Delaware Office of Value-Based Healthcare Delivery

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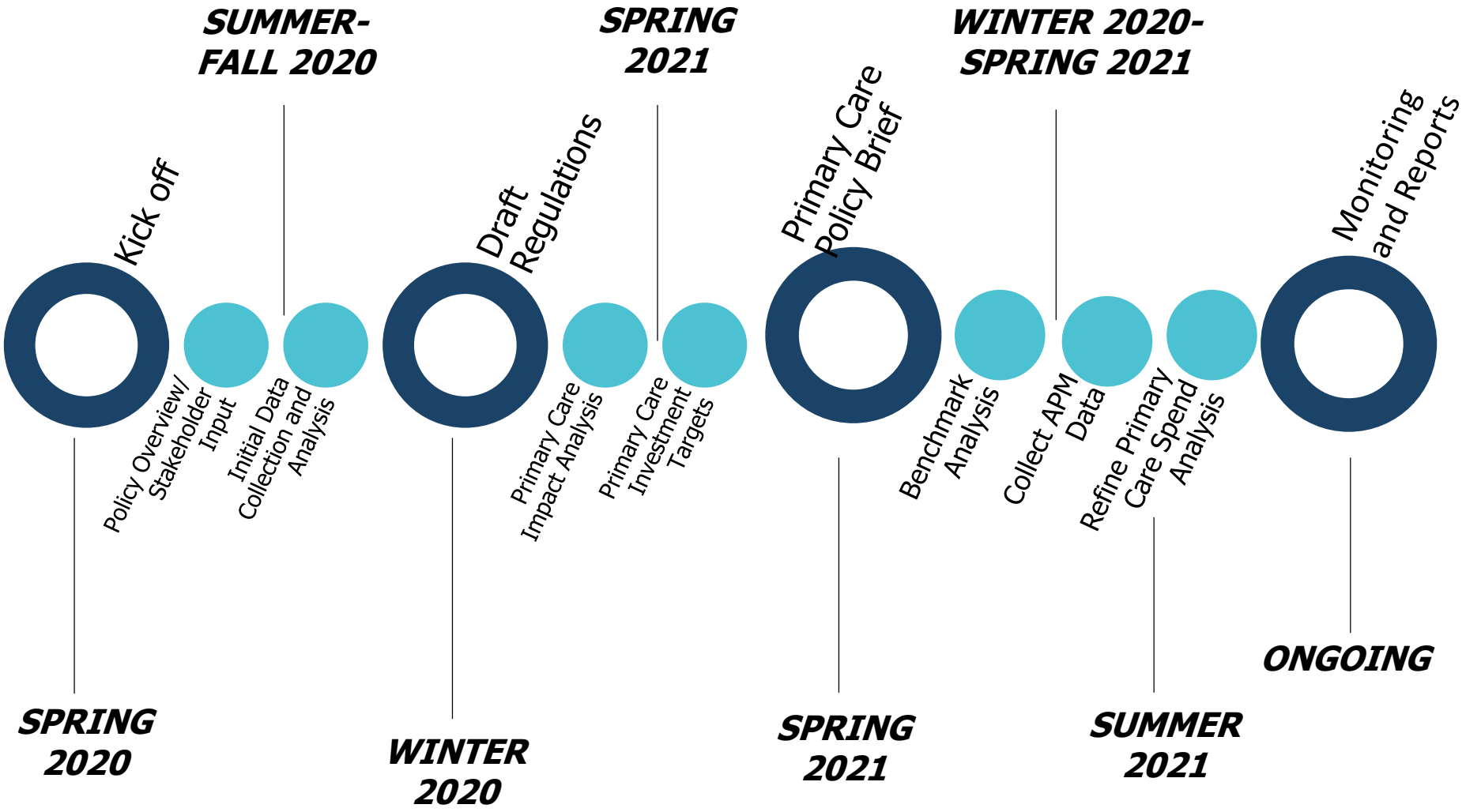
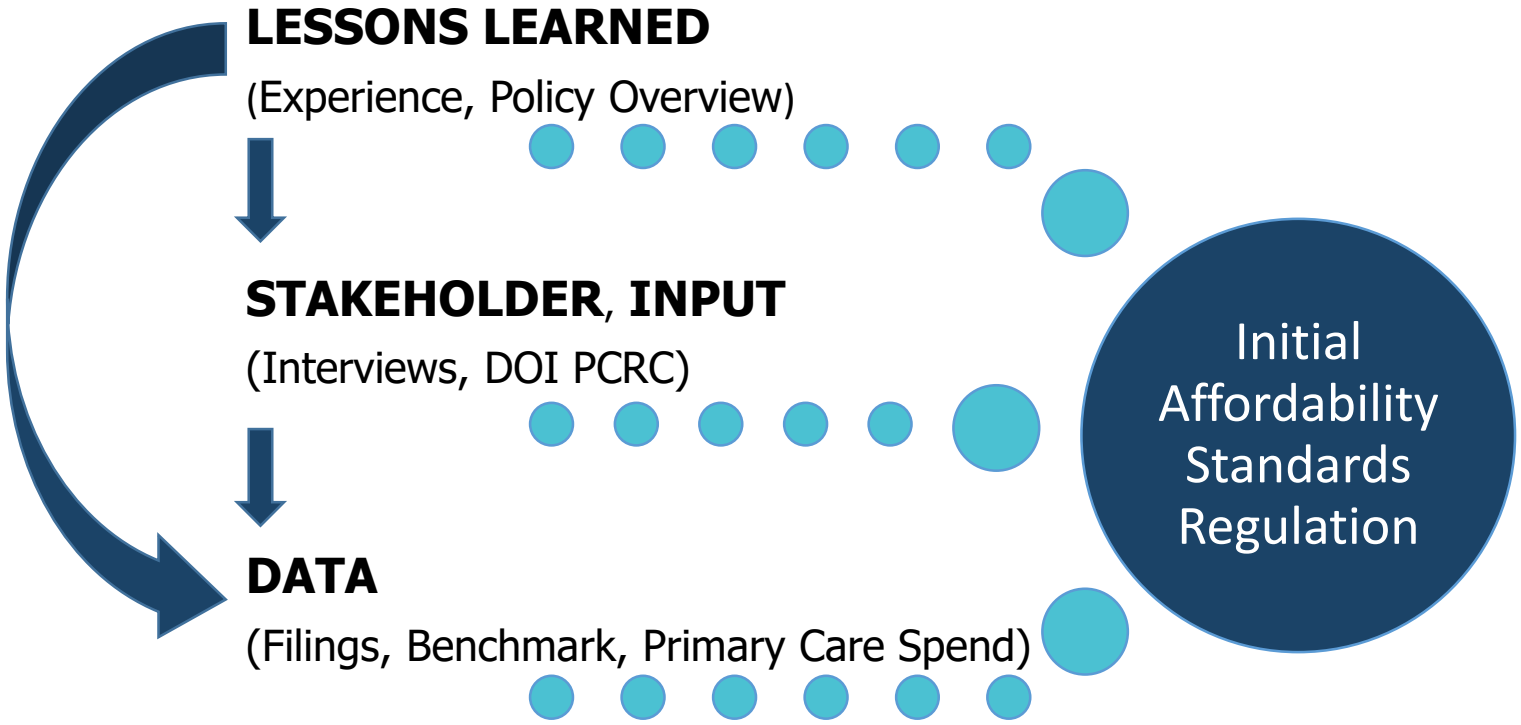
Agenda

