

Draft Pending Adoption

Attachment **XX**
Health Insurance and Managed Care (B) Committee
x/xx/xx

Draft: 12/7/23

Health Innovations (B) Working Group
Orlando, Florida
December 1, 2023

The Health Innovations (B) Working Group of the Health Insurance and Managed Care (B) Committee met in Orlando, FL, Dec. 1, 2023. The following Working Group members participated: Nathan Houdek, Chair, and Jennifer Stegall (WI); Amy Hoyt, Vice Chair, and Carrie Couch (MO); Sarah Bailey (AK); Kate Harris and Debra Judy (CO); Andria Seip (IA); Scott Shover (IN); Julie Holmes (KS); Jamie Sexton and Riley Williams (MD); Marti Hooper and Robert Wake (ME); Karin Gyger (MI); Chrystal Bartuska (ND); Paige Duhamel (NM); Todd Rich (NV); Kyla Dembowski (OH); Glorimar Santiago (PR); R. Michael Markham (TX); Tanji J. Northrup (UT); Jane Beyer (WA); and Joylynn Fix (WV). Also participating were: D.J. Bettencourt (NH); Justin Zimmerman (NJ); and Patrick Smock (RI).

1. Adopted its Summer National Meeting Minutes

Hoyt made a motion, seconded by Rich, to adopt the Working Group's Aug. 14 minutes (*see NAIC Proceedings – Summer 2023, Health Insurance and Managed Care (B) Committee, Attachment One*). The motion passed unanimously.

2. Heard a Presentation on the State AHEAD Model

Commissioner Houdek said the Working Group has a long-standing interest in efforts to control health care costs. He said a new payment model from the Centers for Medicare & Medicaid Services (CMS) Innovation Center will soon be available to support state efforts to limit cost growth.

Emily Moore (CMS Innovation Center) presented on the States Advancing All-Payer Health Equity Approaches and Development (State AHEAD) model. She said the model's goal is to collaborate with states to improve health, advance health equity, and curb health care costs. She said CMS wants to align with and support ongoing state efforts to set limits on the total cost of care. She said a flexible framework allows the model to work with multiple states.

Moore said the model will create accountability for states on the total cost of care. She said the model will also have annual primary care investment targets. She said states would select from a core set of quality measures and be accountable for reaching quality standards. She said states would be provided with cooperative agreement funding. Moore added that the model would support hospitals' global budgets and increase resources for primary care practices.

She said priorities for the model include health equity, behavioral health integration, multi-payer alignment, Medicaid alignment, and accelerating ongoing state innovations. She said the model offers states funding and opportunities to align policies across payers.

Moore said states are eligible unless they are participating in the Making Care Primary model. States may operate the model statewide or in a sub-state region if the region has at least 10,000 Medicare beneficiaries. Up to eight states will be selected to participate.

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She said states, hospitals, primary care practices, and payers all have roles as stakeholders in the model. Since multi-payer alignment is key to the model, states are required to recruit at least one commercial payer to participate by the second year of the model, and Medicaid participation is required. She said Medicaid agencies must participate in global budgets, and Medicare policies could be adjusted to align with Medicaid.

Moore described opportunities for state insurance regulators to participate in the model. She said commissioners could participate in the model governance structure; use state regulatory authority to enforce cost targets for payers; educate state legislators about the model; and support the measurement of costs.

She said statewide cost growth targets would measure the difference between state cost growth absent the model and actual cost growth. She said states would be accountable for meeting the target with regard to Medicare, Medicaid, and participating commercial plan costs. She said the cost growth target and primary care investment levels would be outlined in a contract between the state and CMS as well as in a state executive order or regulation.

Moore said CMS would accept applications from states in cohorts, which allows some states to apply earlier and others later. She said application materials are now available with varying deadlines for Cohorts 1, 2, and 3.

Seip asked about the inclusion of Medicare Advantage and commercial payers. She said there is more transparency in Medicare fees for service claims. Moore said Medicare Advantage and commercial payers would be included in the cost growth targets and encouraged to participate in the hospital global budgets and primary care investments. She said CMS cannot mandate their participation in the model, but states would be required to recruit one commercial payer for hospitals' global budgets. Seip asked if a state must have an all-payer claims database to participate. Moore said it would be an advantage for a state to have an existing all-payer claims database or be working toward one.

Commissioner Houdek asked how a state would approach the model differently if it has an existing cost growth target than if the state does not. Moore said CMS would allow a state with an existing target to continue to use it. She said the model would continue through 2034, so an existing target may need to be extended to reach that date. She said states without a target will need to take time to develop one, so the numerical target is not required to be in place for one and a half or two years into the model.

3. Heard an Update on Value-Based Care

Mollie Gelburd (AHIP) presented on value-based care. She said value-based care, at its core, is about reducing unnecessary spending so that attention can be focused on high-value prevention efforts. She said value-based care uses economic incentives as a lever to drive changes in care delivery and produce better outcomes.

Gelburd said a new survey from the Health Care Payment & Learning Action Network measured how many organizations participate in one-sided or two-sided risk arrangements. She said alternative payment models accounted for 41% of total payments in 2022, with 24% in models with downside risk. She said nearly all plans in the survey perform health equity activities. She said the survey included plans representing 86% of covered lives in the U.S.

Gelburd said Medicare and Medicaid have been the quickest to adopt value-based care, with commercial plans acting more slowly for several reasons. She relayed recent estimates from the Congressional Budget Office that show the CMS Innovation Center has generated additional federal spending, not savings as anticipated. The

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Congressional Budget Office now expects that the CMS Innovation Center will generate savings starting in 2031. She said the Congressional Budget Office estimates do not include savings that the CMS Innovation Center models may have generated outside of federal spending.

Gelburd said value-based care models are now available for small and rural providers. She said more advanced providers can participate in full-risk models. She explained that AHIP members have worked with the CMS Innovation Center through listening sessions and other avenues.

Gelburd described the Future of Value Project, which is a collaboration between AHIP, the American Medical Association (AMA), and the National Association of Accountable Care Organizations. She said work groups have convened to talk about experiences and challenges. She said the project started with data sharing and has developed a playbook with best practices for data sharing, released in July 2023. She said best practices in payment structure will be next.

Gelburd said more value-based care models may include specialty care in the future. She said a continued focus on health equity is critical. Gelburd said more mandatory models could help generate savings in the future. She said AHIP's recommendations include continuing alignment toward evidence-based practices and enabling value-based care to reduce inequities by allowing payment for non-traditional services like improving air quality.

Hoyt asked how health plans can align initiatives from state, federal, and private authorities, and all have different timelines. Gelburd stressed the importance of communication and having timelines that work together. She said models should be adjusted for local conditions, but there should be consensus around key concepts.

Houdek asked how state insurance regulators can help support value-based care. Gelburd said they can convene multiple payers and provide flexibility while plans figure out what works and refine their practices. She said regulators should allow plans and providers to be nimble and innovative.

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

SharePoint/NAIC Support Staff Hub/Member Meetings/B CMTE/Health Innovations WG/HInnMin12.1