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Health Care Payment Reform: Options and Recommendations

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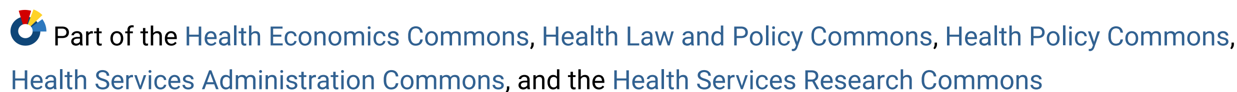

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Health Care Payment Reform: Options and Recommendations

April 20, 2015

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The New Hampshire Insurance Department

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I. Executive Summary

The New Hampshire Insurance Department (NHID) contracted with Compass Health Analytics (Compass) and its partner, the Center for Health Law and Economics at the University of Massachusetts Medical School (UMass), to provide recommendations for health care provider payment reform.[1] In recent years, provider payment reform has shown some promise in its ability to contain health care costs while maintaining access and quality. NHID expressed interest in addressing New Hampshire's high health care spending while protecting health care access and quality through reforms to policies affecting provider payment.

New Hampshire health care spending is high and rising. Data from the Kaiser Family Foundation illuminate the issues facing the New Hampshire health insurance market.[2] Over the period 1991-2009, New Hampshire's growth rate in per capita health spending was 4th in the country at 6.6% per annum, compared to 5.3% nationally. That sustained growth rate caused New Hampshire to move from 32nd in the nation in 1991 to 9th in the nation in 2009 at $7,839 per person per year. New Hampshire's government-financed health insurance spending per person has been below average over the same time period, indicating that cost growth is being driven in the commercial market.

In the New Hampshire commercial fully-insured market, over the period 2010-2013, health insurance premiums increases have been at a modest 2%-3% per year. However, total cost growth over this period has averaged in the 4%-6% range annually, driven by similarly-sized provider price increases. Premium increases have not kept up because utilization of services has been decreasing at about 2 ½% per year, and because costs are being shifted from premiums and onto individuals through much higher out-of-pocket costs, namely higher deductibles and other cost sharing.[3]

Much activity related to payment and system delivery reform has been occurring in New Hampshire, with the formation of a number of accountable care organizations (ACOs), for both Medicare and commercially insured populations. Compass and UMass have reviewed previously collected information about payment reform activities and market information in New Hampshire, and have formulated recommendations intended to encourage and support continued movement toward value-based payment. Specifically, we developed three comprehensive longer-term recommendations, four targeted short-term recommendations, and two stand-alone actions. We address the comprehensive recommendations first, followed by the targeted recommendations.

[1] This report reflects the recommendations of the authors and may not reflect the views of and is not an endorsement by the New Hampshire Insurance Department.
[2] Kaiser Family Foundation, "State Health Facts," http://kff.org/statedata (accessed September 24, 2014). Statistics cited are from KFF unless otherwise noted.
[3] See New Hampshire Insurance Department cost driver reports for 2010-2013, discussed in more detail in section II of this report.

Approach

We evaluated a wide range of payment reform initiatives for their potential to work in New Hampshire. These options ranged from large state-run initiatives to reforms encouraging promising contractual relationships between providers and payers. A full list of options we considered is available in Appendix A of this report.

This study assumes that the goal of reform is to encourage better value for consumers by reducing the rate of cost growth while maintaining or improving quality and access.

In order to narrow our options, we defined four conditions we feel are necessary to successfully implement payment reform. First, incentives are a fundamental basis of payment reform and a system that rewards providers and health plans for providing high quality, cost-effective care. Second, consensus from key stakeholders, including providers, payers, employers, consumers, and state agencies, will help move a viable plan forward. Third, collaboration will align reform across payers and identify areas where shared infrastructure can be effective. Finally, consequences for inaction are imperative for the success of any reform effort.

We applied a set of criteria to analyze the initial "wide net" of options to determine which approaches to include in our recommendations to NHID. Criteria included political feasibility, cost containment, quality of care, access to care, provider solvency, state government costs, legal hurdles, and alignment with other programs. A full list of criteria is detailed in Section III.B of the report.

Recommendations

We recommend three **comprehensive approaches to support payment reform,** four **short-term steps** the state could take to move toward payment reform, and two **stand-alone actions** to address high health care spending in New Hampshire. The strategies are not mutually exclusive, nor are they dependent upon each other. The state may choose to pursue any combination of these approaches, but we believe all would provide benefits to a successful reform process.

Comprehensive Approaches

Payment Reform Strategy 1: Publicly Report Progress Against Benchmarks

Under this option, New Hampshire would set health care cost and quality benchmarks statewide, devise a system to publicly identify entities failing to meet the benchmarks, and develop incentives to keep costs below and quality above these benchmarks.

New Hampshire could designate a state agency or commission to set the health care cost and quality benchmarks. The cost benchmark could be a target growth rate for total medical expenditures, and could be tied to an economic indicator, such as the growth in state domestic product, the Consumer Price Index, or the growth in national health expenditures. The state would measure progress for payers and providers.

New Hampshire should consider monitoring health care cost and quality trends at the state level, as well as for each large provider and payer. We recommend that New Hampshire publicize the names of providers and payers that exceed the cost growth benchmark or fail to meet quality benchmarks. New Hampshire could consider adding additional consequences, such as fines for providers and payers, if cost trends do not moderate.

Payment Reform Strategy 2: Promote Alternative Payment Methods

Under this option, New Hampshire would encourage health care participants to move toward the use of alternative payment methods and ACOs and other integrated care models. We recommend that New Hampshire develop a model contract which contains new payment mechanisms (Model Contract), detailed in this report, for use across payers in their contracts with providers. We also recommend that New Hampshire convene a stakeholder commission charged with evaluating and adopting the Model Contract or proposing a similar alternative, educate stakeholders regarding the use of such types of contracts, and consider regulating provider rates if stakeholders fail to align on a new contract and payment model.

The Model Contract could set forth provisions relating to a global or shared savings methodology, care coordination requirements, quality measures, monitoring for compliance, and grievance and appeals processes. In order to work with stakeholders in this process, we recommend establishing a multi-stakeholder commission to evaluate the Model Contract and either recommend its adoption or suggest a "stakeholder alternative."

Once the Model Contract or approved stakeholder alternative are published, we recommend that New Hampshire engage in stakeholder education – especially of payers and providers – to encourage participation. The educational program could address concerns about entering into alternative payment contracts, describe models of care that have worked in other states, and offer technical assistance on the "nuts and bolts" of entering into alternative contracts. This technical support is consistent with the State Innovation Model (SIM) grant application submitted by the New Hampshire Department of Health and Human Services, and we recommend that New Hampshire coordinate across agencies to offer a clear path for organizations entering into these arrangements.

We recommend that New Hampshire sets forth clear consequences if providers and payers do not pursue alternative payment arrangements. If New Hampshire does not achieve health care cost containment, the state may need to turn to more prescriptive approaches to address the issue.

Some providers may be concerned about the financial and related implications of entering into risk arrangements with payers. To address these concerns, we recommend that New Hampshire develop a structure for regulating provider risk, similar in some respects to the one used to regulate risk held by insurance carriers, in order to ensure provider solvency as providers take on more risk.

Some providers may be concerned about implications in federal and state antitrust law if they take market actions to fit into the alternative payment model. We recommend that New Hampshire coordinate across agencies to address these issues. We also recommend that New

Hampshire consider implementing state action immunity doctrine to protect providers from federal antitrust laws in certain limited circumstances.

Payment Reform Strategy 3: Strengthen Employer Purchasing Power

The third long-term approach would address the relative weakness in purchasing power of employers buying health insurance for their employees. New Hampshire's health care market is characterized by highly concentrated provider markets, a concentrated insurance market with a dominant player, and a relatively disaggregated and disorganized employer purchaser market. In this market structure, it can be difficult to exert competitive pressure on providers, and relatively easy for insurers to mark up the cost of care and pass the bill along to employers. Furthermore, solutions for the lack of competitiveness in provider and insurer markets are not obvious. This context makes exploration of ideas to strengthen the employer purchasing market worthwhile.

We recommend that the state analyze options for strengthening the purchasing power of employers. These options can include taking additional steps to increase transparency (discussed under short-term steps below). We also recommend that policy makers consider a mechanism that allows increased coordination and efficiency on the part of purchasers, as the state monitors market conditions in the small group sector going forward. Any analysis of this type will need to consider issues related to the Affordable Care Act (ACA), anti-trust, and New Hampshire insurance laws and regulations. Success in strengthening purchasers role in the market will complement and support other strategies aimed at controlling cost growth, and may be a necessary part of an overall strategy successful in controlling cost growth.

Short-Term Steps

We also identified a number of steps New Hampshire could take in the short-term to begin to lay the groundwork for longer term payment reform. We recommend that New Hampshire take these steps, in any order, regardless of which comprehensive payment reform strategies it chooses to pursue.

Step 1: Continue to Expand Data Transparency

We recommend that New Hampshire build on NHID's existing price transparency initiatives by continuing to innovate in publishing information on relative efficiency, quality, and access. Total health care spending, carrier premiums, provider prices, and quality measures should be publicly reported through a consumer-friendly website. The state should expand communications to drive consumers to the site, for example, by reaching out to local Chambers of Commerce and consumer groups.

Step 2: Leverage Available Resources

The State of New Hampshire obtained a SIM design award in the first round of SIM funding, and has applied for additional design funds in round two, for which announcement of awards should

occur by the time this report is published.[4] The amount requested for the Round 2 funds is $2 million for additional design, which includes the design of regional technical cooperatives to help providers develop the infrastructure to operate and manage innovative payment models. Also made available by Centers for Medicaid and Medicare Services (CMS) have been much larger "model test grants" which are focused on implementation and testing of model designs. Among the potential uses of these resources would be to fund staffing of the Commissions recommended in this report, funding the development of the expanded data transparency initiatives described below, as well as expanding the ACO technical support and infrastructure requests contained in the most recent SIM application request.

Step 3: Establish a Commission

We recommend that New Hampshire form a commission to choose a payment reform path, draft recommended legislation, and help implement reforms. The commission could include stakeholders from the health care system and representatives of government agencies. The commission should address health care cost containment, health care quality, and health care access.

Step 4: Expand Consumer Protection

We recommend that New Hampshire plan for consumer protection for any approach it takes transitioning to new models of care and payment. Introducing new provider payment mechanisms on a broad scale has the potential to have a negative impact on consumers. Tools for consideration by the state include use of quality measurement, grievance and appeals processes; utilization monitoring; stratifying quality measures for minority populations; providing ombudsman programs; facilitating patient advisory councils; and conducting audits.

Stand-alone Actions

We identified two additional actions New Hampshire could take to contain certain costs without pursuing comprehensive payment reform. New Hampshire could pursue either of these actions independently of our other recommendations.

Stand-Alone Action 1: Reform Certificate of Need

We recommend that New Hampshire revise the CON process to expedite the process for projects that further goals of payment and delivery reform, and shorten time frames overall for CON approvals, to promote efficiency.

[4] For the Round 2 application, see New Hampshire Department of Health and Human Services, "State Innovation Model (SIM) Model Design Application," July 21, 2014, http://www.dhhs.nh.gov/ocom/documents/sim-round2-app-sub.pdf (accessed October 8, 2014).

Stand-Alone Action 2: Reform Nonprofit Requirements

We recommend that New Hampshire leverage its oversight mechanisms for nonprofit institutions to address different aspects of health care prices. New Hampshire could use the community benefits requirement to encourage a more aggressive approach to population health. The level of hospital executive pay might also be addressed.

Conclusion

New Hampshire health care costs are high and rising. Current initiatives to develop value-based payment mechanisms are promising but we believe they need additional support and encouragement to reach their potential. By engaging in reforms supportive to the health care system, New Hampshire has the opportunity to encourage health care cost containment while maintaining access to quality health care.

II. Introduction

The NHID contracted with Compass Health Analytics and its partner, the Center for Health Law and Economics at the University of Massachusetts Medical School (UMass), to provide recommendations for health care provider payment reform.[5] This report suggests approaches to improve health care cost and quality in New Hampshire through reform of provider payment and related policies that support payment reform.

A. Problem to be Solved

New Hampshire health care spending is high and rising. Data from the Kaiser Family Foundation illuminate the issues facing the New Hampshire health insurance market.[6] Over the period 1991-2009, New Hampshire's growth rate in per capita health spending was 4th in the country at 6.6% per annum, compared to 5.3% nationally. That sustained growth rate caused New Hampshire to move from 32nd in the nation in 1991 to 9th in the nation in 2009 at $7,839 per person per year.

While these overall per capita numbers were increasing at a rate well above average relative to other states, spending in New Hampshire on government health insurance programs was growing at a slower than average rate. Between 1991 and 2009 Medicaid spending grew at a rate 39th in the country, while both per enrollee and total Medicare spending in New Hampshire grew at about the national average. Because New Hampshire has the lowest percentage of residents covered by Medicaid of any state, the spending growth in Medicare and Medicaid combined is only slightly below average.

Given below-average spending growth on government programs, the higher-than-average growth in overall spending must be caused by growth in the commercial insurance and uninsured sectors, which are not subject to government pricing for provider services. Between 2010 and 2012 in New Hampshire, provider prices in the commercial health insurance sector grew approximately 6% per year,[7] while utilization declined approximately 2 ½ percent per year,[8] resulting in a 3% annual increase in total spending.[9] In 2013, preliminary data indicated that provider price increases moderated to a rate of 4%,[10] while utilization continued downward at -2.5%,[11] with total medical spending per year moderating to 1%.[12]

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[5] This report reflects the recommendations of the authors and may not reflect the views of and is not an endorsement by the New Hampshire Insurance Department.

[6] Kaiser Family Foundation, "State Health Facts," http://kff.org/statedata (accessed September 24, 2014). Statistics cited are from KFF unless otherwise noted.

[7] New Hampshire Insurance Department, "2012 Medical Cost Drivers," December, 2013, 22.

[8] Ibid., p. 22.

[9] Ibid., p. 20.

[10] New Hampshire Insurance Department, "Preliminary Report on 2013 Medical Cost Drivers," October, 2013, 21.

[11] Ibid., p. 20.

[12] Ibid., p. 19.

