Draft Pending Adoption

Health Insurance and Managed Care (B) Committee

8/11/20

Draft: 7/27/20

Health Innovations (B) Working Group
Conference Call
June 23, 2020

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met via conference call June 23, 2020. The following Working Group members participated: Marie Ganim, Chair; Jay Garrett, and Marea Tumber (RI); Martin Swanson, Vice Chair, and Laura Arp (NE); Andrew R. Stolfi, Vice Chair (OR); Sara Bailey and Jacob Lauten (AK); Anthony L. Williams (AL); Howard Liebers (DC); Cynthia Banks Radke and Sonya Sellmeyer (IA); Julie Holmes and Tate Flott (KS); Carrie Couch, Jessica Schrimpf, Michelle Vickers, Chlora Lindley-Myers, Amy Hoyt and Cynthia Amann (MO); John Arnold, Sara Gerving and Chrystal Bartuska (ND); Tyler Brannen and Maureen Belanger (NH); Philip Gennace and Chanell McDevitt (NJ); Brittany ODell, Paige Duhamel and Viara Ianakieva (NM); Jeremy Christensen and Jack Childress (NV); Sandra L. Ykema, Jessica K. Altman and Katie Dzurec (PA); Doug Danzeiser, Rachel Bowden and Kenisha Schuster (TX); Molly Nollette (WA); Jennifer Steggall, Diane Dambach, Barbara Belling, Mary Kay Rodriguez, Nathan Houdek, Jody Ullman, and Darcy Paskey (WI); and Joylynn Fix and Vanessa George (WV). Also participating were: Erin Klug and Mary Boatright (AZ); Debra Judy (CO); Chris Struk and Carolyn Diggs (FL); Ian Robertson, Arlene Ige and Mavis Okihara (HI); Kristen Finau (ID); Ryan Gillespie (IL); Claire Szpara and Alex Peck (IN); Cathy Grason and David Cooney (MD); Grace Arnold (MN); Jeannie Keller (MT); Rosemary Gillespie (NC); Marjorie Ellis (OH); Andrew Dvorine (SC); Jill Kruger, Gretchen Brodkorb and Candy Holbrook (SD); Shelley Wiseman (UT); Julie Blauvelt (VA); and Denise Burke and Tana Howard (WY).

1. Discussed the Regulation of Coverage for Telehealth Services

Health Commissioner Ganim introduced Joel Ario (Manatt Health) and Jared Augenstein (Manatt Health). Mr. Augenstein presented on state and federal law and regulatory actions related to telehealth. He showed the growth in states with telehealth private payor laws prior to the COVID-19 pandemic. He reviewed federal and state actions taken to expand access to telehealth during the pandemic.

Commissioner Stolfi described Oregon’s recent actions on telehealth and he observed that payment parity can be limited by state authority and disparate access to telecommunications technology is an issue. Mr. Swanson said Nebraska had not issued emergency orders, but the issuers stepped up themselves. He said some fraud issues were emerging. Ms. Arp added that provider groups are asking for extensions of relaxed telehealth policies and for reimbursement parity to be required for at least 12 months. She said stakeholders should be clear that states cannot relax requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Mr. Augenstein shared statistics on the utilization of telehealth during the pandemic. He described equity issues raised by telehealth and several other policy considerations for the states. He also outlined an array of policy levers that states and other policymakers could use to regulate telehealth, including coverage, originating and distant sites, eligible services and providers, eligible communications modes, utilization management, and networks.

Ms. Arnold said some insurance carriers have preferential contracts with telehealth providers that are distinct from the carrier’s contracts with other providers, which can make it difficult for traditional providers to engage in telehealth. She said Minnesota changed state law so that payment parity requirements are agnostic to the existence of a preferential contract between carriers and telehealth providers. She said carriers have not resisted this change.

Ms. Judy said preferential networks may also exist for dental care or preventive services. She questioned how network adequacy should be determined with prevalent telehealth, and she said Colorado’s law specifies that telehealth providers do not modify an issuer’s obligation to meet in-person network requirements. She also mentioned concerns about inequities in access.

Silvia Yee (Disability Rights Education and Defense Fund—DREDF) asked whether issuers offer help for people with disabilities who cannot utilize telehealth services without assistance. Mr. Augenstein said North Carolina allows providers to bill for telehealth, and it provides an evaluation and management code for assistive services in the patient’s home.
2. Discussed Potential Topics for the Summer National Meeting

Health Commissioner Ganim asked the Working Group which topics it should address at the Summer National Meeting. Because time was short, she encouraged Working Group members to submit ideas via e-mail.