- Provide overview of our work together
- Discuss various Affordability Standards, related concepts and how they work together
- Review the experience of other states and how it applies to Delaware

Project Timeline



The Next Few Months



Approaches to Achieving Affordability

	Domain	Definition	Examples
CORE POLICIES	Total cost of care benchmarks	Mandated healthcare spending growth target, typically with hearings, performance improvement plans if failure to meet targets	MA benchmark of 3.1% or potential gross state product minus 0.5%
CORE POLICIES	Primary care spend targets	Mandated primary care investment as a percentage of total healthcare spending	CT 10% primary care spend target by 2025; RI 11%
SUPPORTIVE PROGRAMS	Enhanced rate review and other payer reforms	Consumer subsidies; limits on rate increases, cost sharing; minimum MLR etc.	VT has household spending thresholds for affordability supported by subsidies
SUPPORTIVE PROGRAMS	Provider price regulation	Rate regulation for hospitals and other providers, Rx pricing legislation, surprise billing legislation	RI limits hospital rate increases to Medicare price index plus one percentage point.
SUPPORTIVE PROGRAMS	Market consolidation monitoring	Analysis of change in quality, cost, and access due to changes in the market	MA, CT conduct Cost and Market Impact Reviews on proposed consolidation
SUPPORTIVE PROGRAMS	Alternative payment model adoption targets	Mandated requirements on APM adoption, quality incentive payments, provider risk-sharing, global budgets	OR to require 70% of Medicaid payments to be for value-based contracts by 2024