Provider prices in the commercial and uninsured segments are clearly an important issue in New Hampshire health care cost growth, as these segments constitute a very large part of the market. Approximately two thirds of New Hampshire residents are covered by private health insurance, with about 55% of these in self-funded employer plans and 38% in small and large-group insured plans. New Hampshire has the highest percentage of non-elderly residents covered by employer-based insurance in the nation. In 2012, its single person employer-based premium was $5,688, 11th in the country. In the recent 2010-2012 period, New Hampshire's premium rate of growth for fully-insured products has averaged less than 2%, but large increases in out-of-pocket exposure in policies sold has masked a large increase of health spending in this population.[13] Premium levels would have grown by an additional 4%-6%, to a total of 6%-8% annually, if benefit levels, including cost sharing, had stayed constant.[14] In preliminary 2013 data, this pattern continued at a slightly moderated pace. Premiums increased by approximately 3%, but would have increased an additional 2-4% if consumer exposure to out-of-pocket expenses hadn't continued to increase significantly.[15]

From these data describing trends in New Hampshire, it is hard to escape the conclusion that health care costs are growing rapidly in the state largely because of provider price increases, and that these increases are masked in premium data because an increasingly heavy portion of costs are being borne out of pocket by commercial insured members. On an annual basis in 2012, the out-of-pocket burden for single person coverage was $1,001 per member,[16] on top of what is already the 7th highest employee contribution for health insurance premiums nationally in 2012 at $1,260 annually.

The provider market in New Hampshire is highly concentrated, with little hospital competition in most of the state, and many physician practices owned by hospitals. Despite concentration in the insurance market as well (Anthem Blue Cross Blue Shield is the dominant insurer, with 63% of the fully-insured market[17]), carriers have had very limited success in controlling growth in provider prices. While it may be that insurer concentration has moderated even higher provider price growth, constituents in New Hampshire are unanimous in their belief that healthcare costs are too high and growing too rapidly.[18] In economic theory, when a dominant insurer faces a dominant provider (as is the case in most of New Hampshire), the test of whether the insurer is using its buying power (i) to break the provider dominance, or (ii) to enrich itself, is whether consumers receive more services at lower prices or fewer services at higher prices.[19] As noted above, the commercial utilization trend has been negative in recent years, supporting the notion that dominant insurers are focused on maximizing their profit margins rather than using their market power to help consumers.

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[13] NHID 2012 Cost Drivers Report, op. cit., p. 12. [14] Ibid., p. 15.
[14] Ibid., p. 15.
[15] NHID Preliminary Report on 2013 Cost Drivers, op. cit.
[16] Ibid., p. 20.
[17] Ibid., p. 12.
[18] University of Massachusetts Medical School and Freedman Healthcare, "New Hampshire's Health Insurance Market and Provider Payment System: An Analysis of Stakeholder Views," June 2013, 1.
[19] Mark V. Pauly, "Managed Care, Market Power, and Monopsony," *Health Services Research 33*, no. 5 Pt. 2 (Dec 1998).

Added to this dynamic is the relative weakness of New Hampshire employer purchasing power. New Hampshire is 36th in the country compared to other states in the percentage of its employed persons in firms larger than 20 employees.[20] As a state with relatively low concentration in its business sector, employers as a purchasing force are relatively weak and the data suggest that they do not exert sufficient pressure on providers through carriers to counteract their market power.

In the face of this history of cost growth, both the public and private sectors are taking steps intended to “bend the cost curve.” Like many other states, the State of New Hampshire is examining effects of provider payment systems on the costs of health care, in particular the effect of the dominant fee-for-service model and the closed process for negotiating contracts for provider reimbursement rates. This system might confer a competitive advantage on carriers with established networks and provider relationships, potentially creating barriers to the entry of new carriers. In addition, select providers with well-established reputations with consumers and employers and limited geographic competition may gain market leverage sufficient to drive up provider rates for all carriers. The New Hampshire HealthCost website has been a path-breaking initiative aimed at allowing better transparency surrounding provider prices.

New Hampshire has also been actively pursuing a number of 1115 waiver applications, for Medicaid expansion[21] as well as system delivery transformation. [22] These waiver requests could be expanded – or a new request submitted—to include some of the payment reform initiatives recommended in this report for the Medicaid population, increasing the effectiveness and breadth of any reform it undertakes. In addition, the State has also received one SIM grant from CMS and has applied for a second. The pending second proposal includes funding for developing payment reform infrastructure support to be provided on a regional basis in New Hampshire.

In the private sector, providers in New Hampshire have also been very active in advancing patient-centered care through primary care medical homes, and participation in ACOs for both Medicare and private payers. Providers are participating in the Medicare Shared Savings Program, Medicare Pioneer ACO, Advanced Payment ACO Model, and commercial ACO initiatives. These initiatives, though important, do not yet encompass a large percentage of the care delivered in New Hampshire. Only 11% of insured members were in upside/downside risk arrangements in 2012,[23] although it is likely this percentage has increased in the past two years.

With all these government and state initiatives underway, New Hampshire remains in the top 10 states in health care spending per capita.[24] This report explores additional ways that the State

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[20] United States Census Bureau, “Statistics of U.S. Businesses: 2008: All industries United States - by Employment Size of Enterprise,” http://www.census.gov/epcd/susb/2008/us/US--.HTM#table2 (accessed September 24, 2014).
[21] See http://www.dhhs.nh.gov/pap-1115-waiver/index.htm
[22] New Hampshire has submitted an 1115 waiver application, entitled “Building Capacity for Transformation,” in May, 2014, as amended by an addendum submitted in June, 2014. References to “Medicaid waiver” in this memo refer to an 1115 waiver, the most common waiver utilized by states to implement Medicaid health system and payment reform initiatives. The Transformation waiver request could be amended to include changes needed to implement the recommendations in this report, or a new 1115 waiver request could be submitted, depending on the approval status of the current waiver request with CMS.
[23] New Hampshire Insurance Department, “2012 Medical Cost Drivers,” December, 2013, 46.
[24] Kaiser Family Foundation, “State Health Facts,” http://kff.org/statedata

can support and encourage continued movement in the direction of effective payment reform that moderates cost growth while retaining quality and access for consumers.

B. Discussion of Key Goals (Cost Containment Over Time, Access, Quality)

The primary goal of payment reform is to moderate growth in healthcare costs while maintaining or improving quality, access, and provider solvency. Depending how it is done, maintaining or improving quality, access, or solvency could make cost moderation more difficult, though some assert that the absolute level of healthcare spending can be reduced by 20% or more while enhancing quality.[25]

Economists distinguish between actions that create cost reductions that are one-time events, and those (harder to accomplish) that reduce the rate of growth over time. The former are "removing a layer of fat" from the level of costs, while the latter require some fundamental alteration of the factors that drive cost growth over time. With respect to reducing the rate of growth over time, many economists also question whether people are willing to give up the improvements in healthcare technology, and related actual and perceived beneficial life expectancy and quality of life gains that are a key component of ongoing spending growth. At the same time, there is recognition that a change in the financing model will be necessary to balance these advances against the increasingly large share of national income consumed by healthcare.[26]

Any change in financing and payment models should allow providers to adjust in ways that do not harm the provider system or quality of care, nor impede access to care by consumers, and should be carefully designed to avoid other unintended consequences. Payment models that have a budget or target spending level have inherent incentives to reduce spending, and these methods should be paired with carefully structured, executed, and monitored measurement systems for access and quality to help ensure that the outcome of the new methods are truly "value-based" and not just cost reducing.

More generally, the system is complex, and changes to it should be based on a thorough understanding of the environment in New Hampshire and of the interactions between employers, consumers, government, carriers, and providers.

In considering whether payment reform is a policy tool that has the potential to succeed in achieving the goals of controlling cost without impacting quality negatively, it is useful to touch on some history of Medicare payment systems and previous reforms implemented. The original method Medicare used to pay hospitals was cost-based reimbursement. This method led to rapid cost growth. In the 1980s, Medicare replaced cost-based reimbursement with the Prospective Payment System (PPS), which compensates hospitals based on prospectively determined case-rates that vary based on the diagnosis of the patient and other clinical and demographic

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[25] Donald M. Berwick and Andrew D. Hackbarth, "Eliminating Waste in U.S. Health Care," *Journal of the American Medical Association 307*, no. 14 (April 11, 2012).
[26] Michael E. Chernew and Joseph P. Newhouse, "Health care spending growth," in Handbook of Health Economics 2 (2012), 1-43.

information. The impact of the inpatient PPS was a reduction in utilization, length of stay, and slower cost growth, without reducing quality of care.[27] Similar results were obtained with the implementation of prospective payment for home health.[28]

In general, response to prospective case rates followed the path predicted by economic theory, in that costs per case were reduced, but incidence of cases often stayed constant or increased, or shifted to other settings with less restrictive payment. Because prospective payment systems retained an inherent incentive to provide more cases, their ability to contain costs, while an improvement over cost-based reimbursement, was limited. Medicare in the early 1990s also implemented the Resource-based relative value scale (RBRVS) for physician services. The RBRVS payment method itself is not case-based, and does nothing to control volume. Congress did include a feature to control volume in its physician payment reform, creating a "sustainable growth rate" (SGR) formula that was intended to decrease fee levels if physician service cost growth exceeded a pre-defined rate of growth. However, for political reasons Congress has never allowed this fee reduction to take place, every year going through a wearily familiar pattern of cancelling the now-very-large cumulative payment cut at the 11th hour. While one can debate whether the SGR was a reasonably designed mechanism for cost control, we can say with certainty that it has never actually been tested, and that it has failed the political feasibility test.

In recent years, CMS has implemented a number of initiatives related to budget-target-based ACO payment systems. The Medicare Shared Savings program, Pioneer ACO program, and Advanced Payment ACO program are all intended to address the two primary "leaks" in previous payment reforms – by creating a fixed budget for all services, the incentives for increasing cases delivered and shifting care to alternative sites of service have been reversed. The early evidence on these programs shows results that are mixed, with positive signs that the approach can be very successful.[29] Approximately a third of Pioneer ACO programs have dropped out after having difficulty meeting the cost benchmarks. However, in the second year, 11 of 20 programs earned savings bonuses, and quality measures have improved significantly.

Similarly, the Medicare Shared Savings program in its first year had 53 ACOs generating savings payments and significant increases in quality scores. At this point, a careful assessment of how to evaluate how much cost reduction has occurred on net remains to be done. The organizational changes and infrastructure necessary to manage global payment approaches at the provider level are significant, and it may be more useful to ask if it can work when done well. For example, two Pioneer ACO programs reduced spending relative to the target by an average of 6% in each of the first two years. Learning more about which techniques organizations have used to generate savings, and how much saving is a result of careful execution of required activities and how much is an artifact of the payment methodology are important questions to

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[27] Davis, Carolyne K., and Deborah J. Rhodes. "The impact of DRGs on the cost and quality of health care in the United States." Health Policy 9.2 (1988): 117-131.

[28] Huckfeldt, Peter J., et al. "Effects of Medicare payment reform: evidence from the home health interim and prospective payment systems." Journal of health economics 34 (2014): 1-18.

[29] United States Department of Health and Human Services, "Fact Sheets: Medicare ACOs continue to succeed in improving care, lowering cost growth," September 16, 2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html (accessed October 23, 2014)

monitor going forward. The clear incentive superiority of this approach and the significant success achieved by some ACOs is promising.

C. Findings from Prior Work

Designing effective health care reform requires an understanding of the current environment, experience with potential reform tools, and knowledge of stakeholder views. NHID laid the groundwork for analyzing available provider payment reform options with previous projects summarized below. These projects assessed hospital prices, stakeholder viewpoints, and legal considerations.

1. *UMass findings on price variation in New Hampshire hospitals*: In 2012, UMass conducted an analysis of price variations in New Hampshire and found that the prices commercial insurers pay to New Hampshire hospitals vary widely, even after adjusting for the acuity and complexity (called "casemix") of their patient populations.[30] Unadjusted inpatient average prices varied by a factor of 4 from highest to lowest, and outpatient average prices varied by a factor of 2.4. Even after adjusting for casemix, both inpatient and outpatient average prices varied by more than a factor of 2. In addition, hospitals reported total margins ranging from a 5% loss up to a 22% profit, however there was no statistically significant correlation between a hospital's total margin and its average prices.

2. *UMass findings on New Hampshire's health insurance market and provider payment system*: In 2013, UMass collaborated with Freedman Healthcare to explore these findings further by interviewing key stakeholders and conducting additional analysis.[31]

   Key findings of this analysis included the following.

   - "Every stakeholder interviewed expressed concerns about the high cost of health care in New Hampshire."[32]
   - "Stakeholders cited New Hampshire's high deductibles and premiums as a significant issue."[33]
   - "Most providers interviewed said they have not observed competition among insurance companies. However, the carriers themselves felt they are very competitive."[34]
   - "Interviewees from multiple stakeholder categories mentioned that due to New Hampshire's small population, the addition of new carriers would not improve

[30] University of Massachusetts Medical School, "Analysis of Price Variations in New Hampshire Hospitals," April 2012, http://www.nh.gov/insurance/lah/documents/umms.pdf (accessed October 6, 2014).
[31] University of Massachusetts Medical School and Freedman Healthcare, "New Hampshire's Health Insurance Market and Provider Payment System: An Analysis of Stakeholder Views," June 2013, http://www.nh.gov/insurance/reports/documents/nh_himkt_provpay_sys.pdf (accessed October 6, 2014).
[32] Ibid., p. 1.
[33] Ibid., p. 1.
[34] Ibid., p. 3.

health care costs or delivery and the risk pool is not large enough to support additional carriers."[35]

- "Most providers interviewed said they feel powerless when it comes to negotiations with health plans."[36]
- "When asked about hospital competition, interviewees in all stakeholder groups recognized that due to the state's geography, there is little competition among New Hampshire hospitals, except in the cities of Nashua and Manchester."[37]
- "Carriers interviewed agreed there is little competition among physicians, and they find it difficult to negotiate competitive rates among physicians that have developed geographic monopolies."[38]
- "A number of providers expressed interested in taking on risk, though one hospital was not interested because they do not have the infrastructure or skills needed to manage population health."[39]

Finally, UMass and Freedman Healthcare identified the following recommendations made by stakeholders from one or more market sectors.