Having no further business, the Health Innovations (B) Working Group adjourned.

W:\National Meetings\2020\Summer\Cmte\B\Innovations\WG\HInnMin6.23.docx
HIPAA, COVID-19 and the Future of Telehealth

Presented by: Randi Seigel

July 30, 2020
## Security Rule

### Standards for Safeguarding PHI

<table>
<thead>
<tr>
<th>Administrative</th>
<th>Physical</th>
<th>Technical</th>
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<tbody>
<tr>
<td>▪ Security management</td>
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<tr>
<td>▪ Assigned responsibility</td>
<td></td>
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<tr>
<td>▪ Workforce security</td>
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<td>▪ Training</td>
<td></td>
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<tr>
<td>▪ Incident procedures</td>
<td></td>
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<tr>
<td>▪ Contingencies</td>
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<tr>
<td>▪ Updates</td>
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<tr>
<td>▪ Facility access</td>
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<tr>
<td>▪ Workstation controls</td>
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<tr>
<td>▪ Device and media controls</td>
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<tr>
<td>▪ Accountability</td>
<td></td>
<td></td>
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<tr>
<td>▪ Backup and storage</td>
<td></td>
<td></td>
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<tr>
<td>▪ Access control</td>
<td></td>
<td></td>
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<tr>
<td>▪ Audit controls</td>
<td></td>
<td></td>
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<tr>
<td>▪ Integrity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Access authentication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Transmission security</td>
<td></td>
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</tbody>
</table>

### Implementation Specifications

<table>
<thead>
<tr>
<th>Required</th>
<th>Addressable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk analysis</td>
<td>Log-in monitoring</td>
</tr>
<tr>
<td>Disposal of electronic devices</td>
<td>Data backup</td>
</tr>
<tr>
<td>Unique user IDs</td>
<td>In-transit encryption</td>
</tr>
</tbody>
</table>

- With appropriate documentation, “addressable” specs need not be implemented
- Several factors to consider regarding flexibility in approach to implementing security measures
**Tech Vendors Are Business Associates**

- **Business Associate** – Any tech vendor that creates, receives, maintains or transmits PHI on behalf of a covered entity for functions under the HIPAA rule will in most cases be considered to be a business associate.

- **Downstream vendors** – Any service provider to the tech vendor that creates, receives, maintains or transmits the covered entity’s PHI on behalf of the tech vendor is a business associate.
  
  - **Mere Conduit Exception** – Electronic equivalent of a courier where access to ePHI is transient (not persistent) is not a business associate. Temporary storage incident to transmission.

<table>
<thead>
<tr>
<th>Does exception apply to:</th>
<th></th>
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<tbody>
<tr>
<td>Broadband providers</td>
<td>Yes</td>
</tr>
<tr>
<td>Cellular carriers</td>
<td>Yes</td>
</tr>
<tr>
<td>Email services</td>
<td>No</td>
</tr>
<tr>
<td>Commercial messaging platforms</td>
<td>No</td>
</tr>
<tr>
<td>Mobile app developer</td>
<td>Depends</td>
</tr>
</tbody>
</table>

**HIPAA, COVID-19 and the Future | Manatt, Phelps & Phillips, LLP**
ONC FAQ: Can you use texting to communicate health information, even if it is to another provider or professional?

Answer: It depends. Text messages are generally not secure because they lack encryption, and the sender does not know with certainty that the message is received by the intended recipient. Also, the telecommunication vendor/wireless carrier may store the text messages. However, your organization may approve texting after performing a risk analysis or implementing a third-party messaging solution that incorporates measures to establish a secure communication platform that will allow texting on approved devices.

Source: https://www.healthit.gov/faq/can-you-use-texting-communicate-health-information-even-if-it-another-provider-or-professional
COVID-19 and HIPAA
HIPAA Flexibilities Aim to Promote Use of Telehealth

The HHS Office of Civil Rights (OCR) issued a notice of enforcement discretion that substantially waives federal enforcement of HIPAA in regard to telehealth.

- OCR not to impose penalties for good faith violations of HIPAA privacy, security and breach notification rules by telehealth providers.

- Provides flexibility in key areas:
  - Providers may use nonpublic-facing, unencrypted platforms to communicate with patients.
  - No need for presenting notice of privacy practices.

