

# Oregon Health Policy Board

## AGENDA

August 6, 2013

Market Square Building  
1515 SW 5<sup>th</sup> Avenue, 9<sup>th</sup> floor  
1:00 to 4:15 p.m.

Live web streamed at: [OHPB Live Web Streaming](#)

#	Time	Item	Presenter	Action Item
1	1:00	Welcome, call to order and roll <b>Action item:</b> Consent agenda: 7/2/13 minutes	Eric Parsons, Chair	X
2	1:05	2013 Legislative session recap	Bruce Goldberg	
3	1:45	Health System Transformation August Quarterly Report review	Tina Edlund	
4	2:00	Coordinated Care Model Alignment workgroup	Jeff Scroggin	
	2:15	Break		
5	2:30	Rate review and transparency opportunities	Joel Ario, Manatt Health Solutions	
6	3:45	Public testimony	Chair	
7	4:15	Adjourn		

### **Next meeting:**

September 10, 2013

8:30 a.m. to noon

Market Square Building

1515 SW 5<sup>th</sup> Avenue, 9<sup>th</sup> floor

**Oregon Health Policy Board**  
**DRAFT Minutes**  
**July 2, 2013**  
**8:30 a.m. to 12 p.m.**  
**Market Square Building**  
**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**  
**Portland, OR 97201**

**Item**

**Welcome and Call To Order**

Chair Eric Parsons called the Oregon Health Policy Board (OHPB) meeting to order. All Board members were present, except Felisa Hagins, Brian DeVore, Carlos Crespo.

Tina Edlund and Bruce Goldberg were present from the Oregon Health Authority (OHA).

**Consent Agenda:**

The meeting minutes from June 4, 2013 were unanimously approved.

**Director's Report and Legislative Update – Bruce Goldberg**

Dr. Goldberg provided an update on current legislative activity:

- The medical liability, hospital assessment and four bills aligning Oregon with the Affordable Care Act all passed.
- The work over the next two years will focus on five major domains:
  - Moving health system transformation forward
  - Continuing to transform OHA,
  - Implementing the Affordable Care Act,
  - Implementing mental health system change, and
  - Eliminating health disparities
- A more detailed report on 2013 legislation that affects OHA will be presented at the August Board meeting.

**Medicaid Advisory Committee (MAC): Strategies on person- and family-centered engagement – Karen Gaffney, MAC co-chair; Oliver Droppers, OHA**

The Medicaid Advisory Committee is a federally mandated body which advises the Health policy board, the Office for Oregon Health Policy Research and the Health Authority on the operation of Oregon's Medicaid program, including the Oregon Health Plan.

Starting in January, 2013, the committee began focusing on strategies to support the goal of helping individuals become engaged in their own health and health care. Gaffney and Droppers presented on the MAC's recommendations for person- and family-centered engagement in health care, a direct route to obtaining Oregon's goals of better health, better care and lower costs.

Key recommendations included:

- OHP members provide information to providers and the OHA about how to effectively address barriers to individual and family engagement and improve the health system.
- Ensure ongoing education and training on evidence-based best practices for person- and family-centered engagement in health and health care.
- Leverage resources that support evidence-based best practices for person- and family-centered engagement and activation in health and health care.
- Create opportunities across all levels of the health system to support OHP members as integral partners in Oregon's Health System Transformation.
- Coordinate the adoption and spread of evidence-based best practices for person- and family-centered engagement in health and health care.

The Board requested that MAC determine the top two priorities from the actions and strategies as well as who will have responsibility and how the priorities will be accomplished.

Tina Edlund indicated House Bill 2859 creates a taskforce with legislators and their initial report is due in

November 2013, MAC's report should be presented to the task force as a solid foundation for them to build on.

View the *Strategies on Person- and Family-Centered Engagement Presentation*, [here](#), starting on page 49.

#### **Work plan to address Governor's request – Jeff Scroggin, OHA**

Jeff Scroggin reviewed the proposed timeline and work plan developed to address the Governor's request to have the board make recommendations on coordinated care model alignment and on strategies regarding rate review, cost shifting, decreasing premiums and increasing transparency and accountability.

Key aspects of the work plan include:

- Forming recommendations on strategies to mitigate the cost shift and decrease health insurance premiums.
- Forming recommendations on strategies to increase overall transparency and accountability.
- Establishing a coordinated care alignment work group to form recommendations on strategies that move PEBB, OEBB, Cover Oregon and the commercial marketplace toward one characterized by models of coordinated care.

The final deliverable is the *OHPB healthcare cost sustainability recommendations for action: Recommendations to Governor Kitzhaber and the Oregon Legislature by Dec. 31, 2013*, which include potential statutory and regulatory changes.

Governor Kitzhaber's letter to the Oregon Health Policy Board and the draft work plan proposal can be viewed [here](#), starting on page 72.

#### **Coordinated Care Model Alignment group: Draft charter and charge – Jeff Scroggin, OHA**

Jeff Scroggin reviewed the charter for the coordinated care model alignment group.

An updated and approved charter will be included in the August meeting materials.

View *OHPB Coordinated Care Model Alignment Work Group Charter* [here](#), starting on page 78.

#### **Transparency, Accountability, Coverage and Access framework – Tina Edlund, OHA , Jeff Scroggin, OHA**

Jeff Scroggin and Tina Edlund discussed the framework, focusing on how to better align ACA implementation activities with Oregon's current reform and how it will be known if the charge is being met. Two main areas of focus identified were coverage and access and transparency and accountability. Previous recommendations by the Oregon Health Fund Board were reviewed and the OHA will determine recommendations and possible action items.

*OHPB Framework for: Transparency, Accountability, Coverage and Access* can be viewed [here](#), starting on page 80.

#### **Public Testimony**

The board did not hear any public testimony.

#### **Adjourn**

#### **Next meeting:**

**August 6, 2013**

**1:00 p.m. to 4 p.m.**

**Market Square Building**

**1515 SW 5<sup>th</sup> Ave, 9<sup>th</sup> Floor**

**Portland, OR 97201**

### 2013-2015 Budget Summary

Oregon is keeping our promise to reduce the growth of health care costs while improving the quality of care in our state. Combined with new options for Oregonians through Cover Oregon, our state's insurance marketplace, up to 95% of Oregonians could have health care coverage by 2016.

#### The 2013-2015 budget:

- Based on a public-private partnership where health care is delivered through local coordinated care organizations (CCOs).
- Supports better access to health care in local communities, including a loan repayment program for new primary care providers.
- Substantially increases funding for community mental health for children and young adults so they don't slip through the cracks and face more serious problems later in life.
- Provides more investment in tobacco prevention and cessation to help improve health and lower costs.

#### Reduces wasteful spending

The budget lowers the growth of health care spending by 2 percentage points per capita in Medicaid, reducing waste and inefficiency, while making substantial new investments in community mental health to improve lives and reduce costs into the future.

#### Brings healthcare to more people

The budget makes it possible for more low-income Oregonians to receive health care coverage through the Oregon Health Plan (OHP). This will bring financial stability to hundreds of thousands of people and families, and lower medical debt to local providers. It will end today's "health care lottery" that creates winners and losers depending on whether they were lucky enough for their name to be drawn.

### Legislative Highlights

#### More access to health care

In 2010, the federal government enacted the Affordable Care Act (ACA). The ACA aims to decrease the number of uninsured Americans and reduce the overall costs of health care. During the 2013 Legislative Session, five key pieces of legislation passed to bring Oregon into compliance with the provisions of the ACA, update related programs and help reduce premium costs to consumers.

#### HB 5030

The Oregon Health Authority (OHA) budget for 2013-15 includes federal funding for coverage of approximately 180,000 new low-income adults who will qualify for the Oregon Health Plan under the new ACA guidelines for Medicaid. This will bring people into physical, mental and dental health care who have never been qualified before.

The 2013-2015 budget ends the so-called "Oregon Health Care Lottery," for adults who are qualified for care even under current income limits. Beginning in 2014 through 2016, coverage for those newly eligible for OHP will be funded by the federal government.

# Oregon Health Authority

## 2013 Legislative Highlights

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Additionally, income limits are changing and OHP will be open to adults who earn up to 138 percent of the Federal Poverty Level. That's about \$15,800 a year for a single person or \$32,500 a year for a family of four.

In Oregon, we are doing things differently than other states. New Medicaid enrollees will join local coordinated care organizations, which are designed to provide better care while holding costs down.

### **House Bill 2240-A**

This bill implements federal requirements in the Oregon insurance code and abolishes the Oregon Medical Insurance Program (OMIP) and the Federal Health Insurance Assistance Program (FHIAP), which become obsolete with the provisions of the ACA.

### **House Bill 3458-A**

This bill establishes the Oregon Reinsurance Program, which will help to stabilize rates and premiums for in the health insurance market by providing supplemental reinsurance for insurance carriers.

### **House Bill 2859-A**

This bill updates Oregon's medical assistance programs to reflect federal Medicaid and Children's Health Insurance Program changes. It allows OHA, the Department of Human Services (DHS) and Cover Oregon to share information for purposes of processing eligibility for medical assistance, health insurance exchange, premium tax credits and cost-sharing reductions.

Additionally, this bill establishes an 11-member Task Force on Individual Responsibility and Health Engagement charged with developing recommendations to improve patient engagement and accountability when it comes to their own health, disease prevention and wellness activities.

### **House Bill 2091-A**

The bill also ends the Healthy Kids Connect program and allows children to be quickly transferred to the OHP. Families will be notified of the change and there will be hands-on transition planning.

## **Other Key Initiatives**

### **Hospital Assessment Renewal**

The hospital assessment is a revenue stream created by the Legislature in 2003 to finance OHP services. House Bill 2216 extends the hospital assessment for two more years and also appropriates an additional one percent of the assessment for a hospital transformation and performance fund. It's expected that much of the savings anticipated by the shift to CCOs will come from reduced utilization of hospital services. The fund will help hospitals reduce unnecessary hospital utilization and improve client outcomes.

Additionally, House Bill 2216 extends the long term care facility assessment through June 30, 2020 and requires DHS to take steps to reduce overall nursing facility bed capacity by 1,500 beds by December 31, 2015.

### **Primary Care Loan Repayment**

#### **Senate Bill 440**

This bill establishes the Primary Care Provider Loan Repayment Program within OHA, a requirement of the state's CMS waiver. The program invests \$4 million this biennium for a loan repayment program for primary care physicians who agree to work in rural or underserved communities and to serve Medicaid patients. The new program will help address the need for primary care providers in parts of the state where they are in short supply.

### **Medical Liability Reform**

#### **Senate Bill 568**

This bill requires OHA to adopt a dispute resolution process to resolve disagreements involving termination, extension or renewal of contract between health care entities and CCOs.

### **Cultural Competency**

Limited access to health care disproportionately affects minority communities, creating racial and ethnic health disparities. In order to address these issues, we must develop health-promoting strategies designed to meet the unique needs of the various population groups.

Today the way we gather data from our clients and the general population – about people's ethnicity, race, language preference and disabilities – is inconsistent and insufficient.

#### **House Bill 2134**

This bill creates a uniform standard for demographic data collected by both OHA and DHS. That includes the vital statistics unit in public health, Oregon Health Plan and DHS clients, and grant recipients for OHA agencies.

Accurate data collection will increase our understanding of different populations so that we can do a better job serving them.

#### **House Bill 2611**

This bill requires the 21 health boards that license health professionals to report to OHA how many of those professionals are taking cultural competency trainings every two years. This includes nurses, doctors, chiropractors, massage therapists and home care workers.

The Legislature also gives medical boards the right to include cultural competency education as a prerequisite for licensure.

### **Streamlined Credentialing**

Senate Bill 604, the product of a workgroup consisting of hospitals, insurers, and health care providers, directs OHA to establish a single database that organizations seeking to credential providers must access to obtain the information. This will reduce duplicative efforts by hospitals, doctors, insurers, and health care providers.

## Public Health Initiatives

**SB 375A** creates a Stroke Advisory Committee in the Oregon Health Authority and **SB 728B** creates the State Trauma Advisory Board (STAB) in statute. This bill also provided funding for a full-time position to collect and analyze data related to the state's emergency medical services and trauma system, and to provide the information to the board. The data will enable STAB to make evidence-based decisions in suggesting improvements to the system.

The Legislature allocated \$700,000 General Fund for breast and cervical cancer screening services in **HB 5008**, the budget reconciliation bill. Of this total, about \$400,000 is needed to backfill funding shortfalls in the first year of the biennium, related to reductions in funding from the Komen Foundation, as well as reductions resulting from federal sequestration. The Breast and Cervical Cancer Program currently serves more than 5,000 women a year.

# Oregon Health Policy Board Coordinated Care Model Alignment Work Group Charter

Approved by OHPB on 2 July 2013

## I. Authority

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The Oregon Health Authority (OHA), under Governor Kitzhaber's June 2013 letter to the Oregon Health Policy Board (Board), is establishing a public process to inform healthcare cost containment strategies and recommend delivery system alignment actions.