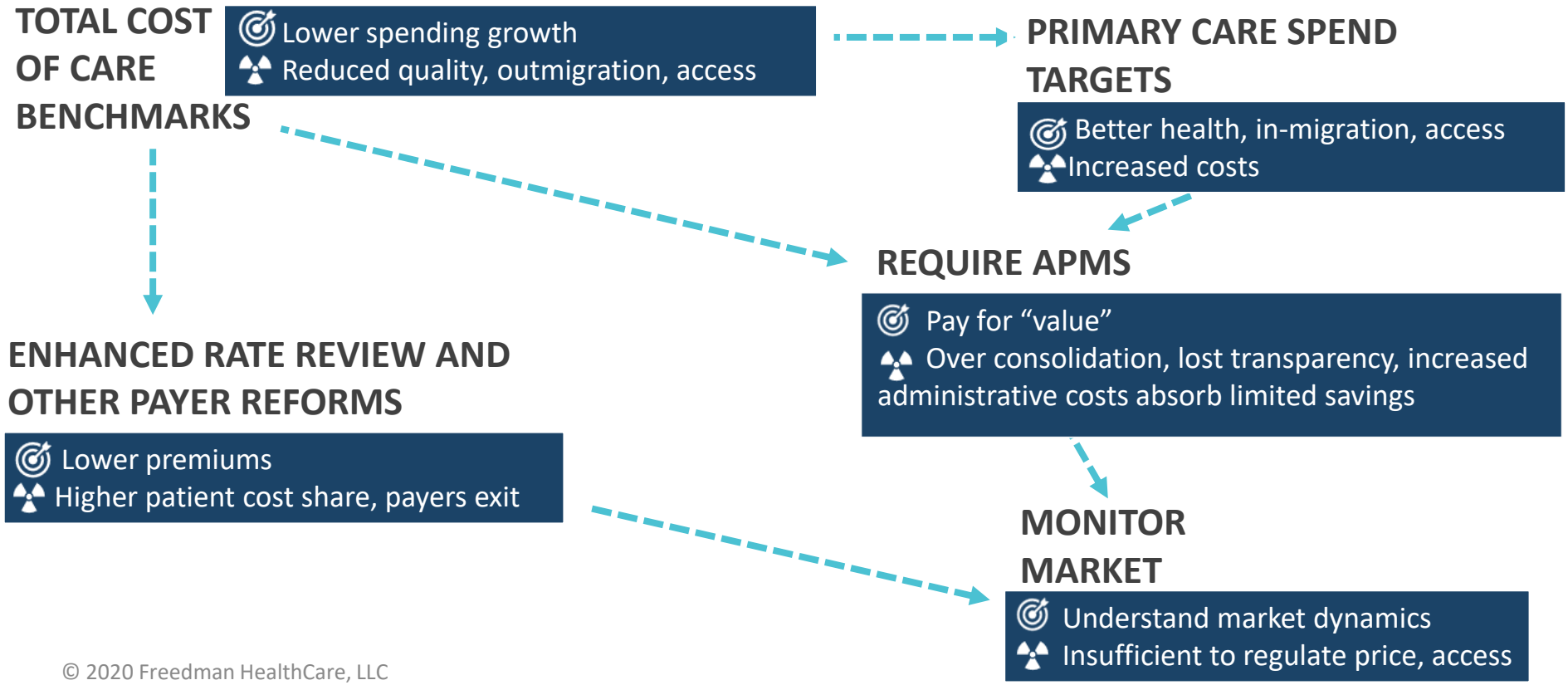
A Simple Equation

Nationally, prices accounted for 75% of spending growth 2014-2018.*

*2018 HCCI Healthcare Cost and Utilization Report

Policies Work Together

By working together, policies can achieve their desired goals and protect against unintended consequences. Below is an example of how some policies might interact.