- "The state should develop a shared long-term vision on promoting the health of the New Hampshire population, improving quality of care, and containing health care costs. Align policies and regulations to support the vision, for example, to guide decisions regarding investing in payers' and providers' infrastructure;
- The state should continue to support transparency and the development of tools that make information, utilization and cost data more accessible to providers, payers and consumers;
- The NHID should play a convening role in the development of new payment models, developing guidelines for new models, and supporting developmental pilots;
- The NHID and other state agencies should review and evaluate stakeholder payment issues to determine whether to intervene in the market;
- The state should increase investment in primary care;
- The state should reform the Certificate of Need process."[40]

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[35] Ibid., p. 3.
[36] Ibid., p. 3.
[37] Ibid., p. 3.
[38] Ibid., p. 3.
[39] Ibid., p. 6. Employer financial risk for costs of health coverage for employees—that is, whether the employer wants to risk owing addition funds if employees' health care costs rise or would prefer to let an insurance carrier assume that risk—is different from provider financial risk—which involves holding providers financially accountable for poor patient outcomes or patient cost of care.
[40] Ibid, p. 7.

3. *Legal considerations raised by Manatt*: As part of this multi-stage analysis of payment reform in New Hampshire, Manatt Health Solutions (Manatt) performed an in-depth analysis of selected key legal issues, which was summarized in a report released in June, 2014 (Manatt Report).[41] Manatt identified the following as areas for further consideration by New Hampshire policymakers:

    - "Implementing a regulatory approach to provider risk-bearing that would permit or even encourage self-insured plans to adopt provider payment reforms";
    - "Evaluating circumstances when it would be appropriate to relax state anti-kickback restrictions on Medicaid contracting that could inhibit provider payment reform"; and
    - "Adopting antitrust enforcement policies similar to those adopted by federal regulators and evaluating whether further action is appropriate to protect providers from antitrust liability."

We have referenced the Manatt Report where it is applicable to our payment reform recommendations.

III. Approach

Developing recommendations for payment reform is a difficult and wide-ranging task. We broke this task down into the following steps.

1. *Identify a "wide net" of potential options for reform.* Based on review of literature and current practice nationally, we identified a comprehensive list of potential candidates for payment reform.

2. *Identify criteria for narrowing the net*. We used a set of criteria necessary for success of a payment reform system.

3. *Cull candidates to "narrow net" options.* By carefully evaluating the wider list of options against the criteria, we reduced the number of potential reforms to a smaller set of options viable in New Hampshire.

4. *Group options into comprehensive payment reform recommendations, short-term steps, and stand-alone actions.*

5. *Identify legal and regulatory barriers affecting "narrow net" options*. For the reduced list of options, we identified legal and regulatory barriers that present in this arena, including federal and state law and regulation, incorporating key legal analyses and policy considerations provided by Manatt on these issues.

[41] Manatt Health Solutions, "Provider Payment Reform in New Hampshire: Legal Considerations for Policymakers," June 2014 (Manatt report) at pp. 1-2; see full report for detailed analysis.

A. Wide Net

In order to develop a set of recommendations for NHID to consider in developing a strategy to contain health care costs in the state, Compass and UMass surveyed the variety of strategies undertaken or considered by other states to identify the full range of options, including regulatory, payment and service delivery reform, and employer- and individual-focused approaches. These options are listed in detail in Appendix A.

B. Criteria and Approach to Narrowing Net

We evaluated each of the approaches in Appendix A for whether it produces the conditions required to create incentives for cost containment, its potential to meet the goals of cost containment in New Hampshire, its likely effects on stakeholders, the associated administrative and legal hurdles, and alignment with health care reform efforts in Medicaid, Medicare and in neighboring states.[42] A summary of our assessment in each of these dimensions follows.

1. Conditions Required to Create Incentives for Cost Containment

We define four factors that are necessary to move reform forward successfully. These are:

- Incentives
- Consensus
- Collaboration
- Consequences

Each of these factors is addressed in turn below.

a) System that Creates Incentives

A fundamental test of effective payment reform is whether it advances the system's ability to reward providers and health plans for providing high quality services for the lowest price. A well-functioning, competitive market would create these incentives on its own. In the absence of a well-functioning market, the state should implement policy initiatives that create these incentives in other ways. These incentives must be established in ways that are appropriate for the size and location of providers and health plans.

b) Forum for Building Consensus

Buy-in from key stakeholders, including providers, payers, employers, consumers, and state agencies, is necessary to maximize the chances of successful reform. Building

[42] The information in this report is intended as a framework for policy strategy, and is not intended as legal advice. The NHID would need to consult with attorneys licensed to practice law in New Hampshire for legal advice on any specific state law issues.

consensus requires a broad forum or vehicle to address and compromise on competing considerations among various stakeholders, as well as sufficient impetus to push to conclusion. The impetus could be statutory language requiring an outcome, creating benefits for achieving the outcome, or creating consequences for failure to hit certain milestones.

c) **Infrastructure to Facilitate Collaboration**

Moving to new payment models requires development of infrastructure related to data sources, information exchange, provider risk bearing, quality measurement, and other aspects of delivery and financing. Aligning the development across payers, including Medicaid, to the greatest degree possible will significantly reduce the total effort and cost required to implement payment reform. Both the state and providers will likely benefit from reduced administrative burden when initiatives are aligned. Interaction between the various constituencies will help share best practices and cross-fertilize ideas as the inevitable challenges of conceiving and implementing such a dramatic change to the payment system.

d) **Consequences that Motivate Active Participation**

Active participation by key participants is crucial to the success of any reform effort. Payment reform presents an absolutely fundamental shift in the business model of providers, requiring changes in methods of contracting, financial and risk management, information technology, strategic planning and alliances, and clinical coordination and communication. These changes are difficult, expensive, and risky to execute successfully. There is the possibility that the current impetus toward payment reform may sputter and reverse, as the movement toward capitation did in the 1990s. Moreover, reform may entail changes that affect the real or perceived financial outcomes for key stakeholders. As a result, some participants could take a wait-and-see attitude, or “dip in a toe” to hedge against different courses the reform movement might take.

Consequences for not participating in payment reform can provide motivation to overcome the hurdles described above. Any such consequences should be appropriate for the size and location of providers and carriers, and to the extent possible focus on positive outcomes for compliance, as well as transparency with respect to performance against the target behavior.

2. Potential to Meet Goals

a) **Political Feasibility in New Hampshire**

Efforts that have been successful in New Hampshire have built upon the state’s culture, which values individual choice. Approaches that require heavy regulation by government were considered to be less feasible in New Hampshire.

b) **Potential to Contain Total Health Care Costs in Southern/Central New Hampshire**

The health care markets of Southern and Central New Hampshire are quite different from Northern New Hampshire, so approaches that are viable in one region may not work as well in the other. In Southern and Central New Hampshire, there are existing large

hospital systems and ACOs: the Southern New Hampshire Health System, and the Dartmouth-Hitchcock Health System. These large networks have the infrastructure to transition to new payment methods and models of care.

c) **Potential to Contain Total Health Care Costs in Northern New Hampshire**
There are fewer health care providers in Northern New Hampshire, and the hospitals in this region are considered critical access providers. New payment and system delivery models must be designed carefully to encourage efficiency while protecting solvency of critical capacity.

d) **Likely Effect on Quality of Care**
Some cost containment approaches, such as patient centered medical homes and ACOs, are designed specifically to improve care quality and include paying for performance on quality benchmarks, while others only focus on managing to a budget. Approaches such as high deductible insurance plans that do not incorporate clinical changes to improve care coordination and performance on established quality measures may have negative health care quality impacts.

e) **Likely Effect on Access to Care**
Cost containment approaches that would be likely to limit the availability of health care services, by incenting providers to accept only healthy patients, or creating a financial disincentive for providers to stay in the market would have a negative impact on access to care. ACO models need to be carefully designed to include risk adjusted payments and quality metrics to minimize the risk.

f) **Likely Effect on Utilization of Care**
Cost containment approaches that focus on managing to a budget are intended to lower provision of unnecessary care that is currently incentivized by fee-for-service payments. This approach can succeed if utilization is lowered only for unnecessary care, rather than encouraging too much utilization control of needed treatment.

3. Potential Impact on Key Stakeholders

a) **Consumer Cost Sharing**
Certain individual approaches, such as high deductible plans with health savings accounts, are intended to reduce unnecessary utilization and incent cost conscious health care purchasing by consumers by having them bear a higher percentage of their health care costs. Such strategies may help mitigate growth of health care costs, but primarily shift costs to consumers. This approach might also result in consumers forgoing needed care, particularly if consumer-friendly price and quality information and decision aids are not available.[43]

[43] Reddy, Sheila R., et al. "Impact of a High-deductible Health Plan on Outpatient Visits and Associated Diagnostic Tests." Medical care 52.1 (2014): 86-92.

b) **Consumer Empowerment**
Consumer-directed health care initiatives are designed to provide information to the consumer to be able to make informed decisions based on cost, quality and clinical recommendations. Public websites with clear provider and carrier specific information on cost and quality can promote consumer empowerment and choice selection by providing this critical information.

c) **Employer and Individual Premiums and Cost Sharing**
Employers and individuals have a strong desire to see premium increases slow down or reverse. An effective cost containment policy should mitigate the growth of premiums as well as out of pocket costs to consumers.

d) **Provider Revenues and Provider Solvency**
Approaches that contain costs by reducing provider revenues may lead to issues with provider solvency. Hospitals need an operating margin that allows them to invest in maintaining and improving their staff, equipment and infrastructure to maintain quality and remain viable business entities. Cost containment efforts need to result in a system where providers are still able to remain solvent (though this may entail a change in their structure to do so, in some cases) and continue to provide needed services to the populations they serve. Otherwise, New Hampshire could experience more consolidation of the health care market, which can drive up costs, or the state could potentially lose critical access hospitals in rural markets.

e) **Health Plans and Ability for New Carriers to Enter New Hampshire Market**
We reviewed the potential impact of cost containment approaches on health plans. We identified and eliminated certain approaches that appeared likely to discourage health plans from either remaining in or entering the New Hampshire market, giving fewer options for New Hampshire residents.

f) **State Government Costs**
As a state with no income tax and a history of constrained government spending, we considered options that required large government investments in order to implement to be less viable.

4. Other Items that Were Considered in Narrowing the Options to Those that Were Feasible

a) **Administrative Costs and Hurdles**
The administrative costs and hurdles to implement cost containment strategies were considered in the review of options. Some of the administrative considerations are described in the legal hurdles and considerations sections of this report.

b) **Alignment with Medicare and Medicaid**
Because the costs can be reduced through simplification of health care administration, we reviewed whether suggested approaches aligned with Medicare and Medicaid approaches.

c) **Alignment with Neighboring States**
As some health care providers provide services across borders, we reviewed whether any approaches were consistent with approaches taken in Vermont, Maine and Massachusetts, or represented any cross border issues for providers serving residents of two states.

d) **Legal Considerations**
We analyzed the legal steps, hurdles and potential risks that may be raised by each of the payment reform options evaluated for this project. A detailed analysis of legal considerations is included in Appendix B of this report.

C. Narrowing the Net

Based on our analysis of all of the above factors, we narrowed the options described in the wide net to a select group of recommendations. To identify which combination of options would be most effective, we focused on those mechanisms that, in the absence of a well-functioning competitive market, would be most likely to create a system that would reward providers for containing costs, while improving or maintaining quality and access. We applied the criteria above to select mechanisms that build on current initiatives and some regional approaches, and which would be most feasible to implement based on stakeholder feedback and the political climate of New Hampshire.

We then grouped the available mechanisms into comprehensive approaches that, as a group, would create the fundamental components of a well-functioning health care system, described in more detail above: a system that creates incentives for cost containment and quality improvement; incentives for building consensus among providers, payers and other stakeholders; infrastructure to facilitate collaboration among stakeholders; and consequences for not actively working to create the new system.

The results of these efforts are three recommended payment reform strategies that New Hampshire could implement to achieve its goals. We also identify a number of steps that New Hampshire could take in the shorter term to move its system closer to being able to implement the longer term options. Finally, we list two stand-alone actions that New Hampshire could take to contain some health care costs.

IV. Recommendations

We recommend three comprehensive approaches to payment reform, four short-term steps the state could take to move closer to payment reform, and two stand-alone actions to addressing high health care spending in New Hampshire. The state may choose to pursue one or more of these approaches.

A. Comprehensive Approaches

1. Payment Reform Strategy 1: Publicly Report Progress Against Benchmarks

a) **PATH: Establish Statewide Benchmarks, Standard Basis of Payment, Reporting, Consequences**

This option aims to establish market-like incentives for cost containment and quality improvement by establishing statewide benchmarks, as well as consequences for failing to meet those benchmarks.

Benchmarks: New Hampshire could establish a benchmark for growth in total statewide health expenditures per capita. The state could consider tying the benchmark to an economic indicator, such as the growth in state domestic product, the Consumer Price Index, or the growth in national health expenditure. The state should also establish appropriate measures of quality of care by service, tied to national benchmarks.

Trusted Entity: The state should consider carefully who should be entrusted with setting the benchmarks. One choice is to require a state agency to take on this responsibility, after consulting with interested parties. Another option is to establish a Commission comprised of impartial members with specific expertise to establish the benchmarks. Appointing authority for one or more members could be granted to several individuals, such as the Governor, Attorney General, Senate President and Speaker of the House.

Measurement and Transparency: The state would then analyze its health care data to determine whether the growth in total statewide health expenditures exceeded the benchmark. The state would also determine whether individual health care providers' and insurers' health expenditures grew at rates greater than the cost benchmark and whether their services met the quality benchmarks. The results of this analysis should be posted publicly. The state should include a process by which health care entities can appeal this determination.

The state could further require all payers to pay using the same basis of payment, such as payment per Diagnosis Related Group (DRG) for inpatient care (using the same software and same version) and payment per Resource-Based Relative Value Scale (RBRVS) unit for professional services. This change would ease comparison of payment levels across payers and providers. Alternatively, the state could convert existing payments to a standard basis for purposes of measurement and transparency.