The goal is a sustainable, affordable, coordinated and high quality health care delivery system.

The Oregon Health Plan (OHP), Oregon's coordinated care delivery model, delivers care through a fixed global budget and maintains costs at a sustainable level. Under this model healthcare is coordinated across the delivery spectrum through locally accountable Coordinated Care Organizations (CCOs). Flexibility to innovate, alternative payment methodologies, and shared responsibility among local providers, patients and health plans are other key aspects of the model. CCOs are charged with delivering healthy outcomes and their ability to meet this charge is measured quarterly through performance data.

As the policy-making and oversight body for OHA, the Board establishes the Coordinated Care Model Alignment Work Group to provide input on potential regulatory delivery system alignment improvements. The Work Group will be guided by Governor Kitzhaber's June 2013 letter to the Board, the Board's 2010 report *Oregon's Action Plan for Health*, and by Oregon's health system transformation goals:

- improving the lifelong health of all Oregonians;
- improving the quality, availability and reliability of care for all Oregonians, and;
- lowering or containing the cost of health care so that it is affordable for everyone.

This charter shall expire on November 30, 2013 or when the Board determines that the charter has been fulfilled, whichever is sooner.

## II. Scope

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The Coordinated Care Model Alignment Workgroup is charged with providing draft recommendations and implementation actions for the consideration of the Oregon Health Policy Board.

Purchasers to be covered in recommendations include but are not limited to:

- PEBB (to include currently underway RFP process for 2015 services)
- OEBC
- Cover Oregon
- Other public and private organizations

OHA staff will provide workgroup members materials in advance of scheduled meetings in order to ensure adequate review time and meaningful input.

The work group will not be asked to approve the final Board recommendations to the Legislature.

## III. Deliverables

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The workgroup will submit recommendations in a report to the Board before November 1, 2013.

## IV. Timing/Schedule

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The Workgroup will complete its work by November 2013; it will meet monthly at a location to be determined. The workgroup will meet at the discretion of the Board.

## V. Staff Resources

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Chairs: TBD

Staff: TBD, Jeff Scroggin

## VI. Work Group Membership

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Workgroup members are appointed by Director Bruce Goldberg. The workgroup will have a chair that will represent the group and present at Board meetings.

Membership: TBD



JOHN A. KITZHABER, MD  
Governor

June 3, 2013

Oregon Health Policy Board  
Chair Eric Parsons  
Vice-Chair Lillian Shirley

Dear Chair Parsons and Vice-Chair Shirley:

As you and the Board are well aware, beginning in 2014, the Affordable Care Act (ACA) will significantly expand coverage to thousands of currently uninsured Oregonians and alter the regulations governing the individual and small group markets. While the ACA makes historic, nationwide changes in coverage expansion and the regulation of the individual and small group markets, I believe there is an immediate need to focus on how to better align ACA implementation activities with our current reform efforts. I want to ensure that our triple aim goals of lower costs, better care and better health across all markets are achieved. To that end, concurrent with the ACA, we have an opportunity to create an environment for the commercial marketplace in Oregon that moves toward one characterized by models of coordinated care and growth rates of total health care expenditures that are reasonable and predictable.

For this to occur, I am asking that by the end of this year, the Oregon Health Policy Board take on the task of recommending to me and the Legislature, possible statutory and regulatory changes necessary to ensure our triple aim goals are met. I would anticipate that such recommendations would include, but not be limited to:

- strategies to mitigate cost shifting, decrease health insurance premiums and increase overall transparency and accountability;
- opportunities to enhance the Oregon Insurance Division's rate review process;
- alignment of care model attributes within PEBB and OEBC contracts;
- alignment of care model attributes within Cover Oregon's qualified health plans.

Thanks to all of your hard work and leadership over the past several years, Oregon has made significant progress in reforming its health care delivery system. Across the state, communities have begun transforming to deliver more effective, efficient care. Critical partnerships are developing to reward quality care, promote prevention and wellness and manage chronic diseases and are building new networks, products and contracting models.

Oregon Health Policy Board  
June 3, 2013  
Page Two

We have an amazing opportunity to leverage all of your great work with the implementation of the ACA and I look forward to working with you to achieve further success.

Sincerely,

A handwritten signature in black ink, appearing to read "John A. Kitzhaber". The signature is fluid and cursive, with the first name "John" being the most prominent part.

John A. Kitzhaber, M.D.  
Governor

MJB/smg

# Rate Review and Next Steps in Health Reform

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Presentation to the Oregon Health Policy Board  
Joel Ario, Manatt Health Solutions  
August 6, 2013

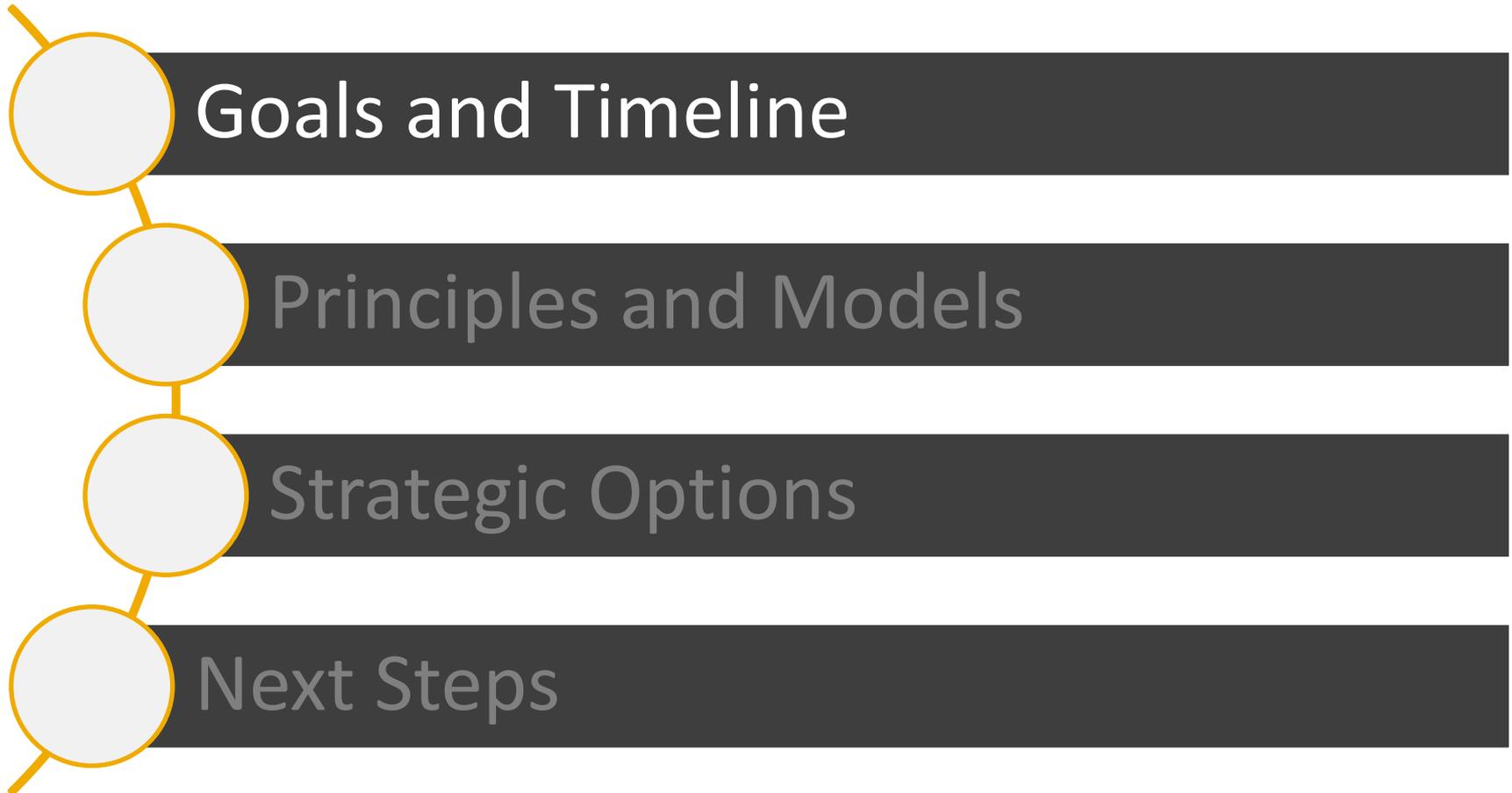
Support for this resource provided through a grant from the  
Robert Wood Johnson Foundation's State Health Reform  
Assistance Network program

MANATT  
HEALTH  
SOLUTIONS



# Overview

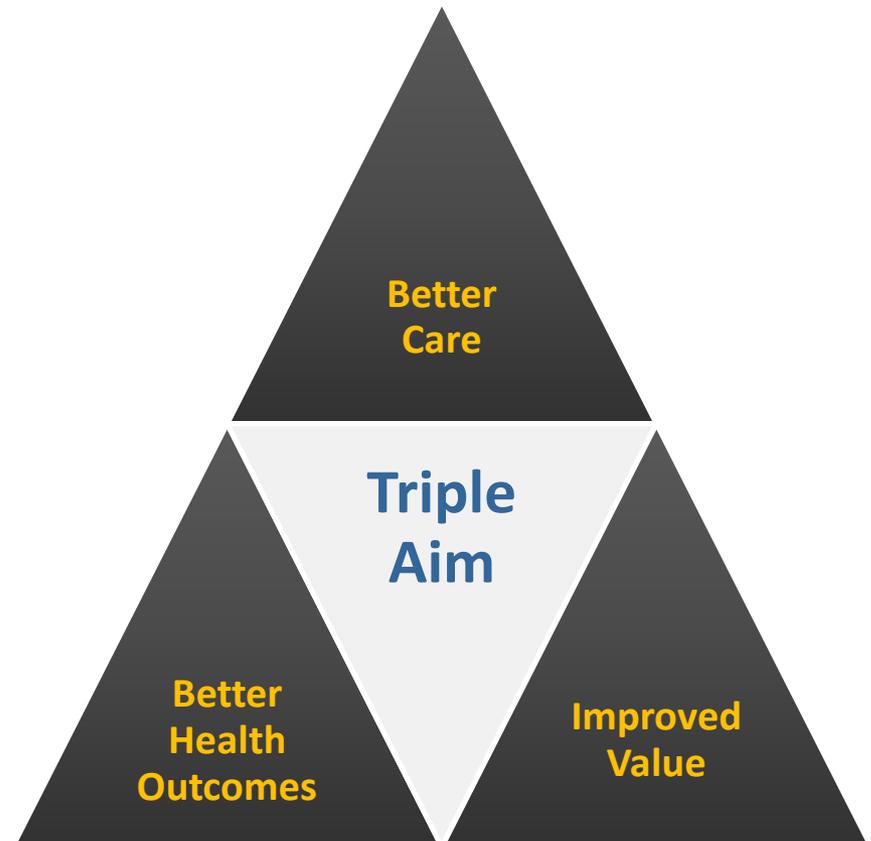
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# The Governor's Charge to the Oregon Health Policy Board

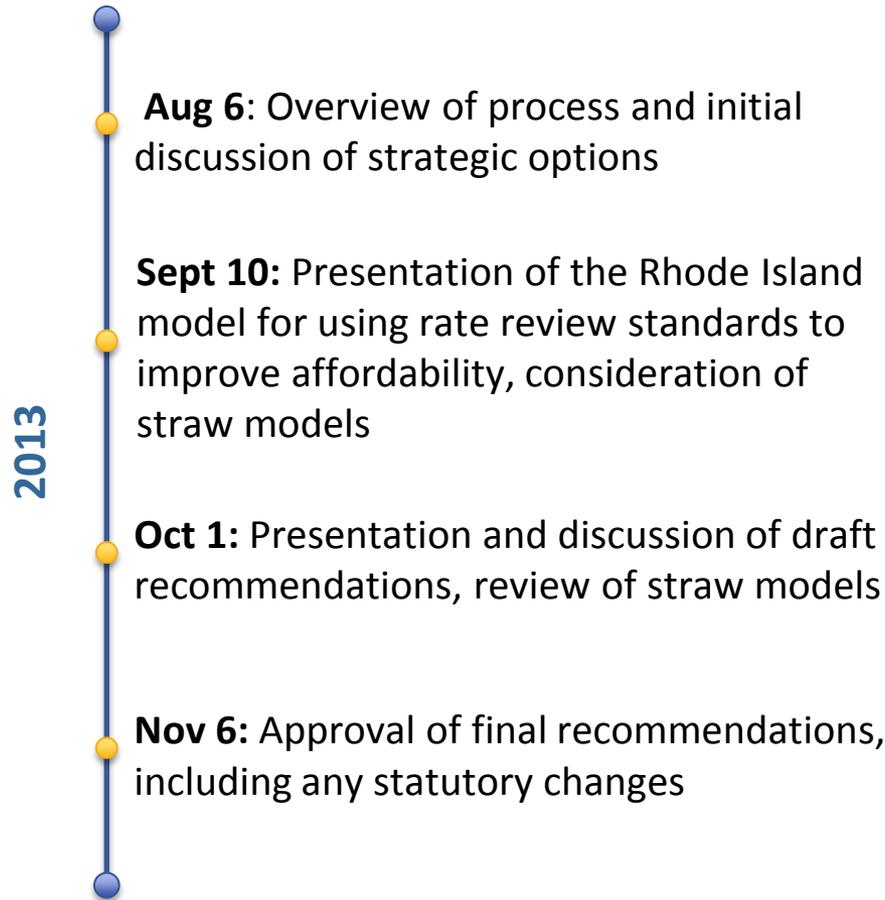
The Governor has asked the Board to recommend statutory and regulatory changes to align ACA implementation with Oregon's CCO reform model and ensure **Triple Aim** goals are met, including strategies to:

- Mitigate cost shifting
- Decrease health insurance premiums
- Increase transparency and accountability
- Enhance the rate review process



# Updated Project Timeline

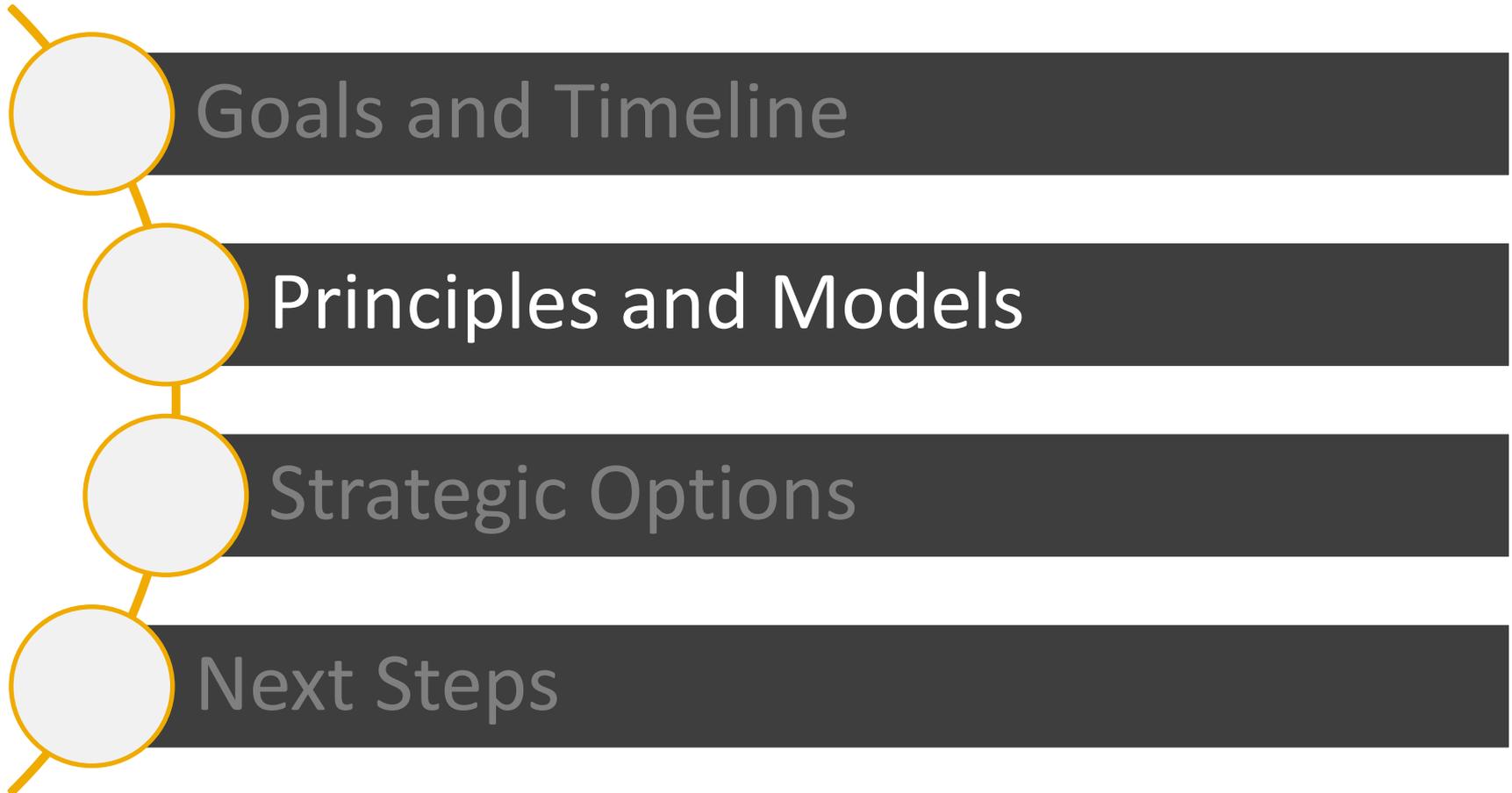
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Manatt and Georgetown will work with OHA, with input from DCBS and Cover Oregon, to support the Board's work.

# Overview

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# Guiding Principles

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Pursue alignment between CCO model, ACA implementation, and Board recommendations



Enhance transparency in rate review and across health system



Promote accountability with clear metrics and public reporting on results



Regulations should focus on outcomes and not be overly prescriptive as to means



Rate review should be actuarially-based **and** hold carriers accountable for quality improvement and cost containment

# Rhode Island Model

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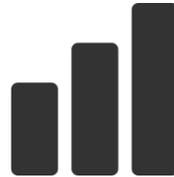


## Process

Identify cost  
containment strategies

Prioritize with  
stakeholders

Develop standards and  
metrics in priority areas



## Affordability Standards

Increase primary care  
spending

Expand commitment to  
medical home model

Support the state's  
health information  
exchange

Reform hospital  
contracting practices



## Lessons

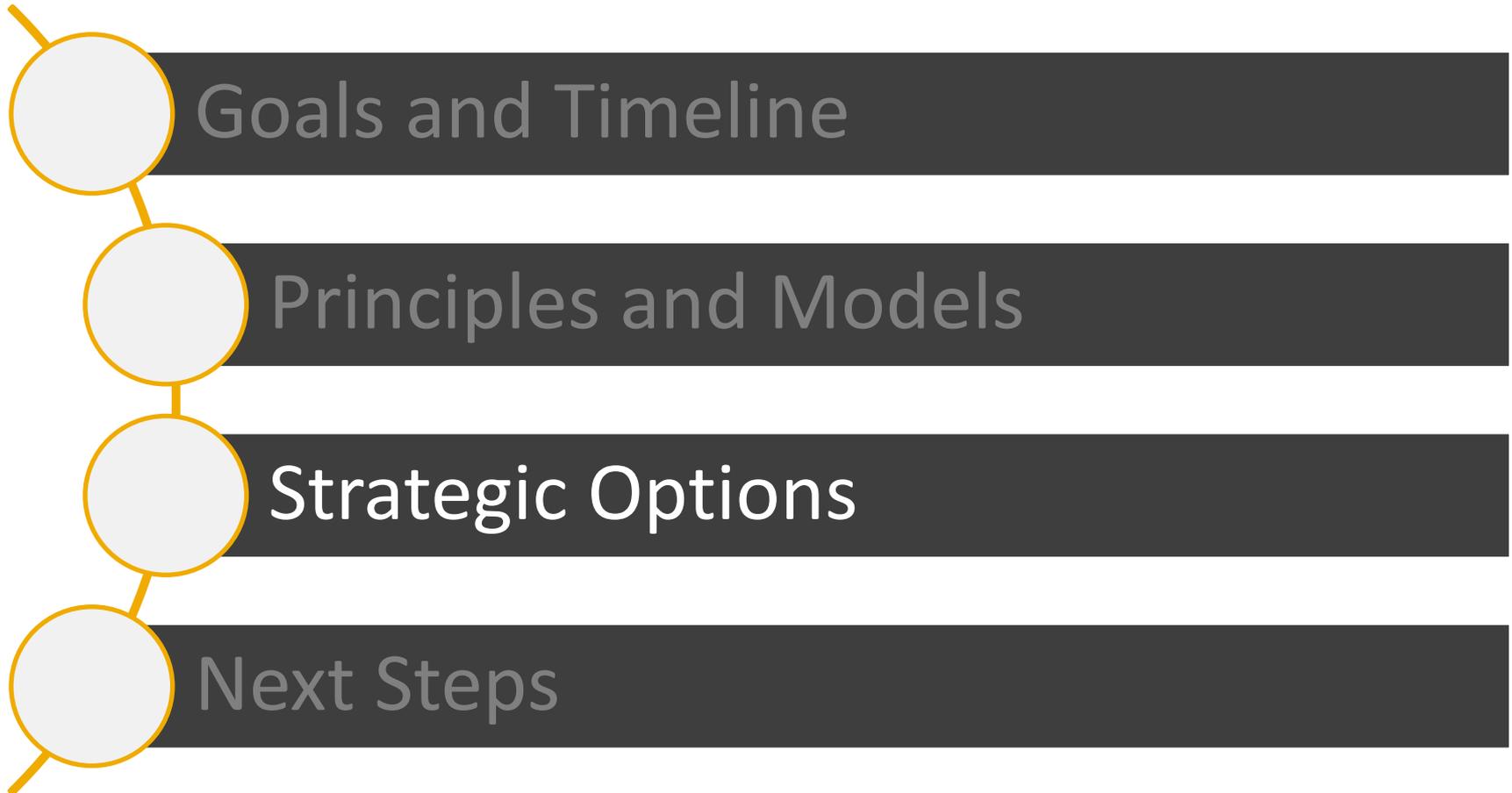
Get buy-in upfront

Develop meaningful and  
measurable standards

Remain flexible and  
adapt

# Overview

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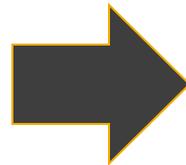


# Transparency Options

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## Baseline

- Rate review: filings are public, public hearings on rate increases, funding for consumer advocacy, consumer friendly rate comparison charts
- Annual report with detailed market profiles and year-to-year comparisons
- All claims all payers data base in development
- Pre-service pricing disclosure for 35 leading services (also in ACA)



## Enhancements

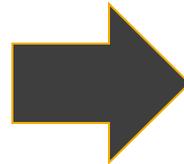
- Rate review: public reporting on key metrics in quality improvement and cost containment
- Expanded annual report based on new reporting
- Enhanced disclosure of hospital and provider pricing
- Public and standardized provider contract terms
- Provider spending trends by region
- Quality reporting/rating (ACA requirement)
- More consumer friendly tools (rate comparison charts, pre-service pricing disclosure)

# Quality Improvement Options

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## Baseline

- Rate review: changes in quality improvement efforts are a consideration in rate review
- ACA requires reporting on five categories: care management, hospital readmissions, patient safety/medical errors, EMRs/other IT initiatives, and health disparities (rules pending)
- QHPs required to develop improvement plans in each category (rules pending)



## Enhanced Accountability Through a Continuum of Strategies

- Set minimum standards (never events, EMR use)
- Set goals at state or carrier level (reduced hospital readmissions)
- Identify and spread/require use of best practices (evidence-based medicine)
- Payment reforms that incent quality (pay for performance, bundled payments)

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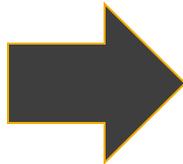
**Work on quality improvement to be coordinated with the Quality Metrics Work Group under HB 2118**

# Cost Containment Options

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## Baseline

- Rate review: changes in cost containment efforts are a consideration in rate review, an indexing system is used as a consideration in reviewing administrative cost trends
- MLR standards and rebates (ACA)



## Enhancements

- Rate review: require carriers to set measurable goals in specified areas, expand administrative cost model to medical trend and/or premium increases
- Require carriers to offer limited or select networks as a reduced price option
- Promote value-based product designs
- Promote wellness incentives and expand to individual market (SB 539)
- Expand use of electronic medical records and other IT initiatives
- Ensure market adjustments to reduced charity care/bad debt
- Move market toward alignment with CCOs generally and in areas such as care coordination, spending on primary care, adoption of patient-centered primary care home model of care, integration of health delivery systems, and outcome-focused payment reform (increased use of alternative payment models)
- Limit rate increases for carriers with “excess” surplus (PA model)

# Overview

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# Next Steps

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**1**

**Presentation by Chris Koller, former RI Health Insurance Commissioner, and consideration of straw models at September Board meeting**

**2**

**Draft recommendations and review of straw models at October Board meeting**

**3**

**Final recommendations at November Board meeting**

# **POTENTIAL AVENUES FOR IMPACTING MEDICAL TREND THROUGH THE RATE REVIEW PROCESS**

**PHASE 2 REPORT**

OREGON INSURANCE DIVISION  
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES



**Lewis and Ellis, Inc. – Actuaries & Consultants**

David M. Dillon, FSA, MAAA  
Jacqueline B. Lee, FSA, MAAA

OCTOBER 2011



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## **Potential Avenues for Impacting Medical Trend through the Rate Review Process**

October 2011

# Executive Summary

### *Background*

Oregon law ORS 742.005 gives the director of the Oregon Insurance Division (OID) authority to disapprove health insurance rates. Rates can be disapproved if there are provisions which are unjust, unfair, or inequitable. Additionally, rates can be disapproved if the benefits provided are not reasonable in relation to the premiums charged.