- Enforcement discretion is premised on “good faith.” Provider acts in bad faith if:
  - Engages in a criminal act, such as fraud or identity theft.
  - Sells data or uses data for marketing without authorization.
  - Violates state licensing laws or professional ethical standards.
  - Uses public-facing remote communication products (e.g., Facebook Live).

Source: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
Other Considerations

Despite OCR flexibility, providers still face legal liability from other sources (state attorneys general, patients) that mandate privacy compliance.

- Comply with recommended but not required practices under OCR’s HIPAA guidance:
  - Enter into business associate agreements with vendors.
  - Notify patients of privacy and security risks.
  - Avoid communicating from public settings.

- Use most secure platform that is feasible (e.g., higher standard if practitioner is at home/office vs. traveling). Never use public-facing platforms (e.g., Facebook Live).

- Provide breach notifications required under state law, if not waived.

- Maintain procedures for compliance with 42 CFR Part 2 if SUD data is involved (general need for written consent absent emergency).
The Future of Telehealth
OCR and Telehealth in the Future

Telehealth is here to stay,

- The report finds telehealth adoption increased by nearly 50 percent in primary care at the peak
- The Study found that in April, nearly half (43.5%) of Medicare primary care visits were provided through telehealth compared with less than one percent (0.1%) in February before the PHE.

- Continue studying the effect of OCR’s enforcement discretion on access to and use of telehealth.
- Encourage more platforms to implement security safeguards consistent with HIPAA.
- Adopt a framework for healthcare providers to perform a risk assessment of using an unsecure platform for telehealth delivery.
Expanding Access to Telehealth During the COVID 19 Pandemic

Presentation to the NAIC Health Innovations (B) Working Group

Andrew Sperling, Director of Legislative and Policy Advocacy
NAIC Consumer Representative
asperling@nami.org

July 30, 2020
Alliance for Connected Care Definition

• Use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

• Includes technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

• Applications include:
  - Live (synchronous) videoconferencing and audio-only communication,
  - Store-and-forward (asynchronous) videoconferencing,
  - Remote patient monitoring (RPM),
  - Mobile health such as health care and public health information provided through mobile devices (including general educational information, targeted texts, and notifications about disease outbreaks)
Harris Poll Released July 27

- 2,019 US adult respondents, May 27-29, 2020,
- 62% of telepsych users surveyed agreed they would not be able to get the care they needed,
- 67% agreed that the telepsych services helped them adhere to treatment,
- 74% of current telepsych users surveyed were interested in continuing to use these services after the current pandemic,
- Both telepsych users (65%) and non-telepsych users (37%) surveyed wished they knew more about how to access telepsych services,
Harris Poll Released July 27

Concerns?

When asked about difficulties or challenges they experience with telepsych services, respondents cited:

- lack of privacy/worry that others in the home may overhear their conversation (25%),
- preference for in-person treatment (24%), and
- lack of time to dedicate to telepsych due to other commitments (23%).
Behavioral health providers are reporting:

- Average time to the first appointment decreased,
- Show rates for first appointments increased,
- Days to first appointment after inpatient care decreased, and
- Average numbers of services per consumer increased significantly.
Consumer Concerns

- Lack of broadband access in rural and remote areas
- Privacy and confidentiality as requirements for use of HIPAA compliant devices are being waived
- Quality - Lack of an integrated electronic medical record accessible during a virtual visit
- Willingness to accept treatment from a provider with no pre-existing relationship
- Willingness to continue using virtual care as the pandemic drags on and restrictions are lifted incrementally
- Need for fraud and abuse guardrails both during and after this public health emergency
The Future of Virtual Care

Kate Berry
Senior Vice President, Clinical Innovations
Trends in Telehealth

Before and During COVID-19
Enablers During COVID-19 Public Health Emergency

• CMS allowed issuers in the individual and group market to make mid-year changes to provide greater coverage for telehealth and/or lower cost-sharing without notice requirements

• HHS OCR waived certain regulatory requirements under HIPAA to lower barriers to providers offering telehealth during the PHE
  − Permitted use of technologies that were not HIPAA compliant (e.g., Facetime)

• Numerous states made temporary changes to their telehealth policies for Medicaid and commercial markets in response to the pandemic
  − Plans contract with telehealth platforms and support contracted providers to deliver virtual care
What Happens After the Public Health Emergency?