Consequences: The state should establish clear consequences that would be imposed under certain conditions. Consequences should be imposed on a health care entity because of excessive cost growth if (i) the growth in total statewide health expenditures exceeds the benchmark, (ii) the growth in the health care entity's health expenditures exceeds the benchmark, and (iii) the entity's average costs, adjusted for health status, exceed the average of its peers, or potentially a threshold above the average of its peers. Consequences should be imposed for poor quality if an entity's quality is below its peers and it fails to meet improvement targets.

Consequences could be imposed with increasing severity over time. For example, the first step could be to post the name of the entity and the benchmark it failed to meet, the second step could be to require a performance improvement plan, the third step could be to impose a fine, and the final step could be to impose state rate-setting on the offending entity.

b) **Legal, Administrative and Cost Considerations for Strategy 1**

Statutory Authority: This option builds on the considerable experience and investment that New Hampshire has made in data collection, analysis and transparency. The state could establish benchmarks and post measurements against the benchmarks without any legal change. However, legislation would be required to impose any further consequences.

Governance: The state would need to establish by law which entity is responsible for each key component: establishing the benchmarks, determining whether the state as a whole exceeded the benchmarks, determining whether individual health care entities exceeded the benchmarks, and imposing consequences. These functions could be assigned to one or more entities. In Vermont, the Green Mountain Care Board is responsible for all of these functions. The Green Mountain Care Board approves hospital budgets and can require a hospital to re-cast its budget to come in under the benchmark. Maryland's Health Services Cost Review Commission sets benchmarks based on growth in Gross State Product, and sets hospital rates within that benchmark. In Massachusetts, the Health Policy Commission sets the benchmarks and imposes consequences, while the Center for Health Information and Analysis measures whether the state and individual health care entities exceed the cost growth benchmark.

If New Hampshire is concerned that increased provider consolidation may contribute to driving up provider prices, it may also establish increased monitoring of and control over merger activity, and would need to identify which agency(ies) were assigned with these functions.

Cost: The state would need to obtain funding for staff or consultants to (i) conduct the analysis required to establish the benchmarks, (ii) determine whether the state as a whole exceeded the benchmarks, (iii) determine whether individual health care entities exceeded the benchmarks, and (iv) impose consequences. Each of these four steps could require the full-time work of several state employees or consultants.

2. Payment Reform Strategy 2: Promote Alternative Payment Methods

a) PATH: Establish Multi-Stakeholder Commission Charged with Adopting Model Contract; Authorize State to Regulate Rates if the Commission Fails to Make Progress; Regulation of Provider Risk

Transition to alternative payment methods and ACOs: The second option aims to shift, system-wide, carriers, other purchasers, and providers to new contracting models that contain features needed to implement payment and system reforms. Under this option the state would transition to more widespread use of new payment methods that are alternatives to fee-for-service, and to more use of coordinated, integrated systems of care delivery, especially ACOs. [44] The federal ACO programs[45] have recently received governmental and media attention for their cost saving results.[46] As the state transitions to new contracting models with ACOs and other provider organizations, it should also consider taking steps to regulate provider risk-bearing, to protect provider solvency and service delivery.

New Hampshire already has several ACOs, including Dartmouth-Hitchcock Health, the Granite Health Network, North Country ACO, NH Accountable Care Partners and the coordinating initiative managed under the Citizens Health Initiative's grant-funded ACO demonstration.[47] These initiatives are aiming to demonstrate that ACOs, global payments, and payment for quality can be successful within the state. A new Medicare ACO initiative, the ACO Investment Model, will offer entities money up-front to transform their practices. The model will also prioritize selection of rural ACO applicants.[48]

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[44] An ACO is a group of health care providers that agree to be collectively accountable for the cost, quality, and care of a population across the continuum. See Elliott S. Fisher et. al., "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," Health Affairs 26, no. 1 (2007), http://content.healthaffairs.org/content/26/1/w44.full.pdf+html (accessed October 8, 2014); Elliott Fisher, "Elliott Fisher: Shift to Accountable Care Organizations," Wall Street Journal, July 19, 2013, http://blogs.wsj.com/experts/2013/07/19/elliott-fisher-shift-to-accountable-care-organizations/ (accessed October 8, 2014).

[45] ACOs rose to national prominence through the Medicare Shared Savings Program (MSSP), established pursuant to Section 3022 of the ACA (2010). Since then, ACOs have proliferated, both in the MSSP and Pioneer ACO Programs (also referred to as federal ACO programs), as well as in the commercial market.

[46] United States Department of Health and Human Services, "New Affordable Care Act Tools and Payment Models Deliver $372 Million in Savings, Improve Care," September 26, 2014, http://www.hhs.gov/news/press/2014pres/09/20140916a.html (accessed October 8, 2014); United States Center for Medicare and Medicaid Services, "Fact Sheets: Medicare ACOs Continue to Succeed in Improving Care, Lowering Cost Growth," September 16, 2014, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-09-16.html (accessed October 8, 2014); Priyanka Dayal McCluskey, "Health Care Pilot Shows Progress in Controlling Costs," Boston Globe, September 18, 2014, http://www.bostonglobe.com/business/2014/09/17/health-care-pilot-shows-progress-controlling-costs/vaIEhpZaXyJnOAEhKvBjEI/story.html (accessed October 8, 2014).

[47] New Hampshire Citizens Health Initiative, "Accountable Care Project," http://citizenshealthinitiative.org/accountable-care-project (accessed October 8, 2014). Two main areas included in the Citizens initiative 2014-2015 are a program for coordinated care for patients with depression and another chronic condition, and implementing a coordinated model for patients with hypertension.

[48] Centers for Medicare and Medicaid, "ACO Investment Model," http://innovation.cms.gov/initiatives/ACO-Investment-Model/ (accessed on 10/27/2014)

However, movement toward capitation of providers in the 1990s failed for reasons that include inadequate infrastructure and expertise on the part of providers. It is critically important to develop more deliberate public policy to support and protect both providers and consumers from negative consequences, including the retreat to inflationary fee-for-service payment that followed the failed capitation experiments. If negative consequences from these contracts occur, or there is a retreat from the current interest in this approach, there are few incentives toward further use of these models in New Hampshire, given the absence of competition or pressures to contain costs and improve quality. Therefore, external incentives and supportive steps to move the market toward these new, cost-saving models of payment and care delivery should be developed.

Model Contract: To move the system to these new payment methods to achieve cost containment goals, the state should devise a model contract which contains alternative payment methodologies (Model Contract) and share it with key stakeholders, including providers, payers, consumers, and employers. Specifically, payers and providers would be incentivized to use the Model Contract as a basis for their contracting, including payment mechanisms that are alternatives to fee-for-service, payment for performance on established quality measures, and sharing in risk for providers able to take on risk. The state could provide training on the use of the Model Contract, offer technical assistance on the "nuts and bolts" of entering into alternative contracts. We recommend that New Hampshire coordinate across agencies to offer a clear path for organizations entering into these arrangements.

State and Federal Use of Model Contracts: State agencies have been using model contracts routinely in the managed care contracting arena, as part of the procurement process, for several decades. For example, the California Department of Health Care Services posts sample contracts that include the varying models of managed care in California.[49] Texas also uses a Uniform Managed Care contract for their Medicaid managed care program.[50] In Massachusetts, a contract model known as the "alternative quality contract" devised and used by a major insurer in the state created part of the early foundation and path for the state's recent legislation (chapter 224) on health care cost containment.[51] More recently, Massachusetts has launched a program called the Primary Care Payment Reform initiative, with bundled payments, shared savings, and coordinated care requirements, which utilizes a Model Contract.[52] On the federal level, the contracts

[49] California Department of Health Care Services, "Medi-Cal Managed Care Boilerplate Contracts, http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx (accessed October 8, 2014).
[50] Texas Health and Human Services Commission, "Uniform Managed Care Terms and Conditions," http://www.hhsc.state.tx.us/medicaid/managed-care/UniformManagedCareContract.pdf (accessed October 8, 2014).
[51] Deval Patrick, Address to the Greater Boston Chamber of Commerce, February 17, 2011, http://www.mass.gov/governor/pressoffice/speeches/021711-greater-boston-chamber-of-commerce.html (accessed October 8, 2014); Commonwealth of Massachusetts, "Patrick-Murray Administration Proposes Comprehensive Health Care Cost-Containment Legislation," February 17, 2011, http://www.mass.gov/governor/pressoffice/pressreleases/2011/administration-proposes-comprehensive-health.html (accessed October 8, 2014). The alternative quality contract contained some of the key components and laid the groundwork for current ACO contracting in the state.
[52] Massachusetts Executive Office of Health and Human Services, "Primary Care Payment Reform Initiative," http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/primary-care-payment-reform-initiative.html (accessed October 8, 2014).

being entered into for the Medicare Shared Savings Program (MSSP) ACO program contain certain core components, used across the nation by many MSSP ACOs.[53]

New Hampshire may use these existing models in designing and releasing a Model Contract in the ACO arena, as there are a number of key similarities (e.g. payment for performance on quality measures, global or other alternative payments (in the managed care context, capitation), and requirements regarding risk). We recommend the Model Contract approach as a more dynamic mechanism to truly move the state forward in achieving its cost containment goals.

b) The Model Contract Could Contain the Following Features:

- Global payments putting providers on a yearly, risk-adjusted budget.

  Slower increase in rate growth over the term of the agreement than under traditional multi-year fee-for-service contracts; coupled with the potential for providers to earn a higher overall total for high performance on all quality measures (see below).

- Shared savings methods in which providers may share in savings, and in some cases, losses for performance on quality and overall savings under the agreement.

  The agreement would include a set of established quality measures, and payment would be conditioned on meeting the standards set forth in those measures.

  Measures would incentivize care coordination across the ACO (for example, reduction in hospital readmissions), and would be balanced between inpatient and outpatient measures.

- Payments would be made to ACOs and other providers able to take on financial risk, which may then distribute payments to providers participating in the ACO (depending on the structure of the provider/ACO-integrated or established by contracts).

  The participating providers could, separately, agree to a mechanism for sharing in the gains or losses under the contract.

- Monitoring and grievance/appeal process requirements to protect consumers and ensure against underutilization.

Additionally, the Model Contract could require care coordination among different providers that are part of ACOs or integrated care organizations, and infrastructure and mechanisms to share in risk and reward from contract performance.

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[53] Peter Wehrwein, "The ACO Contract: Four Parts of the Basic Chassis," *Managed Care*, June 2013, http://www.managedcaremag.com/archives/2013/6/aco-contract-four-parts-basic-chassis (accessed October 8, 2014).

Provider Risk: This new contracting model could place performance risk on providers and new provider organizations such as ACOs, though not all providers would be encouraged to take on risk. Thresholds could be established for which providers would be permitted to enter into (or continue) with downside risk contracts (see discussion on regulation of provider risk below at Section IV.2.d). The Model Contract should also be consistent with other models already in use throughout the state by existing ACOs and integrated care entities.

There are a number of advantages to issuing a Model Contract. The state's model would clearly demonstrate the nature of the contracting mechanism and policy direction towards which the state seeks to have providers move. Additionally, issuing a Model Contract will specify what is meant by terms such as alternative payment methods, ACOs, and shared savings for performance on quality, and how these concepts are to be implemented together.

Educate Stakeholders: The state could provide learning collaboratives, public meetings, and trainings on what is needed to enter into the Model Contract, and the way it is implemented. The educational program could identify and address issues raised by Model Contract implementation and offer technical support. This approach and support is consistent with the SIM grant application submitted by New Hampshire. We recommend that the state coordinate across government agencies to provide a clear path for organizations entering into these arrangements.

However, it is unlikely that without further action, the Model Contract will take hold enough to cause a system wide shift with all payers and providers in the state to using alternative payment methods, and becoming or joining an ACO. The Model Contract may be of interest to some providers and ACOs, but it may not obtain sufficient traction and use to have much impact, without further steps.

These steps –devising a Model Contract and educating all stakeholders about the urgency of its need for health care cost containment statewide – are necessary but not sufficient to transform the market and bring down health care costs in New Hampshire. In order to have the greatest cost containment impact, New Hampshire should pair its Model Contract work with incentives. One way to do this is by establishing a multi-stakeholder commission as described in the next section.

c) One Path to Payment Reform: Establish Multi-Stakeholder Commission

One tactic that could be used to achieve agreement among payers and providers on a Model contract is to use a legislatively created special commission. The stakeholder commission for this option would have a more specific charge than the short-term commission option described in Section IV.B.3.

Commission Charge: The special commission could be given a very specific charge in the legislation: to evaluate the state's Model Contract, and either recommend that it be broadly adopted, or propose a reasonable alternative ("Stakeholder Model"), containing similar features. The commission charge could specify that if stakeholders do not agree to adopt the Model Contract, they must arrive, collectively, at an alternative, but similar agreement. The stakeholders would need to align on payment, care delivery, and quality

performance features of contracts they would use going forward, that the state would then review and approve. The Commission could evaluate issues such as the size of providers which would be required, over time, to shift to the Model Contract or Stakeholder Model, and other key issues, to be specified in the legislation. The Commission would be required to meet regularly (with a minimum set number of times established in the legislation), and those meetings would be open to the public. The Commission would be charged with issuing a final report on its recommendations and choices within no more than one year from the date it is formed.

Commission Advantages: There are a number of advantages to establishing a Commission, rather than trying to legislate the desired result at the outset. One clear advantage is to obtain stakeholder support and buy-in for the payment reform and system delivery reform ideas the state seeks to promote. Another is to create a sense of shared responsibility among the different stakeholders, and an understanding that they are all "in it together." Additionally, the meetings would promote a level of transparency, trust, and obligation among the participants; and the threat of impending rate regulation would encourage more efficient, goal-oriented negotiation and consensus building. Finally, the multi-stakeholder commission approach would also avoid the pitfalls New Hampshire has faced with more prescriptive legislation attempting to regulate health care cooperative agreements, which has not succeeded in gaining passage in the state.[54]

Consequences-Regulation of Provider Rates: If the stakeholders do not arrive at such an agreement, identifying the key features of this new reimbursement model independently, and also refuse to adopt the Model Contract devised by the state, New Hampshire could start setting rates across the board for ACOs, hospitals and other providers. The state could use the threat of regulation of provider rates with carriers as a way to motivate consensus among stakeholders. Specifically, if stakeholders failed to agree either to use the Model Contract or devise a similar Stakeholder Model, the state could begin regulating rates, setting a cap on provider fee-for-service (and potentially other) rates.