The development of premium rates and the reasons for premium changes are highly complex; however, premium changes are generally grouped into five major categories:

1. Incorporation of anticipated changes in future benefit costs including unit cost and utilization trends;
2. Updating the premiums based on actual claims experience;
3. Expected changes in demographics;
4. Changes in benefit plan provisions;
5. Adjustments for future administrative costs and risk margins.

The OID has established a thorough rate review process to assess if health insurance premiums in the state satisfy regulatory provisions. This assessment includes an evaluation of the reasonableness and appropriateness of insurance company assumptions for each of the factors above. The rate review process includes transparency initiatives and the disclosure of new quality initiatives; however, the

process does not currently include any provisions that directly influence or control the underlying cost of care or the delivery of healthcare.

On August 16, 2010 the U.S. Department of Health and Human Services (HHS) awarded the Oregon Insurance Division a grant to enhance current processes for reviewing health insurance premium increases. One of the OID's proposed five activities was a study to explore opportunities to influence the growth of healthcare costs and to improve efficiencies in the healthcare delivery system.

Lewis & Ellis, Inc. (L&E) was engaged to conduct the rate review study. For Phase 1 of the study, L&E sought input from organizations and individuals with a vested interest in the Oregon health insurance and healthcare marketplaces. Stakeholder input was used to develop a list of potential strategies for the OID to consider. The stakeholders included a diverse group of insurance carriers, physician and hospital representatives, regulatory officials, and consumer advocates. Based on discussions with these stakeholders and additional research regarding pilot reform programs, L&E presented twelve strategies with potential to enhance the current rate review process:

**Delivery System Strategies**

- ❖ The denial of reimbursement for preventable errors;
- ❖ Fundamental payment reform and integration of the healthcare system;
- ❖ An increase in primary care spending;
- ❖ Caps on legal damages;
- ❖ Transparency and standardization of network contracts.

### **Policyholder Strategies**

- ❖ Changes to disease and chronic care management programs;
- ❖ Changes to wellness initiatives;
- ❖ Use of evidence-based coverage design;
- ❖ Use of value-based product design.

### **Infrastructure Strategies**

- ❖ The use of electronic health records;
- ❖ Changes to the emergency room delivery model;
- ❖ Implementation of insurance carrier surplus requirements.

For Phase 2 of the study, the OID requested L&E to further outline three strategies to assess how they might be incorporated into the current rate review process, how marketplace premiums might be affected, and how stakeholders in Oregon health insurance system might be impacted.

The three strategies selected for additional discussion were:

- ❖ Fundamental payment reform and integration of the healthcare system;
- ❖ An increase in primary care spending;
- ❖ Transparency and standardization of network contracts.

### ***Overall Strategy and Recommendation***

The OID has historically regulated insurance companies as third-party payors in the healthcare system without directly influencing the delivery of care provided or the management of healthcare costs. L&E recommends an approach where the OID begins to influence and facilitate positive behaviors from health insurance carriers and healthcare providers by coordinating efforts with and by implementing recommendations from the Oregon Health Authority (OHA).

The OHA was created by the Oregon legislature in 2009 to be at the forefront of lowering and containing costs, improving quality, and increasing access to healthcare

for Oregonians. Since the OHA regulates many of the state's healthcare programs, it is well positioned as a large health insurance purchaser to influence health policy and transform the Oregon health system with the goal of lowering costs throughout the healthcare system.

Since the OHA oversees and influences healthcare reform endeavors in Oregon, L&E recommends that the OID transition to an enhanced review program that facilitates the goals of the OHA to transform the Oregon healthcare system. For example, the recently passed Oregon House Bill 3650 establishes the Oregon Integrated and Coordinated Health Care Delivery System which will be administered by the OHA for its covered populations. This system was established to improve health, increase the quality, reliability, availability and continuity of care, and reduce the cost of care. Several of these ideas are similar to, if not identical, to the strategies proposed for possible OID rate review enhancement. Therefore, L&E believes that the OID should enhance the rate review process by monitoring and evaluating the progress of these reform initiatives in the private insurance market. Since the OID is well-positioned to gather health insurance claims information, the OID can collect and disseminate data to inform and educate the public about the medical care delivered in the state and how it affects premium rate increases.

For each of the specific strategies reviewed, L&E discusses the type of measures that should be collected, reviewed, and released to the public. Once this information has been collected and reviewed for a reasonable length of time, e.g. two years, L&E recommends that the OID begin to utilize the collected market-wide measures to establish a five-star benchmarking program.

This benchmarking program would assign a rating for each of the clinical and actuarial measures collected. The rating for each specific measure would be based on the carrier's relative success versus the market and based on recognized care guidelines. The ratings would then be averaged across all measures. A carrier receiving a one star average would represent a poor overall performance while a carrier receiving five stars would represent an exceptional overall performance. This star

rating program would allow the public to easily identify carriers that are providing high quality care.

The ratings could also be used in the OID's rate review determination. If the carrier does not meet or exceed an average rating (three stars), then the OID could use this as a negative rate review consideration even if the claims experience appears unfavorable since a low rating could imply that a carrier may not be properly addressing healthcare cost increases and the efficient delivery of care.

Additionally, the OID could require that if a carrier does not meet a specified star rating, they would not be able to implement a rate increase that exceeded a designated threshold, such as a multiple of the medical care component of the Consumer Price Index (mCPI).

The initiation of a two-year monitoring program followed by a five-star benchmarking program would incentivize carriers to develop high quality, financially efficient ways to provide health insurance coverage.

### ***Specific Strategies***

For the three Phase 1 strategies selected for additional discussion, the following is provided:

- ❖ Background and examples of similar programs implemented elsewhere;
- ❖ Expected costs savings;
- ❖ Guidance to integrate the strategy into the current rate review process;
- ❖ Potential positive and negative impacts to Oregon stakeholders.

### **Fundamental Payment Reform and Integration of the Healthcare System**

This strategy includes three separate approaches that have potential to reduce healthcare costs through payment reform and system changes. The goal of the OID

for this strategy would be to monitor how providers are currently paid and influence changes to these programs to decrease healthcare costs. The three approaches are:

- ❖ **Pay-for-Performance Programs:** These programs provide incentive or bonus payments when certain quality or performance measures are reached.
- ❖ **Payments for Care Coordination:** Payments are made to providers based on an episode of care rather than for each service provided.
- ❖ **Integration of Health System:** These programs include medical homes or coordinated care organizations that coordinate care in one facility.

All three of these approaches have potential to manage healthcare costs and improve the delivery of healthcare; however, the scope of the changes for each of the approaches is significant. The transition from a FFS payment method to a reformed method is expected to be a complex, long-term solution.

The OHA is currently discussing the development of reporting measures for each of the payment reforms. L&E recommends that the OID require that the selected measures be submitted with each rate filing for monitoring and ultimately used to establish a benchmarking program.

### **Require an Increase in Primary Care Spending**

The relationship between a patient and their primary care physician (PCP) is one of the most important relationships in a healthcare system. The PCP typically diagnoses and treats the majority of illnesses and diseases for a patient. A PCP is generally more aware of a patient's medical history and is typically best suited to direct patients to the appropriate place for care. Consistent communication with PCPs also ensures that patients receiving preventive care services which can reduce long-term medical expenses.

In the Oregon private insurance market, approximately 5-10% of an individual's claims are spent for office visits and preventative care. L&E recommends that the OID

monitor the amount and the efficiency of primary care spending for the private insurance carriers. L&E believes that the initial steps of this reform could be implemented in a relatively short timeframe.

L&E recommends that a set of metrics should be developed which focus on primary care practices in addition to assessing whether the approaches are efficiently increasing the money spent on primary care.

L&E does not believe that a specific set of requirements for the carriers to follow to reach established benchmarks is necessary. L&E believes that carriers should have flexibility in tailoring their own programs; however, the programs should be subject to public review and scrutiny.

L&E believes that after the carriers have invested in primary care programs, the Oregon healthcare system should see an increase in primary care physicians, fewer hospitalizations and emergency room visits and an overall medical inflation rate that should stabilize.

### **Require Transparency and Standardization of Network Contracts**

In a fee-for-service healthcare system, healthcare costs can be simplistically represented by the equation:  $\text{Cost} = \text{Unit Price} \times \text{Utilization of Healthcare}$ . Unit prices are typically the largest driver of annual medical care increases. In an internal Lewis & Ellis study, medical claims for a typical major medical policy increased at an annualized rate of 8.5% from 2001 to 2011. Approximately 90% of this annualized increase was attributable to changes in the cost per service.

Unit prices are typically established through a negotiation process between insurance carriers and medical care providers, such as hospitals, physicians, and pharmaceutical companies. Considerations for annual unit price changes in a private health insurance market include salaries, facility and practice expenses, cost-of-living differences, unit

prices for public programs, and other economic factors. Additionally, there is not a standardized payment method that is commonly used across all insurance carriers and provider groups.

Historically, there has been little or no transparency with respect to the negotiated prices paid by insurers to hospitals and doctors for providing a specific medical service.

L&E recommends that additional disclosure should be required concerning network arrangements between insurance companies and providers. Additional transparency around unit prices should give the public key insight into a key medical cost driver.

Once the unit price information has been monitored and reviewed for the most common diagnoses and procedures, L&E recommends that this market-wide data be used to establish benchmarks that must be met for a positive rate review consideration.

The additional transparency surrounding unit prices should also influence the adoption of a standardized payment methodology for use in the Oregon market. A standardization of payment methodologies would be integral in creating a transparent market that would align payment incentives for providers and allow for price comparison.



# Issue Brief

## Using Insurance Standards and Policy Levers to Build a High Performance Health System

MICHAEL BAILIT AND CHRISTOPHER KOLLER

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**ABSTRACT:** This issue brief examines an unprecedented use of state health insurance regulatory authority to promote health system reform. In 2004, the Rhode Island legislature created the Office of the Health Insurance Commissioner (OHIC) with authority not granted to state health insurance regulatory agencies in other states. Specifically, the legislation instructed OHIC to direct insurers toward policies that promote improved accessibility, quality, and affordability for the Rhode Island health system. In 2009, OHIC used this authority to implement a set of standards to promote increased affordability through a series of requirements aimed at strengthening and expanding the state's primary care infrastructure. Insurers are required to increase their investments in primary care on a cost-neutral basis, expand use of the chronic care model medical home, and support implementation of electronic medical records. Rhode Island is testing whether state insurance regulation can foster a profound transformation in health care delivery.



### Overview

States have been regulating private health insurance companies and products since the late 19th century.<sup>1</sup> Regulations typically address insurer solvency and consumer protections relative to marketing, coverage policy, claims payment, access, and quality assurance. The advent of managed care created a flurry of state regulatory activity between 1992 and 2002, fueled by consumer and provider concerns about the potentially deleterious effects of managed care on both patients and providers. There has been dramatically less new health insurance regulatory activity in states since that time.<sup>2</sup>

All of this state regulatory activity has not, however, addressed insurer obligations regarding the systemic issues of medical care affordability and cost containment. This issue brief describes Rhode Island's innovative and unprecedented use of health insurance statutes and regulations to promote system reform

by addressing the need for expanded primary care capacity and transformative changes to primary care delivery.

### **Health Insurance Regulation in Rhode Island**

Rhode Island is the geographically smallest state in the United States and has a population of approximately 1 million. The commercial insurance market is largely divided between two insurers, Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England. The two insurers possess approximately 70 percent and 30 percent of the fully insured commercial health insurance market, respectively. A third commercial insurer, Massachusetts-based Tufts Health Plan, entered the market in the spring of 2009.

In previous years, and in accordance with its statutory authority, the state's department of business regulation performed occasional reviews of the factors health insurers consider when calculating proposed premiums for fully insured Rhode Island employers. Informed by the results of the analysis, the department could approve, reject, or modify the proposed rate factors.

The department evaluated whether the proposed rate factors were “consistent with the public interest and the proper conduct of business”<sup>3</sup> based on two key standards:

- **Solvency and actuarial soundness.** Were the proposed rates sufficient to ensure the continued solvency of the health plan?
- **Consumer protection.** Would consumers receive adequate contractual benefit in return for the proposed rates?

In 2004, the Rhode Island legislature created the Office of the Health Insurance Commissioner (OHIC) to hold health insurers accountable for fair treatment of providers and to direct insurers toward policies that promote improved accessibility, quality, and affordability.<sup>4</sup>

The explicit statutory direction for “affordability” distinguished Rhode Island from other states. It also gave OHIC the ability to exert influence beyond the normal confines of state insurance regulation. The legislation, however, provided little guidance for interpreting or assessing these new criteria. The authority was limited to fully insured commercial coverage and therefore excluded self-insured coverage, Medicare, and Medicaid.