Ongoing Challenges

• Single-state licensure
• Certain state regulations and variability across states
• Requirements regarding coverage or reimbursement that limit flexibility
• Standard of care
• Driving outcome-based care

How States can Promote Telehealth

• Collaborate with other states to promote multi-state licensure
• Embrace cost-saving potential
• Protect patient privacy
• Promote innovation
Questions?

• Additional resources are available at AHIP.org
  - [Telehealth: Connecting Consumers to Care Everywhere (Issue Brief and Fact Sheet)](#)
  - [Telehealth Growth During COVID-19 (Infographic)](#)
  - [Beyond COVID-19: Policy Recommendations to Strengthen and Improve Telehealth Services](#)
  - [Telehealth Solutions to Strengthen and Improve Care Delivery](#)
NAIC Telehealth Discussion

Stephanie Quinn
SVP, Advocacy, Practice Advancement & Policy
Workflow Transformation

• PPE Conservation
• Staffing Shortages
• Scheduling Process
CMS Flexibilities

• Payment Parity
• Audio-only
• Lifting Geographic/Originating/Distant Site Restrictions
• Cost-share Waivers
• New and Established Patients
• HIPAA
Challenges

• 51% report they continue to see negative health impacts of deferred care
• Lack of Alignment Between Payers
• Employer Accounts
• Diversion from Usual Source of Care
• Lack of Broadband Internet Access
Looking Ahead

• Extend supportive policies for duration of PHE and forward
• Ensure that policies support longitudinal relationship
• Integrate into value-based payment models
About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by:

• publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy;

• convening state health policy decision makers on issues they identify as important to population health;

• and building communities of health policymakers to enhance their effectiveness.
Why Innovate Anyway (Vision)?

(Focus here is on Delivery System – not Benefits)

- To promote a more sustainable commercial health insurance market
  - Costs rising in line with wages
- To improve the health care system as a whole
  - Price and Quality: Poor results for the money
    - Life expectancy decreasing
    - Chronic disease burden increasing
    - Social and economic factors not well addressed by health care
- Encourage personal engagement
Building a better health system requires a vision and strategy

Strategy elements

- Address underlying health care costs across all payers (price and utilization)
- Address distortions resulting from uneven payer-provider private negotiations
- Transparency and Education
- Shift funds and responsibility to primary care as foundation for sustainable health system
- Address social and economic factors that affect health (outside health care system)
Commercial Health Insurance Oversight Can Both Innovate and Encourage It in Carriers

• Tools:
  • Rate Review – *Rhode Island Affordability Standards*
  • Forms approval – *Coordination with SBE’s (Many states)*
  • Examinations
  • Financial Filings
  • Hearings and public meetings
  • Reports and Analysis – *Mass Health Policy Commission*
  • Collaboration with state partners
    • Medicaid – *CO DORA and HCPF*
    • Public Health- *Recent Telehealth changes*
    • Public Employees – *OR and WA Health Authorities*
    • Data/analytic infrastructure – *Health Care Cost Growth Targets*
COVID, Racial Justice and Health Insurance Innovations
Is This Crisis an Opportunity or Train Wreck?

[Images of a hospital setting and a computer screen]
Five Areas of Innovation in this Time

1. Building Strong Primary Care as part of a More Equitable and Pandemic-Resilient Health System
2. Accelerating the Adoption of Alternate Payment Mechanisms
3. Rate Review as a tool for public education
4. Health Care Cost Growth Targets
5. Persisting with Multiagency System Affordability Efforts
I. **Primary Care** As Foundation of Pandemic-Resilient Health System

- Why: Primary Care Oriented Delivery Systems produce better health, more equity and lower costs.

Exhibit 2: Per Member Per Quarter Savings for All Program

<table>
<thead>
<tr>
<th></th>
<th>CPC Classic</th>
<th>CPC+</th>
<th>Arkansas PCMH</th>
<th>CPC Extended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Difference-in-Difference Coefficient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>$-35.37*</td>
<td>$-27.23*</td>
<td>$-33.37*</td>
<td>$-16.13</td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td>$-33.37*</td>
<td>$-16.13</td>
<td>$-17.87</td>
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<td>2014</td>
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<td>2015</td>
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<td>2017</td>
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<td></td>
<td></td>
<td>$-47.02*</td>
</tr>
<tr>
<td>2018</td>
<td></td>
<td></td>
<td></td>
<td>$-79.35*</td>
</tr>
</tbody>
</table>

