008 base year data, submitted by carriers to OHIC October, 2009

3. Primary Care spend = Money spent to Peds, FPs and IMs, plus approved projects.

Meeting Affordability Standard #1 for 2010

Given the Goals stated by HIAC, Key Policy and Strategy Tradeoffs:

- ❖ Target high performing sites or spread broadly?
- ❖ Many initiatives or few?
- ❖ Coordinate between plans or build on plan-specific initiatives and strengths?
- ❖ Incentives: how high to set the bar? Process and Structural vs. Outcomes?

Meeting Affordability Standard #1 for 2010

Summary of Plans by Health Insurers to Increase Primary Care Spend

<u>Total (\$)</u>	<u>Portion</u>	<u>Category</u>
\$5.0 M	46%	Patient Centered Medical Home (all payor and plan-specific)
\$1.2 M	11%	Electronic Medical Records Incentives
\$0.8 M	8%	FFS Fee Improvements
\$0.6 M	5%	Loan Repayment
\$3.4 M	31%	Other, carrier-specific investments (Pay for Outcomes, Pay for Structure, Benefit changes to increase volume, etc.)
\$11.0 M	100%	Total Year 1 Planned Investment, 2010

(See appendix for details by plan)

Clinician Feedback and Suggested Follow Up

Feedback:

- ❖ Bigger bets – focused investment on a few items
- ❖ Coordinate efforts among plans wherever possible
- ❖ Development of Patient Centered Medical Homes are top priority. Means more dollars to fewer practices – at least initially.
- ❖ Medical Home initiative does not capture all practices. Need an additional, coordinated focus on after hours/Emergency room use.
- ❖ Another evaluation measure focused on population health.

Resulting Plan Adjustments:

- ❖ **CSI Expansion:** Moved from 15 physicians to 25*
- ❖ **New Coordinated Program: ER Diversion**
PCPAC coordinate planning - starting with data review - for ER Diversion Plan/Incentive Program to be implemented in 2011

* Implementation date also specified. Final carrier plans reflect 25 physician expansion AND 4/1 implementation date.

Proposed Oversight and Monitoring

Standard #1, 2009/2010

Primary Care Investment Plans (Overall)

OHIC, with PCPAC, HIAC support

All Payor Patient Centered Med Home

CSI

EMR Incentives and Adoption

RIQI

ER Diversion planning

PCPAC

Loan Repayment

RI Foundation

FFS Fee Improvements and other carrier
specific investments

OHIC

System Evaluation Measures

Department of Health to OHIC

BCBSRI Investment Plan Detail*

Category	Description	% (Final)
1) Patient-Centered Medical Home	Funding to support adoption of PCMH. Includes: 1) BCBSRI-only program, focused on complex members, with funding for infrastructure (e.g. nurse case manager) and PMPM payments 2) expansion of CSI-RI program	50.0%
2) Electronic Health Record	Funding to support implementation and use of electronic health records. Includes: 1) funding for pre-implementation readiness assessment for new EHR users 2) funding for new EHR users (including training/implementation support) 3) funding for existing EHR users 4) enhanced fee schedule for qualified providers	10.0%
3) Behavioral Health and Primary Care	Funding to improve behavioral health access and communication between primary care and behavioral health providers. Includes support for co-location of behavioral health in primary care practices and for the development of collaborative agreements (at least 5 new co-located practices and several collaborative agreements)	5.0%
4) Value-based Benefits	Co-pay waivers to incent use of targeted PCPs	2.5%
5) Delivery System Improvement (Specialist Focus)	Funding for specialist providers to improve coordination with primary care. Includes 1) Enhanced fee schedule for specialist EHR users who coordinate care/communicate w PCPs 2) bonus based on PCP satisfaction with specialist services / care coordination 3) develop principal care centers (specialist "medical homes" - Ex. end stage CHF/Cardiology) 4) lump sum funding for "urgent" access to specialists as alternative to ER/urgicenter	5.0%
6) Delivery System Improvement (Hospital Focus)	Support the development of a patient-centered medical "neighborhood" - new contracts/ initiatives to support care coordination among hospital, specialists , and PCPs [i.e. funding to hospital for NCM who provide care coordination services to multiple local PCP practices]	5.0%
7) Pay for Performance	Incentive to promote more cost effective drug utilization [i.e. therapeutic substitution for cholesterol lowering /PPI drugs] - gainsharing with "non-engaged" PCPs	7.5%
8) Accountable Care Organizations	Incentives [lump sum grants] to encourage the development of accountable care organizations. Examples include: 1) incentives for smaller practices to merge or join larger organizations 2) incentives for quality improvement activities [i.e. educational meetings] 3) incentives for practices to improve access by extending office hours 4) Discharge Care Coordination	5.0%
9) Fee Schedule Increase		5.0%
10) Loan Repayment	Funding available in the Rhode Island Primary Care Educational Loan Repayment Program	5.0%

100.0%

*The programs listed here are subject to implementation. Actual spending may differ from projected because of change in program details, changes in implementation, or variation in number of providers who meet standards of program. Health plans will be held accountable for achieving overall primary care spend rate targets.

UHC Investment Plan Detail*

Investment Plan Detail	Description	Revised 10/13/09
Structure and Process Incentives:		45%
CSI All payer medical home	Health plans commit to establish a NCOA certified Medical Home and commit to supporting an expansion of either the Rhode Island Chronic Care Sustainability Initiative or an alternative all payer medical home model. THealth plans commit to establish a NCOA certified Medical Home and commit to supporting an expansion of either the Rhode Island Chronic Care Sustainability Initiative or an alternative all payer medical home model. As directed by the health insurance commissioners office, UHC assumed that the CSI project will increase by 25 PCP FTEs effective 4/1/10.	25%
EMR Incentive Programs	Health plans to commit to implementation of a certified electronic medical record (i.e. certification by the Commission for Healthcare Information Technology (CCHIT) physician primary care and/or specialty care EMR adoption incentive that pays: (i.e. United: \$2,500 or more, up to a practice maximum of \$7,500) in bonus in the form of pay-for-participation payments equal to \$.60 PMPM or in increased fees, totaling in value at least 3% great than the insurer's standard fee schedule.	13%
Primary Care QTIAC Requests	UHC Quality and Technology Investment Advisory Council (QTIAC) consists of constituents who guide and participate in the selection of community quality and technology health care initiatives based on projects' value to the health care community, including its value to providers, employer and consumers of the RI health care system. QTIAC will invest in certain primary care initiatives such as Loan Forgiveness, RICCC, and others.	7%
Outcomes Incentives:		30%
Pay for Performance	Practice Rewards - a United Healthcare National program that offers financial recognition for physicians who have met the highest quality and cost efficiency criteria under the United Health Premium Designation program. A 5% fee schedule differential recognizes physicians who meet or exceed guidelines for quality and cost efficient care. A 3% fee schedule differential recognizes those physicians and facilities who have shown improvement from the previous year (this is new for 2010). United expects more will be paid under this program in 2010 as more physicians exceed guidelines and for the new improvement program	25%
After hours Incentives	Additional payment to physicians who offer extended hours or provide services in office to their patients resulting in lower ER visits and other cost savings advantages	5%
Fee Schedule, bonus enhancements and volume enhancements:		25%
Shift of Services	Plan design changes currently under review expected to shift utilization to PCP offices	5%
Vaccine Administration	Increase in physician and flu clinic administration fees.	20%
		100%

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