In 2007, OHIC substantially revised the rate factor review process. In addition to solvency and actuarial soundness and consumer protection, additional criteria were added to address fair treatment of providers and health plan policies to improve affordability, quality, and accessibility of medical care. In addition, OHIC made its rate factor review more consistent across lines of business and insurers, instituting a comprehensive annual process. Finally, the process was made substantially more transparent, with information on the rate factors disseminated to the public.

In the initial years, OHIC did not systematically address the directive to promote improved affordability. In 2008, OHIC required spring annual insurer rate filings to be accompanied by a description of activities insurers had undertaken to address affordability of coverage.

### **Process to Develop Affordability Standards**

In fall 2008, OHIC began developing formal affordability standards for commercial health insurers. The goal was to identify a small number of systemic affordability priorities and set expectations for health plans. Working with state staff, consultants, and OHIC's health insurance advisory council, the agency pursued an open process to identify and assess potential approaches.<sup>5</sup> OHIC's rationale for affordability standards and for using a public process to develop them was as follows:

- Health plan activities can affect medical cost trends.
- Reasonable alignment among payers is possible and beneficial to achieving systemic goals.

Without alignment, health plan affordability efforts will be limited by the ability and willingness of each health plan to influence change.

- Communities can identify system priorities.
- Public discussion of tradeoffs and priorities is better than private discussion.

The work began with identifying a range of options, placing emphasis on those that:

- were unlikely to be advanced absent some degree of state action;
- were shown in the research literature to have a demonstrable, favorable effect on medical cost trends; and
- could reasonably be considered to be within the scope of a health plan’s control.

Ultimately, OHIC grouped options into three categories:

- strategies focused on providers: realigning provider payment incentives and practice, beginning with primary care;
- strategies focused on consumers: changing consumer behavior and reducing use of unnecessary services through information dissemination and benefit design;
- strategies focused on health system infrastructure: upgrading and simplifying administrative and clinical information processing and analysis functions.

Exhibit 1 presents the options proposed to the council. Exhibit 2 presents the supporting rationale for each option.

### Exhibit 1. Proposed Options for Health Plan Affordability Priorities

	<b>Option 1: Delivery System Focus</b>	<b>Option 2: User Focus</b>	<b>Option 3: Infrastructure Focus</b>
<b>Description</b>	Focus on payment levers of the insurers to realign incentives for care delivery, beginning with primary care	Focus on insurers’ ability to change consumer behavior and reduce unnecessary services through information and benefit design	Use insurer funds and national standards to upgrade and simplify the administrative and clinical information processing and analysis functions in the medical care system
<b>Short-term strategies</b>	Increase primary care spending (with limited ability to pass on costs in premiums) Chronic care model medical home	Select wellness performance standards (e.g., increased smoking cessation counseling) Reduce emergency room visits for ambulatory care-sensitive conditions	Standard incentives to use electronic medical records Standard incentives to use e-prescribing
<b>Long-term strategies</b>	Fundamental payment reform	Evidence-based coverage (i.e., use of medical evidence to inform coverage policy)	Create regional health information organization/ health information exchange

Source: Rhode Island Office of the Health Insurance Commissioner.

**Exhibit 2. Supporting Rationale for Proposed Options for Health Plan Affordability Priorities**

	<b>Option 1: Delivery System Focus</b>	<b>Option 2: User Focus</b>	<b>Option 3: Infrastructure Focus</b>
<b>Rationale</b>	<p><b>Primary care spending</b></p> <p>++ General decline in physicians’ choosing primary care residencies.<sup>6</sup></p> <p>++ A higher ratio of primary care doctors results in better health outcomes.<sup>7</sup></p> <p>++ Increasing share of primary care physicians would result in overall healthcare cost savings.<sup>8</sup></p> <p>≈ Increasing primary care payments will stem decline in numbers of primary care physicians, promote shift to primary care-centric model.</p> <p><b>Chronic care model medical home</b></p> <p>++ Implementing a chronic care model medical home delivers higher quality care, reduced costs.<sup>9,10,11</sup></p> <p><b>Fundamental payment reform</b></p> <p>++ The current fee-for-service system is inflationary.<sup>12,13</sup></p> <p>≈ Alternative payment model should produce cost savings.<sup>14</sup></p>	<p><b>Wellness performance standards (smoking)</b></p> <p>++ Tobacco use, obesity results in higher health care costs.<sup>15,16</sup></p> <p>++ Increased smoking cessation counseling will reduce costs.<sup>17</sup></p> <p>≈ Less evidence of the value of other wellness-related interventions.</p> <p><b>Reduce emergency room visits for ambulatory care-sensitive conditions</b></p> <p>++ Solid evidence of overuse of emergency rooms.<sup>18,19</sup></p> <p>+ A reduction in emergency room use and hospitalizations for ambulatory care-sensitive conditions can be achieved through a combination of health plan-driven strategies.<sup>20</sup></p> <p><b>Evidence-based coverage</b></p> <p>++ Solid evidence of misuse/overuse of services.<sup>21</sup></p> <p>≈ The value of establishing consistent, collaborative, evidence-based health plan coverage is relatively unproven. However, limited applications have demonstrated value.<sup>22,23</sup></p>	<p><b>Standard incentives to use electronic medical records</b></p> <p>++ Solid evidence of the cost-effectiveness of electronic medical records.<sup>24,25</sup></p> <p><b>Standard incentives to use e-prescribing</b></p> <p>++ Adoption of e-prescribing saves money and reduces medical errors.<sup>26,27</sup></p> <p><b>Regional health information organization /health information exchange</b></p> <p>≈ Some evidence that a coordinated regional health information organization/health information exchange increases quality of care.<sup>28</sup></p>

Note: OHIC conducted a review of the evidence of effectiveness of each strategy, using peer-reviewed literature and other sources. Each strategy was rated in terms of the strength of the supporting evidence: ++ = solid evidence, + = equivocal evidence, ≈ = relatively unproven.  
 Source: Analysis by Rhode Island Office of the Health Insurance Commissioner (OHIC).

The council eventually recommended the development of standards that focused on the delivery system (Option 1), as well as electronic medical record adoption (an element of Option 3). The final recommended priorities statement, approved by the council, read as follows:

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

care. Achievement of this goal will not add to overall medical spending in the short term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:

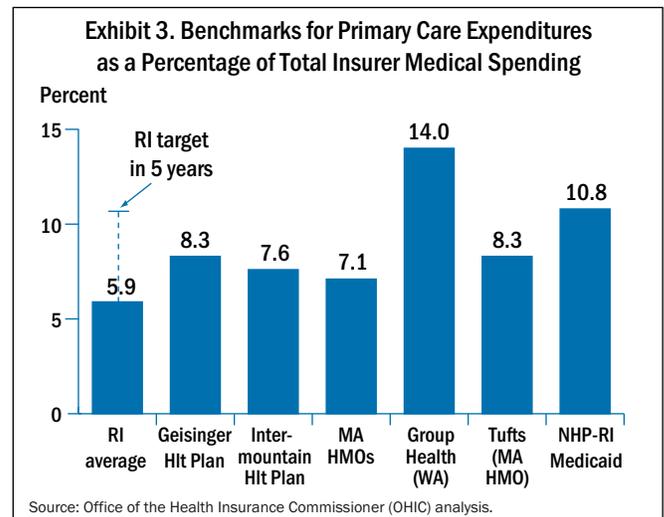
1. Expand and improve the primary care infrastructure in the state—with limitations on ability to pass costs to premiums.

2. Spread adoption of the chronic care model medical home.<sup>29</sup>
3. Standardize electronic medical record (EMR) incentives.
4. Work toward comprehensive payment reform across the delivery system.”

**Rationale for Rhode Island’s Approach**

OHIC and the council decided to focus on the delivery system and adoption of EMRs for the following reasons:

- Fee-for-service payment is widely understood to be a major contributor to health care inflation because of its incentive for increased volume of services. The system is unlikely to be replaced by an alternative without government action.
- In 2008, Rhode Island insurers spent 5.9 percent on primary care, which compared poorly against benchmark data from high-performing health systems identified by The Commonwealth Fund’s Commission on a High Performance Health System and against other benchmark data (Exhibit 3).
- OHIC and the three commercial insurers had recently collaborated to implement a multipayer chronic care model medical home initiative, which provided a base for expanding primary care payment reform and coupling reform with practice transformation.<sup>30</sup>
- Blue Cross Blue Shield of Rhode Island was offering an incentive to practices to use EMRs; UnitedHealthcare was preparing to introduce such an incentive.
- There was not yet the necessary level of consensus and political support to undertake a larger-scale payment reform initiative.
- Evidence supporting Option 2 strategies (i.e., user focus) was limited and not as compelling as that for Option 1.



**Process to Develop the Regulatory Standards**

OHIC staff and consultants then undertook an effort to develop draft standards, gathering data and input from Rhode Island insurers, advice from an expert panel assembled by The Commonwealth Fund, and data and experience from outside of Rhode Island.<sup>31</sup> The insurers were generally supportive of the areas selected for focus in the affordability standards, and provided constructive, informative data, feedback, and recommendations during the development process.

The expert panel was likewise supportive, but voiced caution about focusing on increased primary care spending without also ensuring improvements in practice performance. They urged attention to the development of clinical microsystems within primary care practices. These are specific processes used by interdependent teams that collaborate on care for patients. Examples include appointment scheduling or follow-up with patients who are not refilling chronic care medications. They also recommended clinical management of high-need patients to reduce hospital admissions and readmissions and advocated the use of metrics focused on clinical outcomes to assess impact.

The council reviewed multiple rounds of standards during the development process and solicited and obtained public testimony at one of its meetings.

## Final Approved Affordability Standards

The final standards are summarized below. Complete standards are available at: [http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/2\\_System%20Affordability%20Standards%20and%20Priorities%20for%20Health%20Insurance.pdf](http://www.ohic.ri.gov/documents/Committees/HealthInsuranceAdvisoryCouncil/affordability%202009%20/2_System%20Affordability%20Standards%20and%20Priorities%20for%20Health%20Insurance.pdf).

**Standard 1: Primary care spending.** The proportion of the insurers' medical expense to be allocated to primary care for the 12 months starting January 1, 2010, will be 1 percentage point higher (e.g., increase from 6% to 7% of medical expenses) than reflected in actual spending for the 12 months starting January 1, 2008. Specifically:

- Blue Cross Blue Shield of Rhode Island: 1 point increase by 2010 from 5.6 percent to 6.6 percent
- UnitedHealthcare: 1 point increase by 2010 from 7.3 percent to 8.3 percent
- Tufts Health Plan: 6.9 percent primary care spending by 2010. (There was no baseline for 2008 because the plan was new to the market. Standard was set at Rhode Island statewide commercial insurer average.)

The proportion will continue to increase by 1 percentage point per year for five years.

Each insurer must submit a plan to OHIC that demonstrates how the increase will be achieved. They must show that it will be accomplished without contributing to the increase of premiums, with an emphasis on innovative contracting and payment and primary care system investment, not merely fee schedule manipulation.<sup>32</sup>

**Standard 2: Spread adoption of the chronic care model medical home.** Insurers will support (with a commitment in writing) an expansion of either the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) or an alternative all-payer medical home

model with a chronic care focus. Support will start in July 2009 and continue through June 2010, with an increase of at least 15 full-time equivalent primary care physicians by the end of the period.<sup>33</sup> CSI-RI, also initiated by OHIC, is a voluntary multipayer chronic care model medical home initiative that involves all commercial and Medicaid carriers but not Medicare.<sup>34</sup>

**Standard 3: Standard incentives to use electronic medical records.** By January 1, 2010, insurers will demonstrate the implementation of an incentive program for physicians to adopt EMRs that meets the following standards:

- Initial payments per physician to subsidize the cost of EMR acquisition, adjusted for insurer market share, are as follows<sup>35</sup>:
  - Blue Cross Blue Shield of Rhode Island: \$5,000 or more, up to a practice maximum of \$15,000
  - UnitedHealthcare: \$2,500 or more, up to a practice maximum of \$7,500
  - Tufts Health Plan: \$500 or more, up to a practice maximum of \$1,500
- Ongoing financial support to a practice for the cost of EMR implementation, worth at least 3 percent more than the insurer's standard payments to the practice.

Insurers may establish an annual cap on enrollment in the EMR incentive program at not less than 200 new providers per year. This cap will be revisited annually by OHIC.

**Standard 4: Work toward comprehensive payment reform across the delivery system.** Insurers will commit in writing to participate in a state-facilitated process to explore, assess, recommend, and adopt reforms to health care service payment in Rhode Island, including:

- active engagement as a member of the stakeholder body to be convened by OHIC in coordination with other state governmental entities; and
- provision of noncompetitive information to the body to assist it in its deliberations.