Providers would be given the opportunity to control costs voluntarily, using either a state-issued Model Contract or another contract with terms the state approves as achieving similar cost containment goals. The state would only exercise its rate setting authority if the stakeholders failed to agree to use the Model Contract or Stakeholder Model. The legislation authorizing this approach should make clear that the state's regulatory authority would only be exercised in this manner. The state should have discretion as to when, and whether, to exercise this targeted authority to regulate provider rates.[55] Without the potential ability to regulate provider costs, the state's issuance of a Model Contract is unlikely to succeed in bringing down overall health care costs in the state.

[54] New Hampshire State Senate Bill 308, 2014 Session, http://gencourt.state.nh.us/bill_status/bill_status.aspx?lsr=2682&sy=2014&sortoption=&txtsessionyear=2014&q=1 (accessed October 8, 2014).

[55] NHID could be the regulating agency, and regulate carrier rates with providers, or another government agency could be designated to have authority to regulate rates in the event stakeholders could not come to consensus and use a new contract model.

The threat of broad rate regulation would operate as a strong force to motivate the stakeholders to work hard and negotiate well to reach agreement, either to use the Model Contract or devise their own Stakeholder Model, to be approved by the state, within the specified time frame. By requiring that providers either lower their rates in carrier contracts and use a new Stakeholder Model voluntarily, or switch to the Model Contract which contains lower rate increases, the state would provide several options for stakeholders, to avoid rate setting.

d) Provider Risk Regulation

As New Hampshire transitions to new models of contracting and payment, providers will be encouraged and incentivized to take on more financial responsibility for services. Providers and ACOs will transition to assuming the risk of gain and loss on performance and quality measures, and managing global payments for their patient populations. To help ensure a smooth transition and protect against provider insolvency, the state should consider taking steps to regulate provider risk bearing.[56]

Require certification of providers for risk level assumed: State-level insurance regulation of carrier solvency relies on a methodology of comprehensive risk assessment compared to financial assets known as "risk-based capital" (RBC), developed by the National Association of Insurance Commissioners (NAIC). This allows a very helpful, if imperfect, way of determining whether insurers have the capital to absorb the underwriting and investment risks they take. With the emergence of provider risk contracts, no parallel method exists to ensure provider solvency in the face of risks assumed.

Methodology-Example: One state has taken a first step down this path, and recently issued guidelines for risk-bearing provider organizations (RBPO) to obtain independent review in order to qualify for issuance of a risk certificate.[57] In order to obtain the risk certificate, the RBPO must have a "Review Statement" from an independent actuary that the RBPO meets the requirements for risk bearing laid out in the Guidelines.[58]

The guidelines require the reviewing actuary to carry out a sequenced set of steps that become more extensive depending on whether or not it can be quickly established that the RBPO is capable of bearing the downside risk of its portfolio of risk contracts. The review in the first year of the certification program is retrospective (this will likely change to being prospective in future years), assessing the risk of the organizations contract during the current year already in progress. In brief, the steps are as follows:

1.) Calculate the total value of the budget target as defined by the contract documents and accepted payment/budget rates.

[56] See Manatt report at page 15 for additional discussion and analysis of need for regulation of provider risk bearing.
[57] Massachusetts Division of Insurance, "Guidelines for Conducting Independent Reviews of Risk-Bearing Provider Organizations in Conjunction with the Application for Risk Certificates for the Term Beginning March 14, 2015," September 26, 2014, http://www.mass.gov/ocabr/docs/doi/rbpo-guidlines09252014.pdf (accessed October 8, 2014). These guidelines and the requirement for a risk certificate are pursuant to the requirements set forth in Massachusetts General Laws Chapter 176T and 211 CMR 155.06(2) and 155.07.
[58] In the first year only, the reviewer can be an actuary or other independent financial professional.

2.) Using independent information provided by the insurance regulator based on APCD-based estimates, calculate the expected level of budget target for each contract by using the combination of Payer and RBPO.
3.) The projected loss or gain is the sum across contracts of item #1 minus sum across contracts of item #2, which is then reduced by the risk sharing percentage in each contract applied to its share of the total dollars.

If the result of these calculations is positive, the reviewer can issue a positive review statement. If negative, the review needs to continue with the following steps:

4.) Calculate net working capital (current assets – current liabilities), as well as other sources of payment for losses (e.g., resources from parent organization).
5.) Compare the net loss from #3 to the resources in #4

If the net result of this comparison is positive, the review statement may be issued. If not, additional information must be reviewed including the RBPOs infrastructure for managing claims risk, and terms in the contract that allow termination of the contract by the RPBO in case of financial risk. The reviewer must then make a judgment as to whether these factors offset the potential loss sufficiently to merit issuance of a review statement.

Methodological Considerations: The above-described methodology and approach represent a dramatic improvement over not assessing whether providers have the ability to assume risk. However, this approach does have significant limitations relative to a more well-developed approach like the NAIC's RBC methodology for regulated health insurers. These limitations include the following:

1.) It does not assess risk in the usual sense meant in an insurance context, which is fundamentally tied to variations in claim expense outcomes. It uses a reasonable approach drawing on publicly available information to make sure that budget targets are similar to historical costs for similar populations. However, it does not assess potential variation in claims outcomes around the target and whether the organization has the financial means to absorb random variations in claims expense. The claim target could equal the historical level of spending, but if random variation causes actual claims to be 3% higher than the target, the review steps had already stopped after determining that the target was reasonable and do not proceed to assess financial strength to absorb the random variation.
2.) Hospitals have many other sources of risk that are not assessed by this method. The RBC formula attempts to measure the related underwriting and investment risks of an insurer. The approach described above does not assess risk from sources like fee-for-service contracts that are below cost, risk of government payment cuts, investment loss risk, medical liability risk, and other sources.

Overall, this approach is admirable for being proactive, beginning the conversation on provider risk assumption, and capturing the primary and most important source of risk, which is whether the provider has negotiated appropriate budget targets with the carriers.

Minimum Size: A related issue that should be considered is the minimum size of the population to be served by an ACO contract. In a small state like New Hampshire, the number of individuals that can be attributed to a specific payer and provider combination is often quite small. As providers, ACOs, and other provider organizations transition to providing more integrated care, the state could consider establishing a minimum number of individuals attributable to a provider organization in order for that organization to participate in new payment models that involve provider risk bearing. For example, the Medicare Shared Savings Program requires ACOs to cover at least 5,000 beneficiaries.[59] Some states have also used 5,000 as the minimum attribution number for ACO programs; New Hampshire could consider whether this minimum is appropriate for its payment reform initiatives.

e) Path to Regulating Provider Risk

To achieve regulation of provider risk on a system-wide level, New Hampshire could take the following steps:

Enact broad legislation: Enact legislation directing NHID to regulate provider risk in carrier contracts with providers (including ACOs) taking on significant risk. Options could include process (review, risk certificate) as well as substance (rules re: stop loss insurance, performance bonds, etc.).

For the risk assessment to be comprehensive, the state could include Medicaid and other public payers as well as commercial carrier contracts. The state could include in legislation provisions applicable to all providers taking on provider risk (e.g. require that they obtain risk certificates and meet any other requirements related to provider risk).

Adopt Risk Certificate Requirements: Additionally, the state could consider requiring providers to obtain risk certificates prior to entering into/ renewing any contract under which they accept risk, unless they apply for and receive a waiver. Legislation in this arena could establish broad criteria, with more specific details delegated to regulation by NHID.[60]

The state could define the types of organizations that must apply for a risk certificate, including questions about new provider organizational structures and ACOs. The state will need to collect information on the nature of provider risk contracting arrangements, and determine what types of evidence it will need to adequately ensure provider solvency for providers that take on risk.

Educate Stakeholders: The NHID could hold sessions with stakeholders on this issue of provider risk, to obtain more information about current risk-based provider contracting and other stakeholder concerns around new payment models.[61] Once the state has

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[59] 42 C.F.R. § 425.110.

[60] The approach described in this subsection is based on the approach in Massachusetts. See M.G.L. c. 176T.

[61] In Massachusetts, the Division of Insurance held special sessions on issues relating to the implementation of chapter 224 of the Acts of 2012, which focused largely on obtaining stakeholder input on regulation of provider risk. See Massachusetts Division of Insurance, "Division of Insurance, Health Policy Commission to Focus on Key Health Care Cost Containment Strategies," March 21, 2013, http://www.mass.gov/ocabr/press-releases/2013/doi-hpc-focus-on-health-care-cost-containment.html (accessed October 8, 2014).

gathered sufficient information, NHID could promulgate regulations, which may include a transition period, with transitional waivers, to allow regulated parties to come into compliance with the new rules.

Monitor Risk and Provider Solvency: As the state begins to regulate provider risk bearing, it could monitor the transitions in the market broadly, as well as changes to provider solvency status, to ensure that its regulatory approaches are appropriate and effective. Where the state would be somewhat new to this area of regulation, regular monitoring and evaluation of the impact of provider risk bearing requirements would be important to their appropriate implementation and effectiveness in promoting payment reform goals.

f) Path to Addressing Anti-Trust Concerns[62]

Provider payment reform can raise antitrust concerns, both at the state and federal levels. Mergers, affiliations, and consolidations may result from payment reforms, because larger organizations may be more advantageous for care integration and risk assumption purposes. However, health care consolidation can still lead to higher prices due to market clout. The state needs to balance these competing health reform concerns. We recommend that New Hampshire communicate and coordinate its payment reform efforts across state agencies, including the state Attorney General office, to address these issues. Additionally, the New Hampshire Department of Justice could be given more powers to oversee mergers as incentives to consolidate increase.[63]

As part of this coordination effort, New Hampshire should consider enacting state action immunity legislation. The theory of state action immunity is as follows: when a state establishes a program that encourages activity that might otherwise be viewed as anticompetitive, and the state establishes and implements a comprehensive process of supervision, the participants in the program may be able to receive immunity from federal anti-trust rules.[64] The state would then invoke the state action immunity doctrine as needed, to promote specific elements of its policy agenda, such as new payment methods and programs to promote ACOs and integrated care. If the state decides to invoke the state action immunity doctrine, it should consider ways in which it – through NHID, New Hampshire Department of Health and Human Services, or another agency – can take an active and ongoing role in implementing and overseeing the integration or ACO

[62] The information in this report is intended as a framework for policy strategy, and is not intended as legal advice. The NHID would need to consult with attorneys licensed to practice law in New Hampshire for legal advice on any specific state law issues.

[63] In Massachusetts, the state's cost containment legislation expanded the power of the state and Office of the Attorney General to monitor and regulate market consolidations that may not rise to antitrust violations. M.G.L. c. 12 § 11N.

[64] State action immunity doctrine is an evolving area of law. Recently, the U.S. Supreme Court narrowed this doctrine, clarifying that state action immunity may only be invoked in certain specific circumstances, where the state has had an ongoing and active role (defined rather narrowly) in overseeing a clearly defined initiative and actively supervising its implementation and impact FTC v. Phoebe Putney Health System, Inc., 33 S. Ct. 1003 (2013). To meet this standard, the state needs to be able to demonstrate clear and ongoing direct supervision of the implementation of the program in question in order for program participants to avoid antitrust liability. Another case, The N.C. Bd. of Dental Examiners v. F.T.C. (2015) denied state action immunity to a state agency that was "controlled by active market participants." These cases could also affect the viability of state action immunity.

formation process. Use of the state immunity doctrine should be targeted towards those programs that the state is actively promoting.

These actions are within state control and provide some important potential anti-trust protections to stakeholders as the state transitions to new payment and system delivery approaches. [65]

g) **Legal, Administrative and Cost Considerations for Strategy 2**
There are a number of additional steps the state could take to implement Strategy 2. The steps include enacting legislation to establish the commission and the authority to set rates if the model contract or approved alternative is not broadly adopted. Additionally, the state could seek approval for Medicaid and Medicare participation, to include public payers in the new contracting and payment mechanisms. Steps could be taken to encourage voluntary participation by self-insured entities.[66] The state would need to obtain funding for staff or consultants to devise the Model Contract, participate in the stakeholder commission and evaluate the commission recommendations.

These steps and related legal considerations are described in more detail in **Appendix C.**

3. Payment Reform Strategy 3: Strengthen Employer Purchasing Power

PATH: Take Steps to Study Alternatives for Improving Purchaser Negotiating Position
New Hampshire's health care market is characterized by highly concentrated provider markets, a concentrated insurance market with a dominant player, and a relatively disaggregated and disorganized employer purchaser market. In this market structure, it can be difficult to exert competitive pressure on providers, and relatively easy for insurers to mark up the cost of care and pass the bill along to employers. Furthermore, solutions for the lack of competitiveness in provider and insurer markets are not obvious. This context makes exploration of ideas to strengthen the employer purchasing market worthwhile.

One approach considered in the past is the use of a purchasing collaborative, sometimes called "HIPCs" (for Health Insurance Purchasing Collaboratives). These are nonprofit or government entities that accept all small employers and offer employees of participating employers a choice of health plans. These features distinguish HIPCs from association health plans, which aggregate purchasing power of employers but may have none of these features.[67]

[65] A legal analysis performed by Manatt Health Solutions identified "adopting antitrust enforcement policies similar to those adopted by federal regulators and evaluating whether further action is appropriate to protect providers from antitrust liability" as "areas that merit further consideration by New Hampshire policymakers." See Manatt report at pp. 1-2 and 25-27 for additional analysis of anti-trust issues.
[66] Changes to existing commercial carrier laws may also be needed, including amending the statutory provisions of RSA 415 and RSA 420.
[67] Elliot K. Wicks and Mark A. Hall, "Purchasing cooperatives for small employers: performance and prospects," *Milbank Quarterly* 78, no. 4 (2000), 511-546.

Purchaser collaboratives have the potential to encounter antitrust issues, although this risk has been more theoretical than practical.[68] However, attempts in the past to form and successfully operate HIPCs have failed to gain significant traction in part because their voluntary nature has allowed two vested interests to prevent the one thing that HIPCs need to succeed at their mission: scale.[69] Both insurers, who stand to lose the high margins generated by small group plans, and insurance agents, who would lose commissions on sales for groups that joined a cooperative, have financial reasons to not support the success of HIPCs. As HIPCs were launched in the 1990s, in states including California, Florida, North Carolina and many others, a chicken and egg problem prevented growth – without scale, discounts couldn't be negotiated, and without discounts, scale couldn't be achieved.