Affordability Standards Overview

	TOTAL COST OF CARE BENCHMARK	PRIMARY CARE SPEND TARGETS/ REDESIGN	ENHANCED RATE REVIEW AND OTHER PAYER REFORMS	MARKET CONSOLIDATION MONITORING	PUBLIC OPTION	APM ADOPTION TARGETS	PROVIDER PRICE REGULATION
Connecticut	✓	✓		✓			✓
Colorado		✓	✓		✓	✓	✓
Maryland	●	✓				✓	✓*
Massachusetts	✓	✓	✓	✓			✓
Rhode Island	✓	✓				✓	✓*
Oregon	✓	✓**				✓**	✓
Vermont	●		✓	N/A		✓	✓
Washington					✓	✓	✓

Developed: ✓ In progress: ✓ Special CMS Negotiation: ● Medicaid Focused: ✓** Rate Caps: ✓*

Common Attributes of Successful Programs

- ☑ Multi-payer alignment
- ☑ Consumer perspective reflected
- ☑ Strong state multi-agency alignment
- ☑ Enforceable pressure on total cost of care, sometimes with focus on hospital prices
- ☑ "Action-forcing event" catalyzes change
- ☑ Effective, robust supplemental data collection
- ☑ Provider leadership and buy-in

Delaware's Priorities

DOMAIN	FREEDMAN ROLE	DISCUSSION IN DELAWARE
Total Cost of Care Benchmark	• Collect data, develop reports regarding carrier investments in health care to monitor and evaluate data from benchmarking process	• Benchmark analysis underway, awaiting results
Primary Care Spend Target/ Redesign	• Establish targets for carrier investment by 2025; • Collect data, report carrier investments in health care to monitor and evaluate primary care spending	• State should mandate increases in primary care spend to reach 12% • Upfront investment to build infrastructure, HIT, team care • Should only promote sustainable increases in TCOC

Enhanced rate review and other payer reforms	• Establish affordability standards, for health insurance premiums based on PCRC recommendations
	  • Enhance consumer premium subsidies <400FPL
	  • Limits on rate increases, contribution to reserve, administrative charge
	  • Stricter MLR Requirements
	  • Provider rate review
	• Carrier compliance with reimbursement rates for primary care for OB-GYNs
	• Recommend appropriate primary care reimbursement rates
		• New office to allow regulatory oversight of plan rates:
		  • Assess rates holistically, including specialty/hospital care, to limit spending growth, ensure access
		  • Can establish hospital rate caps
		• Hospital prices in DE are higher than national; hospital profits higher; lower comm benefit
		• Reduce hospital inpatient spend by 10% of Medicare rate/yr each year until 190%, likely over 5yrs

The Work Ahead

As we work together to develop affordability standards for Delaware, we'll be thinking through…

- Availability of data
- Existing competitive landscape
- Desire to regulate
- Level of multi-stakeholder engagement
- Complimentary programs
- Adapting in a time of great uncertainty

State Profiles

Connecticut

- **Background:**
  - Office of Health Strategy leads, largely building on SIM efforts
  - Efforts to finance primary care transformation via custom CMS deal stalled

- **Key Policies:**
  - Benchmark coupled with 10% primary care spend target, performance improvement plans, public reporting of cost trends recently launched
  - CMIR, quality benchmarks and "monitoring" of ACOs used to regulate market dynamics, quality and access
  - Self-Sufficiency Standard defines the income necessary to meet basic needs, likely to be incorporated into benchmark work

- **Lessons Learned/Impact:**
  - CMS less interested in custom arrangements than under previous administrations
  - Communication and alignment across state agencies is key
  - Overcoming stakeholder conflict requires strong state leadership

Colorado

- **Background:**
  - Passed legislation that set targets for investment in primary care and established a primary care payment reform collaborative in the division of insurance
  - Draft regulations were under consideration when the COVID-19 pandemic hit
- **Key Policies:**
  - Carriers to move at least 50% of applicable medical expense to APMs by 2023 or face DOI performance improvement plan
  - Carriers to increase primary care spend as a percent of total medical expense 1 percentage point per year in 2021, 2022 and report how investments support advanced primary care
  - State considering Public Option for individual market. Carriers would administer. It sets reimbursement for hospitals at 155% Medicare.
  - New reinsurance program aims to reduce costs for the individual market
- **Lessons Learned/Impact:**
  - Obtaining data to operationalize policy goals is an important and sometimes frustrating process
  - Progress takes time. The state's primary care collaborative has spent about 18 months working to develop the draft regulation.