### **Anticipated Impact of the Standards and Future Challenges**

Rhode Island anticipates that the five-year collective impact of the standards will be an increase of \$150 million to \$200 million to primary care across the state—almost double the amount spent previously.

It is unclear how the insurers will respond to the requirement and make the investment in primary care. Two options are: straight rate increases for primary care providers and restructured payment arrangements (e.g., medical home supplemental payments beyond the requirement in the standards, enhanced pay-for-performance, etc.). OHIC has committed to a public process for the development of these investment plans. It also remains to be seen how the insurers will make the investment without driving up health care costs. Potentially, they could fund the increase through savings achieved from improved care management and delivery. Another option is to redistribute dollars from hospitals and specialists to primary care practices.

### **Evaluation Metrics**

To evaluate the impact of the standards, OHIC developed a set of evaluation metrics, with plans to assess performance annually and to report results publicly (see [Appendix](#)). The use of systemwide metrics was designed not only to support evaluation but also to keep involved parties focused on the goals.

### **Issues to Watch**

Rhode Island has produced a bold innovation by using state regulatory authority as a driver of health insurance reform. The state has addressed failure in the health care marketplace—evidenced by continued high levels of health cost inflation—by using regulation to drive changes aimed at improving affordability. These

actions, coupled with prior steps to launch a multipayer medical home initiative, form an intriguing experiment. In the coming years, this experiment may serve to answer the following questions:

- Can state insurance regulation that is targeted at insurers' financial arrangements with providers significantly slow the growth in commercial health insurance premiums?
- Will limitations in the authority of OHIC—specifically the lack of regulatory authority over Medicare, Medicaid, and self-insured commercial coverage, which account for an estimated 45 percent of the state's covered population—constrain OHIC's ability to achieve its health care reform objectives?
- How will carriers respond? Do OHIC's affordability standards give insurers enough leverage to make necessary changes?
- Revitalizing primary care is a necessity, but not sufficient, delivery system reform. Will this effort make other needed reforms more likely in Rhode Island?
- Can carriers significantly increase the percentage of medical spending to primary care without increasing overall spending? If so, how?
- Will the standards achieve the desired behavior changes?
  - Will increased primary care spending increase the number of practicing primary care physicians in the state?
  - Will increased payment to primary care, coupled with a modest-sized chronic care model medical home initiative and EMR adoption incentives, produce improved primary care delivery?
  - How will specialty physicians and hospitals respond to the regulatory standards?

- As this effort is implemented, what are the implications for the private contracting model between provider and health plans? This process has taken a traditionally private contractual relationship and opened it to public review and oversight. Will this inhibit or promote innovation?
- Will any federal reforms that are passed increase or diminish the number and effectiveness of these state-led initiatives?

Regulation is a broader, blunter, and more direct form of state action than other state levers, such as purchasing or public exhortation. In setting the standards, Rhode Island surmised that without state regulatory action, systemic affordability initiatives were unlikely to happen. As other states grapple with the affordability problem and the role of health insurance regulation, time and experience will show whether Rhode Island's assumptions and efforts can provide insight and guidance.

## NOTES

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- <sup>30</sup> For information on the Rhode Island Chronic Care Sustainability Initiative (CSI-RI), see [www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009\\_02\\_13\\_medical\\_home\\_case\\_study\\_presentation.ppt](http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_02_13_medical_home_case_study_presentation.ppt).
- <sup>31</sup> The experts participating in a Feb. 23, 2009, conference call with OHIC included John Colmers, secretary of the Maryland Department of Health and Mental Hygiene, Michael Cropp, M.D., president and CEO of Independent Health, Glenn Steele, M.D., Ph.D., president and CEO of Geisinger Health System, and Anne Gauthier, assistant vice president, and Cathy Schoen, senior vice president, The Commonwealth Fund.
- <sup>32</sup> It was the general opinion of the council that increases in primary care fee schedules should be a necessary component, but would not be sufficient to meet the standard. That is, the standard could and should result in an increase in primary care fee schedules to better attract and retain primary care physicians in Rhode Island. The standard, however, will not successfully improve affordability unless this investment includes more innovative payment models that move beyond the traditional fee-for-service system. The council made no specific recommendations about the alternatives, but referred to models in the literature and in practice in other communities, including pay-for-performance incentives, case management fees, and carefully conceived risk-sharing mechanisms.
- <sup>33</sup> The addition of 15 full-time equivalent physicians would increase the patients affected by the program, as a percentage of the total state population, from 2.38 percent to 3.69 percent, the latter being the national multipayer medical home benchmark level that Pennsylvania intended to achieve in 2009.
- <sup>34</sup> Office of the Health Insurance Commissioner, State of Rhode Island, [www.ohic.ri.gov/Press\\_IntheNews\\_CSI\\_2008.php](http://www.ohic.ri.gov/Press_IntheNews_CSI_2008.php). (accessed Aug. 31, 2009).
- <sup>35</sup> Based on a per-physician EMR adoption cost of \$33,000, a target of 25 percent overall subsidy, and market shares of 62.5 percent/32.5 percent/5 percent, respectively.
- <sup>36</sup> Survey of all physicians in Rhode Island (6.9% response rate). OHIC intends to modify the instrument to capture physician specialty and increase the response rate.
- <sup>37</sup> Blue Cross Blue Shield of Rhode Island, measured as of June 2008. Includes physician assistants, nurse practitioners, primary care physicians (PCPs), and specialists who also serve as PCPs and receive PCP fees for primary care services. UnitedHealthcare provided a comparable estimate
- <sup>38</sup> Kaiser Physician Counts, Dec. 2007.
- <sup>39</sup> K. Williams and J. Buechner, "Hospitalizations for Ambulatory Care Sensitive Conditions," *Health by Numbers* (published by the Rhode Island Department of Health), Mar. 2005 7(3). Data from Exhibit 3 (Discharges for Ambulatory Care Sensitive Conditions as Percent of All Discharges, by Age Group and Insurance Status, Rhode Island Residents, 2001–2003). Note that benchmark is for commercial insured population only, but the Rhode Island statistic is across all populations. Carriers will self-report commercial data for ongoing assessment.
- <sup>40</sup> 2000 AHRQ data obtained at [www.ahrq.gov/data/hcup/factbk3/fbk3fig6.htm](http://www.ahrq.gov/data/hcup/factbk3/fbk3fig6.htm).
- <sup>41</sup> C. M. DeRoches, E. G. Campbell, S. R. Rao et al., "Electronic Health Records in Ambulatory Care, A National Survey of Physicians," *New England Journal of Medicine*, July 3, 2008 359(1):50–60; Physician Health Information Technology Survey Pilot Results, Oct. 29, 2008. OHIC calculated 7.2 percent as a lower estimate for the general physician population to address a likely nonresponse bias in the Rhode Island Department of Health survey (i.e., those who have EMRs would be more likely to respond to an EMR survey) <http://www.health.ri.gov/publications/quality-reports/physicians/HealthInformationTechnology/SummaryReport2008.pdf>.
- <sup>42</sup> Rhode Island Quality Institute. Carriers will not be held accountable for increased adoption rates, but will have to show that they have an incentive program in place.

## Appendix. Evaluation Metrics

### Metrics for Standard 1: Primary Care Spending

- Primary care satisfaction (OHIC annual survey)  
Baseline: 30.8 percent of all providers satisfied with reimbursement<sup>36</sup>
- Primary care supply: number of total primary care providers  
Baseline: 1,035 total primary care providers in Rhode Island<sup>37</sup>  
Baseline: 33.5 percent of Rhode Island physicians identified as primary care physicians<sup>38</sup>
- Primary care supply: primary care physicians as a percentage of Rhode Island physicians  
Baseline: to be reported by the insurers
- Incidence of hospitalizations for ambulatory care–sensitive conditions (Agency for Healthcare Research and Quality)  
Current Rhode Island incidence: 16.6 percent of all Rhode Island hospitalizations of insured patients<sup>39</sup>  
National benchmarks: 11 percent of all hospitalizations of commercially insured patients<sup>40</sup>
- Incidence of emergency room visits for ambulatory care–sensitive conditions  
Baseline: to be reported by the insurers in annual metrics report
- Overall Rhode Island medical trend, for fully insured, commercial business  
Metric will be based historical data filed as part of commercial filings

### Metrics for Standard 2: Spread Adoption of the Chronic Care Model Medical Home

The Chronic Care Sustainability Initiative project has programmatic goals for improved performance on quality measures for three chronic conditions—coronary artery disease, diabetes mellitus, and depression—as well as for reduced emergency room visits, inpatient readmissions, and system costs. In addition, a third-party evaluation, funded by The Commonwealth Fund, is being conducted as part of the project.

### Metric for Standard 3: Standard Incentives to Use Electronic Medical Records

- EMR adoption vs. national benchmark  
Currently somewhere between 7.2 percent and 14.8 percent of all Rhode Island licensed physicians have adopted an EMR vs. 13 percent nationally<sup>41,42</sup>

### Metric for Standard 4: Work Toward Comprehensive Payment Reform

OHIC did not define a metric for this standard. It remains to be developed in future years.

## ABOUT THE AUTHORS

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By Christopher F. Koller, Troyen A. Brennan, and Michael H. Bailit

# Rhode Island's Novel Experiment To Rebuild Primary Care From The Insurance Side

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**ABSTRACT** Primary care is viewed both as the solution to better health care in the United States and as a threatened institution, beset by poor payment and difficult working conditions. Rhode Island has taken a direct approach to making primary care more effective for patients and more attractive for physicians. In 2009 the state's Office of the Health Insurance Commissioner developed "system affordability priorities" for Rhode Island's commercial insurers, including a directive to almost double the portion of their medical expenses devoted to primary care. Initial plans of those insurers to meet those expectations are now being implemented; this paper describes those plans.

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Rhode Island's original Charter in 1663 granted its residents permission for a "lively experiment," allowing greater religious freedom in a civil society.<sup>1</sup> The phrase, chiseled on the face of the Rhode Island State House, is invoked regularly to embolden lawmakers and citizens to take civic action. It is an apt description for current attempts by state officials to promote delivery system reform by strengthening the state's primary care.

In 2009 the Office of the Health Insurance Commissioner, a small state agency with broad regulatory authority over commercial health insurers, embarked on a process to strengthen and expand primary care in the state. The consensus in Rhode Island, as in much of the country, was that primary care was slowly being starved because of payment policies. There was also agreement that a health care system is only as good as its primary care base. Thus, the obvious answer was that more money needed to be pumped into primary care.

The commissioner's bold step was to do just that. Working with both insurers and providers, the commissioner's office has hammered out a workable format that will rapidly increase funding for primary care doctors to manage

patients' health. Many questions remain about how to do this, such as specifically how and where the funds should be targeted. The experience in Rhode Island, even in the early part of this "lively experiment," deserve national policy attention.

## Policy Background

In 2004 the Rhode Island legislature separated health insurance regulation from the Department of Business Regulation and created the cabinet-level Office of the Health Insurance Commissioner. In doing so, it added two new standards to the traditional roles of a health insurance regulator in ensuring health plan solvency and protecting consumers. Specifically, the office was required to hold health insurers accountable for fair treatment of providers, and to direct insurers to promote improved accessibility, quality, and affordability.<sup>2</sup>

**STATUTORY GUIDANCE** The explicit statutory direction for "affordability" distinguished Rhode Island from other states. It also gave the Office of the Health Insurance Commissioner the ability to exert influence beyond the normal confines of state insurance regulation. The legislation, however, provided little guidance for interpret-

ing or assessing these new criteria. The office's new authority is also limited to fully insured commercial coverage and therefore excludes Medicare and Medicaid recipients and large self-insured employers, which, under the Employee Retirement Income Security Act (ERISA), are exempt from state regulatory oversight.<sup>3</sup>

**SEEKING AFFORDABILITY** After its establishment, the Office of the Health Insurance Commissioner determined that it could most effectively implement the directive to promote improved affordability through a more systematic review of rates charged by insurers. Historically, commercial health insurers in Rhode Island were required to file with regulators the methodologies, or "rate manuals," that they use for calculating rates. They also were required to refile the estimated inflation rates, administrative costs, and profit margins—collectively known as "rate factors"—used in those methodologies whenever those factors changed.

In 2007 the insurance commissioner's office substantially revised this process to make the filing of rate factors annual, consistent across lines of business and insurers, and transparent. More information was collected and made public, and more public input was solicited. In 2008 the office required these rate-factor filings to be accompanied by a description of activities that insurers had undertaken to address the affordability of coverage. These descriptions were also made public to promote awareness and discussion of what the insurers believed were the drivers of health insurance premiums, and what they were doing to address them.