In order to overcome these barriers, some form of legislative mandate or incentive could be necessary to generate the scale that would engender discounts. A transition to a purchasing collaborative could be overseen by NHID, subject to its authority and review.

However, such a step could be politically difficult, as a mandatory collaborative would be opposed by insurers, agents, and possibly even many of the businesses such a collaborative might benefit. In recent years, small group health insurance profit margins in New Hampshire have been only slightly higher than large group margins,[70] which appears to fail to support the most obvious argument for forming a collaborative. However, it is possible that carrier overhead allocations conceal the level of profit on small group coverage. Although the increased leverage on the buying side might help to dampen trend, particularly if the collaborative could coordinate with Medicaid managed care purchasing, this argument is more speculative and much less likely to be effective in a public policy process. In addition, a successful purchasing collaborative would require funding for staffing and data systems.

Overall, a purchasing collaborative as an option may not be a strong candidate for near-term pursuit as a policy, but it, or some other mechanism that allows increased coordination and efficiency on the part of purchasers, is an option that policymakers should keep in mind as they monitor market conditions in the small group sector going forward, as success in strengthening purchasers' roles in the market will complement and support other strategies aimed at controlling cost growth.

B. Short-Term Recommendations

The following short-term recommendations have immediate benefits, and they lay the groundwork for more comprehensive approaches later if they prove necessary and politically possible. New Hampshire could take these steps in any order.

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[68] Francis H. Miller, "Health Insurance Purchasing Alliances: Monopsony Threat or Procompetitive Rx for Health Sector Ills?" *Cornell Law Review* 79, Issue 6 (September 1994), 1546.
[69] Elliot K. Wicks and Mark A. Hall, "Purchasing cooperatives for small employers: performance and prospects," *Milbank Quarterly* 78, no. 4 (2000), 523.
[70] New Hampshire Insurance Department, "2012 Medical Cost Drivers," December, 2013.

1. Continue to Expand Data Transparency

The New Hampshire HealthCost website is a path breaking information resource for comparative costs on health care services that draws on the New Hampshire Comprehensive Healthcare Information System (CHIS), the state's multi-payer claims database. In the previous work commissioned by NHID, one recommendation was that "The state should continue to support transparency and the development of tools that make information, utilization and cost data more accessible to providers, payers and consumers."[71] Drawing on data already being collected by the State, there are several ways that New Hampshire can continue to innovate in transparency initiatives in ways that will provide important new information to consumers.

a. *Premium Transparency:* In addition to the CHIS multi-payer claim database, NHID also collects from carriers the Supplemental Report (SR) data set. The SR contains a detailed summary of health insurance products sold by licensed New Hampshire carriers, including premium, claims, membership, and actuarial value. Actuarial value (AV) is an index of the relative benefit level of each product. So, a product with an AV of 0.8 has 20% less benefit coverage value than a product with an AV of 1.0. By use of this index, plan coverage can be compared on a simple metric, even when benefit differences of covered services, deductibles, and copayments are complex. The AV also can be used to adjust premiums to a common standardized benefit level basis, so that plan value comparisons can be made on an "apple and apples" basis. The example here illustrates:[72]

"List" Premium	Actuarial Value	Adjusted Premium
$500.00	1.00	$500.00
$425.00	0.80	$531.25

It is difficult for consumers to get a sense of whether the $75 difference in premium is "worth it" for the differences in the benefit structures, but the adjusted premium provides a valid comparison of value. The first plan here is a better value for the money spent.[73]

[71] University of Massachusetts Medical School and Freedman Healthcare, "New Hampshire's Health Insurance Market and Provider Payment System: An Analysis of Stakeholder Views," June 2013, http://www.nh.gov/insurance/reports/documents/nh_himkt_provpay_sys.pdf (accessed October 6, 2014) at 7

[72] The calculation would in practice be slightly more complicated. The AV would adjust the medical portion of the premium, and then the AV-adjusted medical premium would be added to the administrative and profit charges.

[73] This approach is similar to but different from that used in the Federal Health Care Exchange. Exchange plans are required to be set at one of four "metal levels" into Bronze, Silver, Gold, and Platinum categories, corresponding to actuarial values of 0.6, 0.7, 0.8 and 0.9 respectively. This restricts the available plans to those with benefits at or near to these specific actuarial value levels. Outside the Exchange, plans can have any actuarial value level above

Because the SR data is provided after a plan year is over, it would not be available before purchase decisions were made. It would provide useful general information on plan values that are likely to provide useful information for the subsequent year's purchase, as well as being useful for retrospective analysis by the NHID.

Because the AV is also provided in rate filings that carriers submit for approval before health plans are sold, calculation of AV-adjusted values may also be publishable before consumers purchase policies. Publication of such information on a website would be a very powerful additional purchasing tool for consumers. Measurement of AV is imperfect but for the first time NHID is now collecting the information on a standardized basis, and application of this information to premiums would provide a dramatic improvement in information available to consumers. This information could be used for shopping purposes in the non-group and small-group markets, and to benchmark plan costs in the large-group market.

b. *Universal Provider Price Transparency:* Significant additional pricing transparency for provider services could be gained by taking the step of requiring all provider bills to include sufficient information for pricing using Medicare payment systems, so that prices for DRGs (inpatient services), APCs (Ambulatory Payment Classification for hospital outpatient services), and RBRVS (professional services) could be determined for all services in the CHIS. This would require some billing conventions for provider bills.[74] This would not require payment to be made via these methods, only that the bills include information that would then become available in the CHIS claims data set for analytical addition of pricing information by analysts using the CHIS. By applying Medicare pricing information to the claims in the CHIS, the actual payments can be compared to the Medicare payment level that would apply, and rigorously case-mix adjusted average prices could be developed in aggregate for each provider and for any sub-category of payers and services. This would dramatically increase the ability to measure and compare provider prices in a standardized way.

c. *Increased Quality Transparency:* As the public becomes more aware of provider prices, one unintended consequence could be that consumers equate higher prices with higher quality. This would undermine transparency's goal of cost containment. To address this concern, New Hampshire could report quality measure data alongside price information for providers. This approach would require some standardized quality measurement across providers and other health care entities. Standardization of quality measures is also recommended in order to reduce each provider's administrative burden.

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the required minimum level, and so the ability to compare plans value directly is not obvious. Using the available actuarial value information as suggested to standardize the premium levels would serve a similar purpose of making costs comparable.

[74] For an example of changes required in provider billing for DRGs, see: http://www.dhcs.ca.gov/provgovpart/Documents/W141%20SDN%20Enclosure-DRG%20Pricing%20Requirements%20(Chapter%207%20of%20PDD).pdf.

2. Leverage Available Resources

The State of New Hampshire obtained a SIM design award in the first round of SIM funding, and has applied for additional design funds in round two, for which announcement of awards should occur by the time this report is published.[75] The amount requested for the round two funds is $2 million for additional design, which includes the design of regional technical cooperatives to help providers develop the infrastructure to operate and manage innovative payment models. If approved, other payment reform activities in New Hampshire should be coordinated with the activities that take place under this grant.

Also made available by CMS have been much larger "model test grants" which are focused on implementation and testing of model designs. These grants are available for up to $100 million; Maine was awarded a model test grant in 2013 for $33 million. At this point, we are not aware of any specific announcements by CMS to make available additional rounds of SIM grants, but the statutory funding authority of the Center for Medicare Innovations runs through 2019.[76] The State should investigate availability and timing of future funding rounds and plan payment reform activities with available funding in mind. Among the potential uses of these resources would be to fund staffing of the Commissions recommended in this report, funding the development of the expanded data transparency initiatives described below, as well as expanding the ACO technical support and infrastructure requests contained in the most recent SIM application request.

3. Establish a Commission

The state could enact legislation establishing a multi-stakeholder commission and charge it with recommending legislation to contain health care costs, improve health care quality and ensure access to care in New Hampshire. There is already broad stakeholder support for the state, and NHID, to play a convening role in developing new payment models, and more broadly formulating a vision for health care delivery, improving quality and achieving cost containment in the state. These were some of the primary findings in the previous UMass report on stakeholder concerns and recommendations. [77]

The commission could include representatives from major stakeholders in the health care system, such as hospitals, clinicians, payers, employers, and consumers. These members could be appointed by the Governor, or several different elected officials could each appoint one or more members. The commission could also include representatives of government agencies such as NHID, the Department of Health and Human Services, the Office of the Attorney General, and other relevant agencies. The charge for a short-term commission

[75] For the Round 2 application, see New Hampshire Department of Health and Human Services, "State Innovation Model (SIM) Model Design Application," July 21, 2014, http://www.dhhs.nh.gov/ocom/documents/sim-round2-app-sub.pdf (accessed October 8, 2014).

[76] Section 1115A of the Social Security Act, codified at 42 U.S.C. §1315a.

[77] University of Massachusetts Medical School, "Analysis of Price Variations in New Hampshire Hospitals," April 2012, http://www.nh.gov/insurance/lah/documents/umms.pdf (accessed October 6, 2014).

would be to report on cost containment issues facing the state, and potential mechanisms for controlling costs, such as a transition to alternative payment methods and integrated care.

The special commission should be given funding for staffing to be provided either by designated state employees or by consultants. The legislation could require the commission to consider specific options and to conduct analysis to project the likely outcomes of each option. The commission should be required to meet regularly (with a minimum set number of times established in the legislation), and those meetings would be open to the public. The commission could be charged with issuing a final report and recommended legislation by a date certain, perhaps eighteen months from the date the law is enacted.

4. Expand Consumer Protections

As the state transitions to new models of care and payment, it should consider enacting legislation to ensure adequate consumer protections. Where ACOs, integrated and coordinated care models, and alternative payment methods are designed to improve care delivery efficiency and quality and contain costs, they may potentially result in unintended consequences of reducing appropriate care utilization as well as “cherry-picking” healthier patients.

The suggested consumer protection tools are useful for monitoring consumer care in all health care systems, and are especially helpful in a transition to new models of care and payment. Since New Hampshire already has some ACOs, the state should consider implementing consumer reforms for the current system in the short-term, as well as incorporating these reforms with any of the longer term options.

We recommend that New Hampshire consider adding some or all of the following consumer protections:

a. Quality measurement by providers, ACOs, and other health care entities;

b. Robust grievance and appeals processes;[78]

c. Monitoring for under-utilization;

d. Provisions for obtaining second opinions;

e. Stratifying quality measures by race, disability, ethnicity, language, etc.;

f. Ombudsman program with data collection monitoring types of complaints;

g. Patient advisory councils; and

h. Audit requirements.[79]

[78] This could include provisions regarding what constitutes an “appealable” service decision, internal appeal processes for ACOs and risk-bearing organizations, and adequate external appeals to a state agency.
[79] See 42 CFR 425.316(b) for Medicare Shared Savings Program approach

All of the approaches described in this report have a better chance of resulting in higher quality and better outcomes for consumers if appropriate consumer protections are included as part of the reforms.

C. Stand-Alone Actions

We identified two additional actions New Hampshire could take to contain certain costs without pursuing comprehensive reform. New Hampshire could pursue either of these actions independently of our other recommendations.

1. Reform Certificate of Need

Certificate of Need (CON) programs are generally designed to contain health care facility expenses, and facilitate coordinated planning of new services and construction. The laws and regulations that authorize CON programs and procedures are one method states use to reduce overall health-related and medical expenditures. [80] Under payment reform initiatives, especially global payments, providers have different incentives to invest in expensive clinical technologies which often trigger the CON process. These become cost centers and may only be helpful to profits to the providers under a global budget if they attract new members. Onerous requirements for determining need for additional clinical facilities may be unnecessary if global payment replaces fee-for-service as the norm. Additionally, there is already considerable stakeholder consensus in New Hampshire that the state's CON processes are not effective and should be changed.[81]

Many states continue to have CON programs, as part of their health resource planning procedures. [82] New Hampshire currently has CON regulations in effect.[83] The state should consider reforming its CON process, as part of a short-term approach to payment reform.[84] It could change its CON process to expedite review for certain categories of projects that further the states' health reform goals, consolidate the criteria for review, and modify the thresholds

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[80] For additional background on origin and evolution of Certificate of Need laws nationwide, see National Conference of State Legislatures, "Certificate of Need: State Health Laws and Programs," http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx (accessed October 8, 2014).

[81] University of Massachusetts Medical School and Freedman Healthcare, "New Hampshire's Health Insurance Market and Provider Payment System: An Analysis of Stakeholder Views," June 2013, http://www.nh.gov/insurance/reports/documents/nh_himkt_provpay_sys.pdf (accessed October 6, 2014) at 7.

[82] Ibid.

[83] N.H. Stat. Chapter 151-C; N.H. Code R. He-Hea.

[84] Earlier this year, New Hampshire revised some of the statutory thresholds triggering the CON process. See New Hampshire Department of Health and Human Services, "Health Services Planning and Review," http://www.dhhs.nh.gov/DPHS/hspr/index.htm. The state has previously considered a bill to eliminate the CON process, which did not succeed (2012). See Jaimy Lee, "Bill to Repeal CON Law Clears N.H. House," March 14, 2012, http://www.modernhealthcare.com/article/20120314/NEWS/303149944 (accessed October 8, 2014). Other states (including Maine) have sought to eliminate the CON process. Massachusetts modified and amplified its process (new agencies involved; major modifications to nature of entity/process).

regarding the criteria for projects that would trigger the CON review process. The state could also consider new requirements for CON applicants to submit an independent cost analysis.

Current CON law in New Hampshire still requires a lengthy process for a wide variety of capital improvements to a broad set of provider types. The process establishes a detailed CON standard setting process, and application process, that must be coordinated. Additionally, the timeframe for the review process of CON applications is 180 days (six months) from commencement of the review process; there is a 60 day general notification process before the review process can commence, as well.[85] There is currently a rather long review process by the state for expansions/improvements with relatively low thresholds (even under the March 2014 updated standards).