Maryland

- **Background:**
  - Total Cost of Care (TCOC) Model, the first CMS/state "full risk" agreement, sets a per capita limit on Medicare TCOC, with aims to save $1 billion by 2023
  - Builds on 40yrs of fixed payments to hospitals including the 2014 All-Payer Model
  - Hospital cost growth per capita for all payers must not exceed 3.58% per year

- **Key Policies:**
  - **Hospital Payment Program**: Each hospital receives a population-based payment amount to cover all hospital services for a year
  - **Care Redesign Program**: Hospitals incent non-hospital partners to improve quality of care. Total costs, including incentives, cannot exceed fixed global budget
  - **Maryland Primary Care Program**: Incents advanced primary care through CPC Plus "like" program

- **Lessons Learned/Impact:**
  - The All Payer Model (2014-2018) held the cost of hospital care to a cumulative 11.16 percent increase (less than half of the model's target)
  - Stakeholders felt that the All Payer Model made it difficult to engage other aspects of care delivery; the new model aims to give hospitals the ability to incent other providers

Massachusetts

Background:

- An early adopter of a wide range of "affordability standards," Massachusetts has reforms to measure and constrain total cost of care and improve affordability for consumers; extensive supplemental data collection and provider consolidation oversight. Significant provider price variation remains with some providers paid 2x to 3x others.
- Proposed legislation would require primary care and behavioral health spending to increase 30% over the next three years

Key Policies:

- Total cost of care benchmark currently sits at 3.1%. It is reinforced by annual public cost trends hearings and reports, as well as performance improvement plans for providers.
- Additional state-based consumer subsidies, beyond Affordable Care Act minimums
- Carriers face limits on administrative charges, rate increases, and how much profit can be contributed to reserve. Individual and small group must post a higher medical loss ratio than required by ACA and offer a tiered network plan priced lower than a non-tiered plan.

Lessons Learned/Impact:

- In many ways, MA is the national leader in developing policies aimed at improving affordability
- Data reported for the benchmark does not align with premium increases in the market creating confusion and more than 40% of MA consumers still report healthcare affordability challenges

Rhode Island

- **Background:**
  - Rhode Island 2010 Affordability Standards included increased primary care spending and limiting rate increases for hospital services and population-based contracts, regulated by Office of Health Insurances under the umbrella of rate review

- **Key Policies:**
  - Health Care Cost Growth Target is 3.2% through 2022
  - Examples of 2019 Affordability Standard Updates:
    - More flexibility for primary care investments (now required to hit 11% TME);
    - 50% of insured medical payments to APMs, risk-based contracting targets and minimum downside risk standards that increase over time will be released
    - Prospective payment for primary care required by January 2021
    - Carriers must reimburse for BH services at primary care and eliminate second copay for same day PCP/BH services
    - Limits on reimbursement rate increases remain with a one-time adjustment

- **Lessons Learned/Impact:**
  - A study found overall spending declined 8.1% from 2010 to 2016 while primary care spend increased. Decline was largely attributed to hospital price constraints.
  - RI said the 2019 revisions would be necessary to continue to see progress.

Oregon

- **Background:**
  - Oregon has been working to increase primary care spend for several years and Medicaid has a 12% primary care spend target.
  - Medicaid has been held to a 3.4% growth rate since 2012, public employee health plans have been held to the same rate since 2014.

- **Key Policies:**
  - In 2019, Oregon became the fourth state to adopt a benchmarking program. It aims to align providers and payers around a common set of cost control strategies.
  - At least 70% of Medicaid payments to providers are supposed to be in the form of a value-based payment by 2024
  - Primary care efforts focus on a multi-payer primary care payment model to standardize payment methodologies, increase investment in primary care

- **Lessons Learned/Impact:**
  - Global budgets for Medicaid have led to increased primary care spending, and savings of about 7%. Savings were primarily attributed to lower inpatient spending.
  - Significant variation in primary care spending across payer types

Vermont

Background:

- Green Mountain Care Board oversees health care payment and delivery system reform, provider rate-setting, health IT, workforce plan approval, hospital and ACO budget approval, insurer rate approval, CON, and the APCD.
- Single regulatory home for the state's affordability policies, which focus on the state's ACO and consumer affordability measures

Key Policies:

- Vermont All-Payer ACO Model offers investment to help providers transition to value-based care. Limits major payers growth to 3.5%, with CMS enforcement beginning at 4.3% growth.
- In Vermont, if a household's premium is more than 9.69% of income or the deductible is greater than 5% of income, a plan is unaffordable and subsidies and other supports kick in.

Lessons Learned/Impact:

- Vermont TCOC per member per month (PMPM) increased 4.1% across all payer types in 2018, narrowly avoiding CMS enforcement action, thanks in large part to Medicare Advantage, a small part of the market that experienced dramatic reductions in cost
- Lower than expected attribution to all-payer ACO

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