**OUTCOMES** Unfortunately, these efforts produced only limited results. Publication of projected price and utilization trends by type of provider rendering the service did generate greater public awareness. However, publication of efforts to address affordability resulted in poorly defined, nonspecific lists of ongoing management activities by insurers in areas such as disease management, high-cost case and formulary management, wellness programs, and benefit design. These failed either to engage the provider or purchaser community or to focus on the changes needed to improve system affordability.

**REVISITING AFFORDABILITY** In response, in the fall of 2008 the insurance commissioner began developing formal affordability standards for commercial health insurers. The goal was to identify a small number of general affordability priorities and to set expectations for health plans, using as the point of leverage the annual rate-factor approval process described above.

Working with state staff, consultants, and its Health Insurance Advisory Council, the office pursued an open process to identify ways in

which commercial health insurers could facilitate system improvement. The insurance commissioner's rationale for this process was as follows: (1) Health plan activities can affect medical cost trends. (2) Reasonable alignment of policies and actions by insurers is possible, and is beneficial to achieving systemic goals. Without alignment, health plans' affordability efforts will be limited by the ability and willingness of each health plan to influence change. (3) Communities can identify system priorities. (4) Public discussion of trade-offs and priorities is better than private discussion.

**ADVISORY COUNCIL** The Health Insurance Advisory Council was established by statute as a group of representatives from small and large employers, providers, and consumers who were to give advice to the commissioner on issues facing the office. The council's work on this issue began with identifying a range of policy options to improve system affordability, placing emphasis on those that were unlikely to be advanced without some degree of state action.

The council also wanted to endorse interventions that had been shown in the research literature to have a demonstrable, favorable effect on medical cost trends.<sup>4</sup> Most important, any new activities had to be considered to be reasonably within the scope of a health plan's control.

Ultimately, the council grouped these affordability options into three categories: (1) strategies focused on providers: realigning provider payment incentives and practice, beginning with primary care; (2) strategies focused on consumers: changing consumers' behavior and reducing the use of unnecessary services through information dissemination and benefit design; and (3) strategies focused on health system infrastructure: upgrading and simplifying administrative and clinical information processing and analysis functions.

The council eventually recommended that health plans in Rhode Island focus their affordability efforts on provider payment reform, starting with primary care and without adding to the overall costs of care. They recommended the adoption of four priorities for insurers: expanding and improving the primary care infrastructure in the state; promoting the adoption of medical homes based on the Chronic Care Model;<sup>5</sup> promoting the adoption of electronic health records by physicians; and implementing more comprehensive payment reform.

### Rationale For Rhode Island's Approach

The Office of the Health Insurance Commissioner and the council decided to focus health

plan affordability efforts on the delivery system and payment reform for several reasons.

**HOLDING INSURERS ACCOUNTABLE** First, the commissioner's office thought that health insurers should not be held accountable for items beyond their direct control. For example, payers could not be held solely responsible for reducing regional variations in practice, or increased adoption of certain prevention-focused strategies.

**ALTERING PAYMENT SYSTEMS** Second, it is relatively simple to alter primary care payment systems. Fee-for-service payment is widely understood to be a major contributor to health care inflation because of its incentive for increased volume of services.<sup>6</sup> Health plans cannot move from it unilaterally for institutional providers, such as hospital-based specialists, but they can do so readily for the primary care sector.

**PHYSICIAN SUPPLY** Third, there is compelling evidence that population-based quality and cost measures, both nationally and internationally, are positively correlated with the supply of primary care physicians.<sup>7,8</sup> Although health plans cannot directly influence primary care supply, they can spend more money on primary care, creating a stronger primary care system that results in either more primary care physicians or more highly compensated ones (which presumably would also influence supply.)<sup>9</sup>

In 2008 Rhode Island insurers spent 5.9 percent of their medical services expenditure on primary care, which compared poorly to benchmark data from other high-performing health

systems identified by the Commonwealth Fund's Commission on a High Performance Health System. For example, Geisinger Health System's health plan in Pennsylvania reported using nearly 9 percent of its total spending on primary care (Exhibit 1).

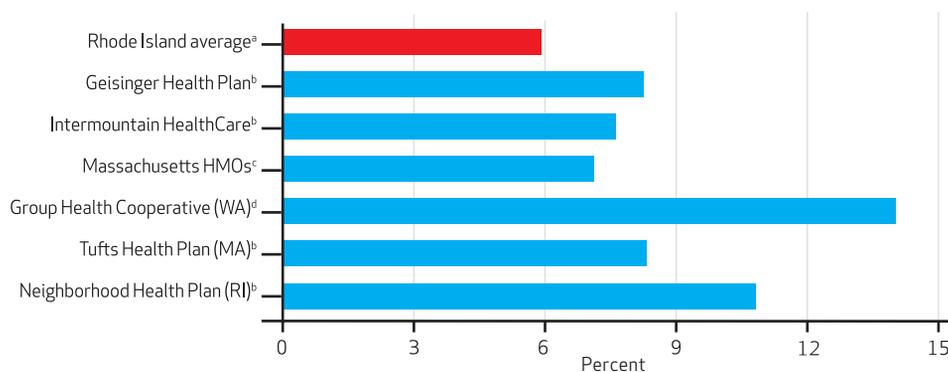
**HISTORY OF COLLABORATION** In addition to these compelling reasons for reform, another factor facilitated the program: a history of collaboration between insurers and state officials. The Office of the Health Insurance Commissioner and the three commercial insurers in Rhode Island had recently collaborated to implement a multipayer Chronic Care Model medical home initiative, which provided a base for expanding primary care payment reform and coupled reform with practice transformation.<sup>10</sup>

Moreover, with guidance from the state-designated Regional Health Information Organization, the Rhode Island Quality Institute, and the Department of Health, Blue Cross Blue Shield of Rhode Island was offering a number of incentives to practices to use electronic health records. UnitedHealthcare was preparing to introduce a similar incentive. The subsequent introduction of federal funds through the Health Information Technology for Economic and Clinical Health (HITECH) provisions of the American Recovery and Reinvestment Act (ARRA) of 2009 strengthened these incentives.

Finally, all players recognized that there was not yet the necessary level of consensus and political support to undertake a payment reform

**EXHIBIT 1**

**Primary Care Spending As A Percentage Of Total Medical Spending, Rhode Island Average (Baseline) And Benchmarks From Six Large Insurers**



**SOURCES** Office of the Health Insurance Commissioner, Rhode Island; and various other sources (see below). **NOTES** The Rhode Island average is the mathematical average of the two largest commercial insurers in the state, Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England. The Rhode Island target is 10.9 percent, which is the current rate plus five percentage points, as set in affordability standards. <sup>a</sup>Plan-specific spending rates are greatly influenced by membership mix. <sup>b</sup>Source: Self-reported by insurers. <sup>c</sup>Source: Oliver Wyman Study, 2008 Sep, based on commercial, fully insured health maintenance organizations (HMOs) only. Primary care includes obstetrics/gynecology; excludes pay-for-performance. <sup>d</sup>Source: Wagner EH, director of the MacColl Institute for Healthcare Innovation, Center for Health Studies, Group Health Cooperative. Group Health Cooperative is a group-model HMO with owned facilities, like Kaiser Permanente.

initiative on a larger scale. Insurers, physicians, and regulators agreed that primary care reform would be difficult enough, especially as the threat or promise—depending on one's point of view—of federal health reform loomed.<sup>11</sup>

### Developing Regulatory Standards

Once these priorities were agreed upon, specific standards were needed to set expectations and allow for assessment. To this end, the Office of the Health Insurance Commissioner staff gathered data and input from Rhode Island insurers, advice from an expert panel assembled by the Commonwealth Fund, and data and experience from outside Rhode Island.

**PROCESS** The council reviewed multiple rounds of standards during the development process and solicited public testimony on them. The insurers were generally supportive of the areas selected for focus in the affordability standards, and they provided data, feedback, and recommendations during the development process. The iterative nature of the standards development, the participation of insurers, and the knowledge that standards would be consistently applied all added to their acceptability. Four key standards emerged.

► **STANDARD ONE:** First, each insurer's proportion of medical expense to be allocated to primary care for the twelve months starting 1 January 2010 was to be one percentage point higher than actual spending for the twelve months starting 1 January 2008. This proportion was then to increase by one percentage point per year for five years. At the end of 2014, on average, 11 percent of commercial insurers' medical expenses were to be devoted to primary care.

Each insurer was required to submit a plan to the Office of the Health Insurance Commissioner each year that demonstrates how the increase will be achieved. An insurer must show that the increase will be accomplished without contributing to growth in premiums. There was to be an emphasis on innovative contracting and payment, as well as primary care system investment, not merely fee-schedule manipulation—that is, simply changing rates of reimbursement for specific diagnosis and management codes. Insurers' plans are to be subject to public review and discussion.

► **STANDARD TWO:** Second, insurers were required to support an expansion of the medical home initiative mentioned above that was based on the Chronic Care Model. The formal name for this is the Rhode Island Chronic Care Sustainability Initiative. Support was to start in July 2009 and continue through June 2010, with an increase of at least fifteen full-time-equivalent

primary care physicians to be hired by practices participating in the initiative by the end of the period.

This program, also initiated by the Office of the Health Insurance Commissioner, is a voluntary, multipayer initiative started in the fall of 2008. In the program, all health plans pay a selected group of primary care sites the same amount per member per month and a supplemental amount for nurse care managers. In return, participating physicians agree to achieve certain levels of accreditation in the National Committee for Quality Assurance's (NCQA's) patient-centered medical home standards, to learn collaboratively how to implement changes in their practice structures and processes for the care of chronically ill patients, and to measure their performance. These agreements are commemorated in a common contract between each plan and each site. It involves all commercial and Medicaid carriers but not traditional fee-for-service Medicare.<sup>12</sup> The initiative is still relatively small, as it is designed as a pilot project through which state leaders can learn what works in developing medical homes. However, the new standard requires the insurers to commit to doubling the size of the project and extending its duration.

► **STANDARD THREE:** The third standard required that by 1 January 2010, insurers demonstrate the implementation of an incentive program for physicians to adopt electronic health records that meet certain standards. Those standards include initial payments per physician of \$500–\$2,500 per insurer, depending on insurers' market share; and ongoing financial support to a practice for the cost of electronic health record implementation, with support equivalent to at least 3 percent of the insurer's standard payments to the practice.

► **STANDARD FOUR:** The fourth standard simply required insurers' participation in the ongoing discussion about comprehensive delivery system payment reform in Rhode Island. This included active engagement as a member of the stakeholder body to be convened by the Office of the Health Insurance Commissioner in coordination with other state entities. The standard also required insurers to provide certain noncompetitive information to the body, such as the structure of basic payment arrangements and areas of contractual performance incentives, to assist it in its deliberations.

**BEYOND PAYMENT INCREASES** One further issue is worth noting. It was the general opinion of the council that increases in primary care payments were necessary, but that simply increasing fee-for-service payments would not be sufficient to meet the standard. The council made no specific recommendations about alternative pay-

ment programs; rather, it referred to models in the literature and in practice in other communities, including pay-for-performance incentives, case management fees, and carefully conceived risk-sharing mechanisms.

The standards lent themselves to explicit measures, and the council recommended a set of evaluation metrics, with plans to assess performance each year and to report results publicly. These include total and ambulatory care-sensitive emergency room admissions and inpatient readmissions; changes in primary care and specialty physician supply; insurance premium trends; and primary care physician satisfaction.

### Implementation Now Under Way

The exciting aspect of Rhode Island's latest "lively experiment" is that it is not a series of mandates to do pilot studies, or promises of funding years hence. It is under way in 2010, with insurers and primary care physicians working hard to develop new practice models. This vigor, and, we hope, rigor, is based on the fact that the Office of the Health Insurance Commissioner has ensured that rate increases will be predicated on compliance with the program.

The increase in primary care spending is critical. The amount spent on primary care for the fully insured commercial population for 2009 was estimated to be approximately \$52 million. Therefore, to get from 5.9 percent to 6.9 percent of overall expenditures on health care, the additional primary care spending was estimated to be \$11 million in 2010, factoring in overall health care inflation. Similar increases would be \$24 million in 2011 and \$39 million in 2012, in terms of additional primary care expenditures on the 2009 base.

**PROVIDERS' REACTIONS** As might be expected, the primary care community is enthusiastic. Al Kurose, who leads the largest primary care practice in the state, Coastal Medical, notes that primary care practices are energized by these changes in payment, which they believe truly enhance their ability to manage care.<sup>13</sup>

These sentiments are corroborated by Yul Ejnes, who works with Kurose and is a member of the Board of Regents for the American College of Physicians.<sup>14</sup> Ejnes says that although not all primary care physicians are completely informed about the Office of the Health Insurance Commissioner-inspired changes in primary care reimbursement, those who are aware are excited. He also points out that the reforms are occurring at the same time that insurers have begun to review differences between Rhode Island's primary care payments and payments in other

states—with an eye to reducing disparities in rates of payment.