The impact of an improved CON process on state costs could be beneficial, if the state eases and expedites the process for projects that further the goals of health reform initiatives, including, for example, maintaining adequate access in Northern New Hampshire. Note that as competition and/or merger activity increases, the focus on the adequacy and fairness of the state's CON process is likely to increase substantially as well.

2. Reform Nonprofit Requirements

The New Hampshire Department of Justice's Charitable Trust Unit monitors the provision of community benefits by health care charitable trusts and executive pay at New Hampshire nonprofit hospitals.[86] These powers could be used to promote payment reform in a number of ways, as follows:

a) *Community Benefits.* In order to claim certain federal and state tax exemptions as nonprofit entities, hospitals must show that they provide "community benefits." The federal Internal Revenue Service oversees this process for federal tax exemptions, and the New Hampshire Department of Justice oversees this process for New Hampshire tax exemptions.[87] In New Hampshire, community benefits are generally seen in the form of patient financial assistance ("charity care"), public health programs, support for community health needs, and research.[88] Some analysts have found that the federal and state community benefits requirements are not as robust as they could be.[89]

New Hampshire requires nonprofit hospitals whose fund balances exceed $100,000 to submit community benefits reports.[90] The New Hampshire Certificate of Need process also requires community benefits (see discussion of CON process, above).

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[85] See RSA Title XI c. 151-c1-8.
[86] New Hampshire Department of Justice, "Community Benefits," http://www.doj.nh.gov/charitable-trusts/community-benefits/index.htm (accessed October 8, 2014).
[87] N.H. Stat. Chapter 7 §7:32-c et. seq.; 26 U.S.C. 501(c)(3)
[88] N.H. Stat. Chapter 7 §7:32-d (definition of community benefits).
[89] See Health Affairs blog, "Hospital Community Benefit Expenditures: Looking Behind the Numbers," http://healthaffairs.org/blog/2013/06/11/hospital-community-benefit-expenditures-looking-behind-the-numbers/ (accessed October 22, 2014).
[90] N.H. Stat. Chapter 7:32-c et. seq.

The ACA has some implications for hospital community benefits. First, Section 9007 directly amends the federal community benefits process, requiring hospitals to conduct a community health needs assessment, develop a written financial assistance policy, and limit certain hospital charges and collection policies.[91]

Second, the ACA presents a couple of competing factors that will influence how much hospitals pay for charity care. On one hand, as more New Hampshire residents obtain health care through health exchanges or Medicaid under the ACA, the demand for charity care may diminish.[92] On the other hand, ACA reductions of Disproportionate Share Hospital payments to hospitals could offset these cost savings.[93]

We recommend that New Hampshire evaluate the impact of the ACA's insurance expansion and Disproportionate Share Payment provisions on New Hampshire hospitals' financial contributions to charity care. If New Hampshire hospitals receive a windfall as a result of ACA insurance expansion, we recommend that New Hampshire consider expanding its community benefits requirements. For example, New Hampshire could encourage or require nonprofit hospitals to invest more funds into public health or community health programs, such as care coordination, health education, and health promotion, and to demonstrate how these programs improve population health and contain costs.[94] New Hampshire could also increase the number of patients eligible for subsidized care by expanding income limits.[95]

b) *Executive Pay.* The New Hampshire Department of Justice collects reports of executive pay at nonprofit hospitals. In a recent report commissioned by the Department of Justice, the New Hampshire Center for Public Policy Studies found that executive pay generally met IRS standards for nonprofit status, and that Executive pay was roughly in line with New England hospital executive pay (though higher than other northern New England states).[96]

As payment reform progresses, we recommend that New Hampshire continue to monitor executive pay levels. The state should consider requiring that nonprofits report the 5 or 10 highest paid employees to the New Hampshire Department of Justice. Additionally, the Department of Justice could provide information to non-profit boards regarding

[91] Affordable Care Act § 9007
[92] See United States Department of Health and Human Services, "Impact of Insurance Expansion on Hospital Uncompensated Care in 2014," September 24, 2014, http://aspe.hhs.gov/health/reports/2014/UncompensatedCare/ib_UncompensatedCare.pdf (accessed October 8, 2014).
[93] Ibid.
[94] See Chris Kabel, "What is the Future of Hospital Community Benefits Programs?" Stanford Social Innovation Review, June 5, 2013.
[95] According to New Hampshire regulations, hospitals required to show community benefit must have in place a financial assistance policy that provides free care to any individuals whose household income is under 150% of the Federal Poverty Level. N.H. Code Admin. R. He-Hea 303.04(d). New Hampshire could increase that minimum income threshold, perhaps with a sliding fee scale above 150% of the Federal Poverty Level.
[96] New Hampshire Center for Public Policy, "Executive Compensation at New Hampshire Non-Profit Hospitals," June 2012, http://doj.nh.gov/charitable-trusts/documents/20120702-nh-public-policy-report.pdf (accessed October 8, 2014).

regional norms for executive pay. To the extent the Department of Justice finds a nonprofit's salaries exceeds regional norms for health care organizations of similar size, the Department could consider several consequences. The Department could begin by informing the board that executive pay is excessive and asking it to make adjustments to bring salaries into line. Next, the Department could issue a public notice stating that the executive pay is excessive. As a last resort, the Department could replace the board on the grounds that it failed to do its fiduciary duty.

V. Conclusion

A wide variety of new health care payment and system delivery approaches exist which can help states contain costs. New Hampshire should build on existing initiatives in this area, by considering both short-term and longer term reforms. Payers and providers have acknowledged the need for cost containment and new approaches, and the state can build additional stakeholder support by creating a commission, both for short-term and long-term reforms. In the short-term, the state should focus on steps that increase transparency and pricing fairness, establishing a commission, regulate provider risk bearing, enact targeted nonprofit law reforms, and enact antitrust reform through the state action immunity doctrine. In the longer term, New Hampshire should consider: increasing transparency requirements and establishing statewide cost benchmarks; promulgating a Model Contract which incorporates alternative payment methods and requiring its use or the use of a similar contract model designed by stakeholders, and using the threat of rate regulation to incentivize stakeholder consensus; and establishing an employer purchasing collaborative. Using these approaches, either together or separately, New Hampshire can initiate and implement changes to promote effective cost containment while preserving access and quality.

Appendix A: Wide-Net Options

In order to develop a set of recommendations for NHID to consider in developing a strategy to contain health care costs in the state, Compass and UMass surveyed the variety of strategies undertaken or considered by other states to identify the full range of options, including regulatory, payment and service delivery reform, and employer- and individual-focused approaches.

i. Regulatory Options

a. All Payer Rate Setting

In all payer rate setting, the state sets rates that must be used by all payers. While many states regulated rates in the 1970's, today only Maryland sets all-payer rates, and only for hospital services. West Virginia sets hospital rates for Medicaid and commercial payers. Vermont's Green Mountain Care Board is mandated under that state's law to establish all-payer rates for all services, but it has not yet fulfilled that mandate.[97] In these states, regardless of the insurance a person has, or if they are uninsured, the same rate is charged. Under this model, the state has used this authority to keep rate increases low.

b. Cost Growth Benchmarks

Cost growth benchmarks are budget targets set at either the state or provider level, or both, which establish a benchmark for an appropriate rate of growth of health care costs. Both Massachusetts and Maryland are in the process of implementing cost growth targets. Massachusetts establishes an overall target for health care expenditures and rate of growth for entire health care sector. If overall state health care expenditures exceed the statewide target, then individual providers who exceed growth benchmarks are identified in public reporting and must explain their cost increases. The state also has authority to levy fines for providers who do not meet benchmarks (to take effect next year).[98]

c. Publicly Financed Single Payer Plan

A single payer system is one that combines Medicaid, Medicare and commercial plans. Vermont is developing a single payer plan that will be publicly financed, regulated by the state and overseen by the Green Mountain Care Board.[99] The anticipated effect is that a single payer will be able to achieve savings though lowering the administrative cost associated with multiple health insurers and keep overall health costs down. The private insurance market in Vermont will be limited to self-funded employer plans not subject to state law, and insurance for supplemental benefits.

[97] 18 V.S.A. §9376.
[98] M.G.L. c. 6D section 9.
[99] Chapter 48 of the Vermont Acts of 2011.

d. Regulation of Provider Risk

Regulation of provider risk bearing is a tool that is often mentioned in discussions of new payment and system delivery reform models.[100] As groups of providers come together to undertake more coordinated, integrated and cost effective care, regulation is needed to ensure that when providers take on performance risk – financial risk for performing on quality measures, and sharing in any savings or losses with other providers – they do not assume excess risk.[101]

e. Regulation of the Basis of Payment

States may develop regulation that requires all payers to use the same basis of payment, such as a diagnosis-related group (DRG) methodology for hospital stays. Maryland sets rates and mandates the use of the DRG methodology. However, it is possible for states to mandate one payment method, such as DRGs, even if they do not establish the rates themselves. This could reduce the administrative burden on providers, and make prices across payers more comparable.

f. Regulatory/Administrative Simplification

One source of the administrative costs of health care is the many differing procedures for authorizations, billing and reporting that are required by differing payers and government agencies. The state could work with providers and payers to develop unified procedures and data collection, and then require unified procedures and data collection from all payers and agencies.

g. Certificate of Need

The Certificate of Need (CON) process is a state regulatory program intended to determine the appropriateness of new or expanded health care services and facilities. In New Hampshire, providers are required to obtain a CON to construct facilities, purchase certain medical equipment and to add inpatient bed capacity. Many providers consider the process cumbersome and there may be interest in either reforming or abolishing the program. A reformed CON could streamline the process and result in more targeted decisions on the expansion of health care capacity.

h. Nonprofit Law Reforms

A number of reforms to the laws governing not for profit organizations could impact health care costs. For example, the state could take a more active approach in overseeing mergers of nonprofit health care entities, to keep some competition in the health care market. The state could require health care entities to provide certain additional community benefits when they have excess profit margins as compared to the statewide average. The state could more closely monitor executive pay at nonprofit health care providers and impose consequences for organizations where the executive pay exceeds a benchmark tied to the statewide average for such costs, such as

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[100] See, e.g., Commonwealth of Massachusetts, "Recommendations of the Special Commission on Payment Reform," July 2009, http://www.mass.gov/chia/gov/commissions-and-initiatives/health-care-payment-system/recommendations-of-the-special-commission-on.html

[101] See Manatt report at 8-22 for discussion of legal issues in connection with regulation of provider risk.

reviewing an organizations status or imposing additional community benefit payment requirements.

i. **Anti-Trust Law Reforms**
The transition to formation of ACOs and other integrated care entities can raise both federal and state antitrust issues, if it results in increased consolidation and prices. The state can take steps to protect against antitrust violations by enacting legislation establishing the state action immunity doctrine in connection with specific ACO and payment reform related initiatives. The theory of state action immunity is as follows: when a state establishes a program that encourages activity that might otherwise be viewed as anticompetitive, the participants in the program may be able to receive immunity from federal antitrust rules.

ii. Payment and Service Delivery Reform Options

a. **ACOs/Integrated Care Organizations**
The state could develop policies, regulations and contracts that encourage the development of ACOs and other integrated care organizations, defined as groups of health care providers that agree to be collectively accountable for the cost, quality and overall care of an entire population.[102]

b. **Alternative Payment Methods**
The state could develop policies and model contracts that encourage the use of new payment methods that are alternatives to traditional fee-for-service reimbursements. Alternative payment methods could include a range of approaches, including global payments, bundled payments and shared savings for performance on quality measures. The state could develop such payment methods within the Medicaid program, and encourage similar payment strategies among private payers.

c. **Patient Centered Medical Homes**
Patient centered medical homes are primary care practices that include enhanced care coordination and integration of medical and behavioral health. Patient centered medical homes are typically paid a per member per month payment to coordinate care and track and monitor the health of their patients on a systematic basis. The state could develop policies and contracts that encourage the further development of patient centered medical homes at the primary care level.

[102] American Health Lawyers Association, "ACOs and Population Health: What is on the Horizon?" Webinar, September 19, 2014.

d. Public-Payer Approaches

Since the state has more authority over the services it pays for directly, it could develop strategies such as ACO contracts, bundled rates or patient centered medical homes within the New Hampshire Medicaid program. By implementing new payment reform approaches and programs within government programs, the state can lead the way in cost containment with fewer administrative and legal hurdles than it faces in implementing system wide or statewide changes. However, since only 8% of the New Hampshire population is served by Medicaid, the impact of a change in the Medicaid program alone may be considerably less robust and may increase the administrative complexity of the overall health care system and potentially increase costs in the commercial market.

iii. Employer and Individual Approaches

Employer and individual approaches build upon the natural incentive for both employers and individuals to work towards lower health care costs. Large employers particularly may develop innovative approaches to keeping their costs low and their employees healthy and productive. While the state may not be able to require the adoption of these approaches, the state may want to ensure that there are not regulatory barriers to successful approaches that employers develop.[103]

a. **Employer Purchasing Collaborative**

The State could establish a collaborative of employers, obtain funding to staff the collaborative and give employers tools and clout and charge to negotiate reforms. The collaborative could be focused on commercial small employer groups, or could be expanded to include larger employers and even the Medicaid managed care program.

b. Employer Direct Contracting with Providers/ACOs for Provision of Care

Some employers have contracted directly with health care systems to provide for provision of care. Large employers may have clinics at the work-site. These direct contracting and service arrangements are often provided in addition to providing health insurance, and provide ease of access to care for employees.

c. Promote Consumer Value-Based Purchasing through Price Transparency

New Hampshire has the well-developed public HealthCost website that provides consumers with information about the cost of care to help them manage their costs and choose value-based purchasing options for care. This website and requirements for its contents could be expanded to include quality measures and more detailed information on both provider prices and insurance premium levels to help consumers make informed decisions.

[103] See Manatt report at 7, 12-19 for discussion of legal issues in connection with employer approaches.

d. Promote Consumer Value-Based Purchasing through Price Transparency and Individual Health Care Savings Accounts

As more employers and the individual insurance market offer higher deductible plans, individual health accounts become important tools to help consumers afford care when needed. Individual health care savings accounts (HSAs) allow consumers to save for their out of pocket medical costs in designated tax free accounts. HSAs, when combined with price and quality transparency, provide incentives for consumers to choose medical providers who offer high quality services at lower cost.