Primary Care As Foundation of Pandemic-Resilient Health System (cont’d)

• Risk right now: Independent practices close down or bought up by more expensive health systems

• Innovations/What you can do:
  • Maintain parity for telehealth
  • Support/require insurer actions to support primary care (next page)
  • Promote increased use of full or partial primary care capitation
  • Promote BH integration
CPC+ Payer Actions as of 4/2020 to support Primary Care (43 respondents/62 surveyed)

- 90% were paying for video platform telemedicine at par with in-person visit codes, 75% were paying for audio telemedicine at par
- 93% were supporting practices with policy or program changes (NOT directed by federal or state regulation)
  - Accelerated payments (estimated claims and/or quality payments)
  - Relaxation of quality reporting requirements
  - Prior authorizations waived
  - Rx – waived limits on early refills, increase access to 90-day fills
  - Expanded services eg durable medical equipment and food delivery, transportation,
  - Telehealth access, hardware and technology support
  - Pursuing increased practice interest in Alternative Payment Model participation

You can take actions to ensure they don’t backslide
II. Accelerate Adoption of Alternate Payment Models

Why: CMMI Accountable Care Organizations show modest savings (3-5)% compared to FFS that are increasing and compounding over time

Risks: Providers with market power use COVID as reason to slow walk further adoption

Innovations:

• Public reporting by insurers on progress with establishing APMs (RI, OR and MA)
• Establish common quality measures for these contracts
## II. Accelerate Adoption of Alternate Payment Models (cont’d)

### Value Based Payments in Oregon:
% of 2018 dollars in contracts with these elements

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>FFS &amp; other payments with no link to quality</th>
<th>FFS with link to quality*</th>
<th>Shared savings &amp; shared savings/risk</th>
<th>Population-based Capitation payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage</td>
<td>66%</td>
<td>8%</td>
<td>2%</td>
<td>24%</td>
</tr>
<tr>
<td>Commercial</td>
<td>56%</td>
<td>6%</td>
<td>3%</td>
<td>35%**</td>
</tr>
<tr>
<td>PEBB &amp; OEBB</td>
<td>51%</td>
<td>9%</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>Medicaid CCOs</td>
<td>32%</td>
<td>26%</td>
<td>10%</td>
<td>32%</td>
</tr>
</tbody>
</table>

*includes Infrastructure, Pay for Reporting, & Pay for Performance

**Significant variation among commercial carriers

Data source: OHA 2018 Payer Arrangement File.
III. **Rate Review as a Tool for Public Education**

Why: Public does not understand role of provider price and utilization (across all products) in health care inflation

Risk: Competing COVID narratives with no data:
   - “Utilization is down, I am starving”
   - “It is just delayed, I need my increases”

Innovations/What You Can Do:
   - Focus on carriers expected underlying price and utilization factors – *across all products*
   - Report to the public.
III. (cont’d) Use your authority and reporting capacity to create common view of reality

Summary: Updated Findings of the Impact of COVID-19 on Health Care

As the COVID-19 pandemic produces unique challenges to the Massachusetts health care system, the HPC is leveraging its data assets, research expertise, investment experience, and market knowledge to support policy efforts during and after the crisis. A compendium of industry reports on utilization trends and other COVID-related findings may be found on the HPC’s website.

- Health care spending dropped 30% in April. Overall health care spending in 2020 is still on track to be approximately 10% lower than in 2019.
- Health care spending dropped faster than the overall economy in April (30% vs. 14%), but health care employment dropped slower than overall employment (6% vs. 12%).
- Most Massachusetts hospitals had negative margins in the first quarter of 2020.
- One national for-profit health plan that operates in Massachusetts reported a doubling of net income in April–June of 2020, driven by a 70% medical loss ratio (vs. 83% MLR in Q2, 2019)
- Independent primary care practices in Massachusetts are much more likely to say they will close versus hospital or health system-owned practices.
- Pediatric visits remain far below pre-pandemic levels while adult visits have returned to baseline levels as of mid-June when including telehealth.
- Telehealth visits have declined by about a third from their April peak as adult in-person visits have increased.