**INSURERS' REACTIONS** Of course, a good deal of the change in practice will be dictated not by physicians' innovation, but by what insurers will support with the new funds. As noted above, the initiative relies heavily on transparency. As part of this, the major insurers must detail how they plan to spend additional funds. The development of these plans presents challenges for the Office of the Health Insurance Commissioner and other stakeholders. For example, how much diversity should there be among the insurers' plans? What latitude should insurers be given to develop new ideas?

Blue Cross Blue Shield of Rhode Island and UnitedHealthcare are the dominant commercial insurers for the fully insured in Rhode Island. As Appendix Exhibits 1 and 2 reveal,<sup>15</sup> they are pursuing slightly different approaches.

► **BLUE CROSS BLUE SHIELD OF RHODE ISLAND:** Blue Cross Blue Shield of Rhode Island is putting 50 percent of the total funds it is now required to add to primary reimbursement into support for the primary care medical home. This includes both the all-payer initiative and a larger independent strategic effort by the insurer. Blue Cross Blue Shield of Rhode Island has a specific view of the medical home as focused on members with complex medical needs and substantial annual medical costs. Payment in Blue Cross Blue Shield's own medical home project will go to support case managers in physicians' offices, with an additional per member per month payment to the physician or practice. The insurer will also fund a pay-for-performance program as part of the patient-centered medical home initiative.

A significant part of Blue Cross Blue Shield of Rhode Island's support also goes to the adoption and enhancement of electronic health records. Although this represents only 10 percent of the total funding that Blue Cross is putting into increased primary care reimbursement, it is money that primary care physicians will likely be able to use in a more flexible way than similar dollars coming through the federal government as part of the new subsidies for electronic health records.<sup>16</sup> In addition, another 5 percent of the funds would go to specialists to help them purchase electronic health records and therefore better coordinate with primary care physicians.

Blue Cross Blue Shield is also attempting to promote integration across the health care system. There will be funds available to develop accountable care organizations, so that small practices will be encouraged to merge with larger ones. Hospitals will be encouraged to undertake care coordination with physicians'

offices. A pay-for-performance program will support rational and cost-effective pharmacy use, as well as quality improvement activities. And finally, behavioral health gets a boost through funding of behavioral health specialists, who will be located at primary care offices.

Less of Blue Cross Blue Shield's funding will be used for direct increases in primary care reimbursement. Gus Manocchia, the chief medical officer for Blue Cross Blue Shield, notes that the insurer has been working independent of the commissioner's office initiative to improve primary care in Rhode Island—for example, by raising payment to achieve compensation parity with primary care providers in Massachusetts.<sup>17</sup> All the same, Manocchia says, payment directives will in a few years lead to substantial increases in physician payments—and Blue Cross officials believe that much of this investment should go to practice improvements.

One point of debate is likely to persist going forward. Many primary care providers and health policy analysts continue to suggest that the only way to resolve the crisis in primary care is to substantially increase the pay for internists, family practitioners, and pediatricians. But at this point, the Office of the Health Insurance Commissioner and insurers have not promoted this approach. Rather, the advisory council made payment reform—not fee enhancement—the core of its affordability priorities. Substantial additional monies will flow to primary care as a result of this initiative—and presumably into physicians' pockets—but the Office of the Health Insurance Commissioner and its council are clear that funds must be used for improved capacity to provide primary care to patients, not simply higher payment for continuing to deliver the status quo.

► **UNITEDHEALTHCARE:** UnitedHealthcare's investment plan also supports the medical home. The company estimates that 25 percent of the increase it will fund will go directly to expand the chronic care sustainability initiative. Another 13 percent will pay for electronic health records. In the same category of structure and process incentives, an advisory group of physicians and employers will help UnitedHealthcare define other areas of support, such as forgiveness of loans to primary care practices that have open practices for primary care patients. Neal Galinko, the UnitedHealthcare medical director in Rhode Island, states that all of this spending is in line with United's national effort to support primary care.<sup>18</sup>

More UnitedHealthcare money goes directly to primary care providers than in the Blue Cross Blue Shield plan. A quarter of the dollars will be in a pay-for-performance program based on

quality and efficiency measures, with money for both top performers and biggest improvements. Another 5 percent will support incentives for after-hours care. Yet another quarter will be devoted to fee schedule improvements where United's fees trail the market. Galinko is interested in understanding how these reforms will be associated with performance improvement as data are collected over the next two years.

## Discussion

The Rhode Island initiative is striking: compared to other programs around the country, it is causing a real shift of expenditures from other parts of the health care system to primary care. Other states are engaged in various medical home trials in which insurers—separately or convened by state governments—are investing limited funds in practice changes. Many health insurance executives are not certain that these programs will actually improve care or lower costs. In most cases, though, insurers make the key funding decisions.

**THE RHODE ISLAND DIFFERENCE** Rhode Island has clearly taken a different course. Satisfied that the health services research literature demonstrates that stronger primary care leads to better overall health care, and cognizant of the fact that recruiting physicians to Rhode Island primary care is increasingly difficult because of poor overall payment, the state has used existing regulatory authority and created new policy—concentrating on the proportion of health care dollars supporting primary care practice.

The approach is admirably simple: Estimate current expenditures, then force the limited number of commercial companies in the fully insured marketplace, over which the state's insurance commissioner has direct control, to boost payments and identify what is being supported. It is, in effect, attempting to redress the Medicare's resource-based relative value scale (RBRVS) valuation process, which had the unintended effect of devaluing primary care. It also bypasses the usual approach of contractual negotiations between private health plans and providers, which reward provider size and market share, as opposed to high-quality care—especially high-quality primary care.

**WEAKNESSES** Inevitably, this approach has weaknesses. There is no formal study of the merits of the program; this would likely have required a complicated randomization process in a pilot format. Medicare and Medicaid, the large governmental payers, are not participating for their fee-for-service providers; nor are self-insured employers directly, because their regulation by the state is preempted by the federal

ERISA law. So Rhode Island's program is in effect applying to only part of the payment that most physicians receive.

The program is also only a partial solution within the context of the overall health care system, in that there is no real involvement of hospitals. Although much medical care in Rhode Island is provided by hospitals and hospital-affiliated groups, there is not much integration of primary care physicians into these systems. So primary care physicians, and insurers, are largely making their decisions independent of any integration between hospitals and physicians. Such integration is central to the concept of accountable care organizations, which many see as the centerpiece of real health reform. Rhode Island therefore does not exemplify how primary care expansion would contribute to the accountable care organization concept.

Nor is there any aspect of the program that supports primary care training. Although some of this increased primary care spending could go to expanding the pipeline of primary care physicians, it does not support new residency slots. Finally, the dollars for the boost to primary care must come from somewhere else—in all likelihood, from payments to specialists and to hospitals. But thus far, those groups have raised few if any objections.

**BETTING ON THE MEDICAL HOME** Essentially, the Rhode Island initiative is a bet on the medical home, and on different and higher primary care payments, to improve the effectiveness of medical care in the state. From what we know, it is a reasonable bet. But the state and insurers are committed to gathering data that will determine if there are real improvements.

The success of the program thus far may lie in

its strong advisory structures, and its location in a small state where the major decision makers among physicians, hospitals, and insurers can, and do, meet frequently. It is also a transparent program, which allows ongoing debate and, if necessary, midcourse adjustments. These appear to be key to gaining consensus in Rhode Island.

**POLICY DIRECTIONS** With the new money comes responsibility for the state, insurers, and primary care providers. A public priority-setting process must be developed to help guide, react to, and coordinate insurers' proposals for how the money is best spent. Although initial resistance was not great because of the public process and the engagement of stakeholders, the continued success of the project is dependent upon the availability of resources for implementation and evaluation, and of political support. Perhaps most important, a change in the commissioner or a larger executive branch administration change could threaten future prospects.

Primary care leadership and infrastructure must be developed to take advantage of new funds. These capacities must continue to grow as the required spending amounts increase. Incentives and market forces must be aligned so that a stronger primary care infrastructure actually meets the needs of patients and consumers. And other providers in the system have to figure out how to adapt to an environment where more care is overseen by a strengthened primary care infrastructure.

These challenges all follow from a fundamental prioritization of resources for primary care. For this alone, Rhode Island's "lively experiment" is unique, and worthy of ongoing attention from policy makers. ■

## NOTES

- 1 A copy of the Charter granted to Roger Williams by King Charles I is on public display at the Rhode Island State House.
- 2 Rhode Island General Law 42-14.5-2.
- 3 Chirba-Martin MA, Brennan TA. The critical role of ERISA in state health reform. *Health Aff (Millwood)*. 1994;13(2):142-56.
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- 10 Koller C. The Rhode Island Chronic Care Sustainability Initiative (CSI-RI): translating the medical home principles into a payment pilot [Internet]. Providence (RI): Office of the Health Insurance Commissioner; [cited 2010 Apr 8]. Available from: [http://www.mass.gov/Eoehhs2/docs/dhcfp/pc/2009\\_02\\_13\\_medical\\_home\\_case\\_study\\_presentation.ppt](http://www.mass.gov/Eoehhs2/docs/dhcfp/pc/2009_02_13_medical_home_case_study_presentation.ppt)
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- 12 Freyer FJ. R.I. project aims to improve primary care for both doctor and patient. *Providence Journal*. 2009 Mar 29:A1.
- 13 Kurose A. Authors' interview. 2010 Feb 2.
- 14 Ejnes Y. Authors' interview. 2010 Jan 20.
- 15 The online Appendix can be accessed by clicking on the Appendix link in the box to the right of the article online.
- 16 Steinbrook R. Health care and the American Recovery and Reinvestment Act. *N Engl J Med*. 2009;360:1057-60.
- 17 Manocchia G. Authors' interview. 2010 Jan 29.
- 18 Galinko N. Authors' interview. 2010 Feb 11.



August 6, 2013

Chairs, Oregon Health Policy Board  
Oregon Health Authority

Dear Chairs Parsons and Shirley and members of the Board:

The Medicaid Advisory Committee thanks the Oregon Health Policy Board for the opportunity to share its work on Person- and Family-Centered Care and Engagement, and appreciates the Board's support in its efforts to develop a framework for enhancing policies that support this work. Based on the Board's feedback and request, the Committee narrowed the initial set of strategies and actions to two recommendations, which serve as the desired starting point for this work over the next 6-12 months. The full list of strategies and actions<sup>1</sup> provide a broader framework as the Oregon Health Authority (OHA) works to align and spread models of coordinated and integrated care across the agency's health care programs, including Oregon's commercial marketplace.

The Committee prioritized its final recommendations in accordance with the Board's guidance summarized below:

- Consider the roles of all actors in the system and how responsibility can be appropriately assigned across the different parts of the health system.
- Leverage existing infrastructure and health system transformation efforts already underway, specifically the OHA Transformation Center and the Patient-Centered Primary Care Institute.
- Assure expectations placed on providers, practices, and the health care system is balanced with similar expectations and notions of accountability for local and state officials, communities, individuals, and their families/representatives.

**Recommendation #1:** Each CCO and their delivery system partners empower individuals by providing education and support in how to navigate the delivery system and manage their own health by providing timely, complete, unbiased and understandable information in accessible and appropriate formats on health conditions and treatment options, taking into account cultural, linguistic, and age appropriate factors.

**Recommendation #2:** OHA partners with CCOs through the Transformation Center to achieve economies of scale to make the use of the Patient Activation Measure (PAM), shared decision-making tools, and health literacy tools more affordable to all practices and works with the Patient Centered Primary Care Institute to train and educate practices on the implementation of such tools.

<sup>1</sup> For the complete list of strategies and actions, please see the July 2013 MAC Report on Person- and Family-Centered Care and Engagement.

With the upcoming expansion of Medicaid to low income adults up to 138% of the Federal Poverty Level, approximately 240,000 newly eligible low-income Oregonians are projected to enroll in the Oregon Health Plan (OHP) by the end of 2016. This is in addition to the 660,000 individuals currently eligible for the OHP that are projected to enroll within the same timeframe. This presents a historic opportunity to redefine the relationship, expectations, and roles of individuals on the OHP as active participants in Oregon's reformed health system. The overarching goal is to promote deeper engagement across all levels of the health system, and simultaneously encourage individual responsibility for managing one's own health and health care. The recommendations are intended to support individuals as equal partners in and accountable for their own health.

The Committee believes its report and recommendations should serve as a foundation for the Task Force on Individual Responsibility and Health Engagement, whose work will occur over the Fall of 2013. We appreciate the opportunity to create a new understanding of the roles and responsibilities of CCOs, health care professionals, local and state officials, communities, and individuals and families/representatives in support of person- and family-centered care.

Sincerely,

A handwritten signature in black ink that reads "Janet E. Patin MD". The signature is written in a cursive style with a large, stylized initial "J".

Janet E. Patin, MD  
Co-Chair, Medicaid Advisory Committee

A handwritten signature in black ink that reads "Karen Gaffney MS". The signature is written in a cursive style with a large, stylized initial "K".

Karen Gaffney, MS  
Co-Chair, Medicaid Advisory Committee