HPC
IV Interest in Health Care Cost Growth Targets Continues

• Massachusetts legislation 2014
• Delaware (executive order and legislation), Rhode Island (executive order)
• 2019 Oregon and Washington passed legislation, Connecticut executive order
• Milbank will be providing technical assistance to the new states
• Lessons so far:
  • State leadership and stakeholder engagement really important
  • Data capacity is limited – start with the basics and grow from there (need to plan for the governance and resources)
IV. Health Care Cost Growth Targets: You Cannot Improve What You Cannot Measure

Established Health Policy Commission with authority to:
- Set targeted rate of growth for per capita health care expenses
- Monitor statewide performance
- Assess effects of mergers and consolidations

Per Capita Total Health Care Expenditure Trends, 2013-2018

THCE growth per capita equaled the health care cost growth benchmark in 2018, after two years of trending below.

Source: Total Health Care Expenditures from payer-reported data to DHIA and other public sources.
<table>
<thead>
<tr>
<th>Oregon Work: Key Recommendations</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define total health care expenditures, identify included populations and markets</td>
<td>✔</td>
</tr>
<tr>
<td>Select initial cost growth target</td>
<td>✔</td>
</tr>
<tr>
<td>Specify frequency and manner for reevaluating and updating the cost growth target</td>
<td>✔</td>
</tr>
<tr>
<td>Determine how to measure performance against the target</td>
<td>✔</td>
</tr>
<tr>
<td>Recommend principles for the data use strategy</td>
<td>✔</td>
</tr>
<tr>
<td>Recommend what types of data OHA should collect and report upon</td>
<td>In process</td>
</tr>
<tr>
<td>Recommend what types of analyses should be conducted</td>
<td>In process</td>
</tr>
<tr>
<td>Recommend frequency and format for public hearings</td>
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<tr>
<td>Recommend principles for measuring the quality of care</td>
<td></td>
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<tr>
<td>Recommend principles for addressing equity</td>
<td></td>
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<tr>
<td>Recommend future governance structure</td>
<td></td>
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<tr>
<td>Recommend accountability and enforcement mechanisms</td>
<td></td>
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<tr>
<td>Recommend technical assistance and support payers and providers need to meet the cost growth target, and opportunities to provide technical assistance</td>
<td></td>
</tr>
<tr>
<td>Recommend opportunities to use innovative payment models to address cost and quality</td>
<td></td>
</tr>
</tbody>
</table>
V. Maintain Commitment to Multiagency Efforts to Promote System Affordability

Rhode Island Commercial Insurer Affordability Standards: Implemented in 2010 by Office of the Health Insurance Commissioner (OHIC)

- Require increasing investment in primary care, from 5.5% of total spend to 10.5%
- Encourage support for shared advanced primary care transformation
- Promote health information technology adoption (EHR and health information exchange)
- Encourage payment reform/cost reduction (alternative Payment models)
  - Rate increase caps on hospitals in insurer contracts
  - Target adoption rates for APMs

- Some Terms Picked up in Medicaid MCO contracts
“Price inflation caps and diagnosis-based payments… drove a broad and sustained reduction in commercially insured health care spending growth. Furthermore, combining price control measures with a requirement to markedly increase funding to primary care practices led to a redistribution of spending toward primary care without net losses to payers.”
—Baum et al. Health Affairs 2019
V. Maintain Commitment to Multiagency Efforts to Promote System Affordability

What Has Colorado Done?

- GOAL: Affordability

- TARGETS: Consumers, Systems

- INITIATIVES:
  - Consumers: Public Option, Reinsurance, OSFMHC, HTP Affordability Roadmap
  - Systems: Out-of-Network billing, Purchasing Alliances, Community Benefit, PCPRC
V. Maintain Commitment to Multiagency Efforts to Promote System Affordability (cont’d)

Oregon: “Possible Pathways to Support Taking Action”

1. State, payer and provider options to increase use of VBP
   - House, payer and provider options to rebuild a resilient delivery system based upon COVID-19 lessons, and contribute to lower cost growth

2. State-facilitated options to assist payers/providers in meeting the cost growth target

3. Collaborative work to reduce cost growth jointly pursued by multiple private sector organizations

4. Implementation Committee ideas to support reduced cost growth

*These pathways are not mutually exclusive
Five Areas of Innovation in this Time

1. Building Strong Primary Care as part of Pandemic-Resilient Health System
2. Accelerating the Adoption of Alternate Payment Mechanisms
3. Rate Review as a tool for public education
4. Health Care Cost Growth Targets
5. Persisting with Multiagency System Affordability Efforts

Have a Vision
Use Your Tools
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