Appendix B: Legal Hurdles to Wide-Net Options

Legal Hurdles:[104]

We analyzed the legal steps, hurdles and risks that may be raised by each of the payment reform options evaluated for this project, set forth below.

Regulatory

a. All Payer Rate Setting (Maryland)-Legal Hurdles: Medium/High (if Medicare is included; Medium if not)[105]

All payer rate setting raises relatively few direct legal risks. It raises the following hurdles: The state[106] would have to amend its insurance laws, and issue broad legislation allowing the state to set rates across the board for hospital (and potentially other) services, such as is done in Maryland. The state would need to amend its 1115 Medicaid waiver application documents (or submit a new waiver application, depending on the status of its recent application), and would need to amend its State Plan as well. [107] Additionally, the state would need to apply to CMS for a Medicare waiver (similar to that in Maryland). Obtaining a Medicare waiver could be complex and time-consuming. This approach could be combined with global or alternative payment methods/global budget targets and/or ACO initiatives.

The indirect legal risks include the following: The state could face challenges (including litigation) from providers objecting to the rates, if they are not adequate either as is or in connection with other health reform initiatives the state may seek to implement contemporaneously.

The legislation would also need to identify or create the government entity charged with setting and reviewing these rates, which would likely be controversial.

b. "Cost Growth Benchmarks"-Target Growth Rate for Total Medical Expenditures-Legal Hurdles: Medium

For the state to establish global budget targets, it would need to establish targets by which to measure spending (such as the "potential gross state product" in MA, set forth as a measure in chapter 224).

The state would need to obtain funding and establish governmental infrastructure, through legislation, to evaluate the targets, and oversee each provider's expenditures as

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[104] The information in this report is intended as a framework for policy strategy, and is not intended as legal advice. The NHID would need to consult with attorneys licensed to practice law in New Hampshire for legal advice on any specific state law issues.
[105] Designation of high, medium, or low has been made to indicate an estimate of the relative degree of legal hurdles, with "high" being the highest.
[106] All references to "the state" refer to the state of New Hampshire.
[107] See Section II.A. infra. for discussion of Medicaid.

measured against the targets. Additionally, it would need to determine when and whether providers would be subject to any penalties or other action (such as performance improvement plan requirements in chapter 224 in MA). The state could require a state agency to take on this responsibility, after consulting with interested parties. Another option is to establish a Commission comprised of impartial members with specific expertise to establish the benchmarks. The legislature could have ongoing involvement with the new agency, to review and provide input on new targets, at least annually.

c. Single Payer (Vermont)-Legal Hurdles: High

Single payer raises the following hurdles: The state would need broad legislation authorizing single payer, and would need to establish whether an existing government entity would run it (such as NHID) or a new one (such as was established in VT). The state would need to request approval from CMS to use federal funds for such a program, for both Medicaid and Medicare. More specifically, the state would need a waiver from the provisions of Section 1332 of the ACA. Additional governmental infrastructure may be needed (and established through legislation) to implement single payer statewide.

The legal risks include challenges by carriers as their role will effectively be marginalized or eliminated, ultimately. The state could face other challenges depending on the way it decides to fund a single payer initiative.

d. Regulation of Provider Risk-Legal Hurdles: Low/Medium

Regulation of provider risk is an avenue that the state could seriously consider. Please see p. 15 of Manatt report for detailed reasons that regulation of provider risk may be desirable/advisable, and risks of failing to do so (provider solvency, lack of capacity to absorb risk, insurer solvency, consumer access). Regulating provider risk also aligns with federal interest in limiting provider risk, even where insurer maintains full financial responsibility (and note specifically alignment with Medicare Shared Savings Program, Pioneer ACO, as well as Medicare Advantage program requirements).

The state may pursue provider risk regulation in several ways:

i. The NHID could amend its regulations to include additional requirements for carrier contracts with providers that take on significant downside risk

ii. The state could enact legislation directing NHID to evaluate whether and how to regulate downside risk in carrier contracts with providers (including ACOs) taking on significant downside risk. Options could include process (review, risk certificate) as well as substance (rules re: stop loss insurance, performance bonds, etc.).

iii. If the state wants to include all provider/provider organizations in these requirements (not just those entering into commercial carrier contracts, but Medicaid and other public payers as well), in addition to bullet two above, it would need to include in legislation provisions applicable to all providers taking on downside risk (e.g. require that they obtain risk certificates and meet any other requirements related to provider risk).

iv. Alternatively, the state could issue legislation indicating that the respective public payers will separately determine risk rules for their specific programs). This is a less broad based approach, and risks having different rules for the same provider /provider organization.

e. Regulation of Basis of Payment (e.g. Must Pay Using DRGs)-Legal Hurdles: Low/Medium

This model envisions the state establishing the payment structure, but carriers and providers would still negotiate the level of payments for their contracts as they do currently. Note that there is currently an amendment proposed in New Hampshire to require use of DRG payments for reimbursement of hospitals. See: proposed Amendment RSA 420-J adding a new section 8-e as follows: 420-J: 8-e Common Hospital Payment Methodology Required. There are significantly fewer hurdles/risks inherent in this category than in GP's/ACOs. Since Medicare and New Hampshire Medicaid already uses DRGs (uses Medicare DRGs as basis), this approach has the advantage of administrative/regulatory simplification (see below) as well as a less radical "glide path" for state to transition to new payment methods. This would also promote transparency of pricing.

A multi-payer approach to using DRGs (rather than, e.g., per diem or percentage of charge methodologies), for example, would call for amendments to the state's insurance laws, to permit NHID to require all carriers to use DRGs, and potentially specify a uniform way the DRG would be used, and may also require specification of the method and responsibility for estimating DRG cost weights for the commercial population Additionally, the state would likely need to amend its state plan, to clarify that providers would be reimbursed in accordance with this new payment method.

The state may need to submit a waiver, or amend its current waiver request, though where this is not changing provider type or the types of services that Medicaid traditionally pays for (and in any event, is already used by the state Medicaid agency) a waiver may not be needed. The state would need a Medicare waiver if Medicare is to be included in this approach.

The state may face a risk of challenges from certain categories of providers if this new methodology is viewed is inadequate or inappropriate for them. Critical Access Hospitals (CAHs) and rural providers may argue that a specific payment structure doesn't work for them and they should be reimbursed based on costs (or costs +). For example, Medicare and Medicaid do not use DRGs for CAHs — they are paid 101% of reasonable costs. CAHs could be exempted from this requirement.

f. Regulatory Simplification[108]-Legal Hurdles: Low/Medium

Options for regulatory simplification that would likely result in savings include the following:

[108] Some examples are included in this category.

i. Standardization of:

- provider credentialing,
- prior authorizations,
- formularies, and
- claims submission process

ii. Conducting an inventory of data required by state agencies and reducing duplicate requests (common request of providers).

iii. Also see CON reform discussion below.

These reforms would likely call for legislation, and regulatory changes to insurance laws (e.g. for changes to claims submission form/process). If Medicaid is to be included, state Medicaid regulations would need to be revised. Waiver and SPA would need to be analyzed to determine if changes are needed-may not need modifications if not changing system delivery mechanism, reimbursement, or members to be served.

g. Certificate of Need Reform-Legal Hurdles: Low/Medium

See Section IV.C. 1 of this report.

h. Nonprofit Law Reforms Through the New Hampshire Department of Justice- Legal Hurdles: Low-Medium

See Section IV.C.2 of this report.

Promotion of New Payment and Delivery Models

a. ACOs/ Integrated Care Organizations-Legal Hurdles: Medium

See Section IV.A.2 of this report.

b. Global Payments- Legal Hurdles: Medium

See discussion at Section IV.A.2 of this report.

c. Patient Centered Medical Homes (PCMH)- Legal Hurdles: Medium

New Hampshire already appears to have a multi-payer PCMH initiative that has been underway since at least 2009. See: http://citizenshealthinitiative.org/medical-home-project.

Depending on how they are structured/promoted by the state, PCMH programs can raise some of the same legal issues as ACOs, though generally to a lesser degree.

d. Public-Payer Specific Approaches— Legal Hurdles: Medium

The state could promote payment reform through public payer specific approaches, which could include programs through the Medicaid agency such as:

i. Alternative payment pilot for integrated provider, for providing additional nontraditional services for a chronic illness

ii. A new payment method for paying an existing category of providers (e.g. primary care providers) to coordinate primary care and behavioral health services

iii. Establish a Medicaid ACO program with a new category of provider or entity (could be through managed care entity, alternatively) to coordinate wider range of services for members

The legal hurdles for these include amending the state's Medicaid waiver (and possibly state plan as well). It may include amending the state's Medicaid regulations. Finally, a Medicaid ACO program would raise the ACO related legal issues indicated above. Note that the second bullet may raise ACO legal issues as well, depending on program design.

An additional legal obstacle includes the shift to managed care, and relationship to any provider based Medicaid reform. New Hampshire recently moved most of its Medicaid population to managed care (called "Care Management"). So it would add some complexity to try to implement a public payer approach with new provider based models in Medicaid, since the MCOs now establish provider rates through their contracts, not Medicaid. The state would need to negotiate new terms with its MCOs, which could prove challenging. Alternatively, the state could work with its MCOs to align on initiatives that the MCOs are interested in implementing on the payment reform front- though these may be much more modest than those the state would seek to launch with Medicaid providers directly.

Employer and Individual Approaches

a. Employer Purchasing Collaborative

See Section IV.A.3 of this report.

b. Employer Direct Contracting with Providers/ACOs for Provision of Care - Legal Hurdles: High

As insurance costs become more expensive, New Hampshire employers may consider contracting directly with providers or ACOs. New Hampshire might consider encouraging these relationships, but there are a number of legal issues and questions to consider before proceeding:

i. Would this fulfill the employer mandate in the ACA? Or would employers also have to buy insurance for their employees?

ii. Added risk to members – directly contracting with ACOs in essence creates an extremely narrow network. What provisions would be available to protect employees who need specialized care not offered at the ACO, or care that is provided while the employee was out-of-state?

iii. Added risk to employers – Employers who self-fund their insurance sometimes subject themselves to more legal risks. See http://www.nh.gov/insurance/consumers/health.htm

iv. Added risk to providers – Providers who directly contract with employers may have to take on more insurance risk.

v. Less control by the state. These arrangements may be deemed “self-insured plans” and not subject to state insurance law (and instead governed by ERISA). For example, state insurance law regarding mandated benefits may not cover these arrangements. The state may not be able to legislate standards for direct contracting with self-insured plans, and may only be able to encourage participation by such plans in new payment reform initiatives, but not mandate it (so, it would just be voluntary).

vi. Employers may not be well equipped to monitor for quality and under-utilization.

c. Promote Consumer Value-Based Purchasing Through Price Transparency and Individual Health Accounts— Legal Hurdles: Medium/High

New Hampshire might consider promoting a model where consumers take on more risk for their health care costs, with high deductible plans. A number of issues could be considered under this option:

i. The ACA requires insurance plans to devote a certain percentage of premiums to services, rather than administration. An important question is whether these health accounts meet the medical loss ratio requirements in the ACA. See http://www.ncsl.org/research/health/hsas-health-savings-accounts.aspx

ii. Under the ACA, large employers are responsible for offering insurance coverage that meets a certain standard of comprehensive coverage. Certain individuals are also responsible for becoming insured. One key issue is whether these health accounts meet the individual and employer mandates in the ACA.

iii. If these accounts are in the Exchange, the state may end up paying more for wraparound coverage for Medicaid expansion adults.

Appendix C: Legal, Administrative and Cost Considerations for Strategy 2

Legal Considerations: There Are a Number of Steps the State Would Need to Take to Implement Option 2.

(1) **Establishing Multi Stakeholder Commission:** The state would need to enact legislation establishing the multi-stakeholder commission, and its charge and timeframe. It would need to either contain the terms for the Model Contract, or specify when the Model Contract would be issued (prior to the commencement of the commission meetings). The legislation would need to make clear that if the stakeholders did not agree to the Model Contract, or come up with the components for a similar agreement, that would need to be approved by a designated state agency (NHID), the state would start regulating rates across the board.

(2) **Medicaid and Medicare Participation:** For the state to achieve the largest cost containment, it would need to have both Medicaid and Medicare participation in using the Model Contract, and/or its components, such as use of global payments and alternative payment methods. This would require that the state seek and obtain a Medicaid waiver from CMS. The waiver may include a request for providers/ACOs to be able to utilize alternative payments for a wide variety of services, including some not traditionally covered by Medicaid or thought of as a health care service (for example, using a global payment to pay for air conditioners for asthma patients, and thereby reduce hospital utilization). Once obtained, the state Medicaid agency would need to adopt the Model Contract and use it in contracting with its providers, as well. The state would also need to submit a Medicare waiver, for Medicare participation.

Note that the legislation could direct the state to seek these waivers; it could also exempt ACOs already participating in the Pioneer or MSSP programs from using the Model Contract (Pioneer and MSSP contracts contain the above-described features, already).

(3) **Commercial Carrier Issues:** Amendments may be needed to the statutory provisions of RSA 415 and RSA 420, to align with the new legislative provisions authorizing the Model Contract use by carriers and establishing threshold criteria for use of the Model Contract by providers.

(4) **ACO Formation and Global Payment Hurdles:** Finally, there are a number of legal hurdles associated with ACO formation and global and alternative payments, raised by federal and state fraud and abuse laws, and antitrust laws. These are potentially raised by the state requiring the adoption of a Model Contract or similar agreement, which promotes gainsharing among providers, and new care referral relationships. While these are complex

issues, there are potential approaches and solutions that the state can explore as it establishes the commission.[109] Additionally, the state could adopt legislation establishing the state action immunity doctrine, to protect providers participating in state health reform initiatives from the threat of federal antitrust law prosecution (see Section IV.A.2.f of this report for further discussion).

(5) **All Payer Rate Setting:** In the longer term, if the commission failed to adopt either the Model Contract or a similar agreement, the state would need to enact additional legislation to mandate all payer rate setting. Rate regulation raises relatively few direct legal risks, but involves the following: The state would have to amend its insurance laws, and issue broad legislation allowing the state to set rates across the board for hospital (and potentially other) services, such as is done in Maryland. The state would need to amend its 1115 Medicaid waiver application documents (or submit a new waiver application, depending on the status of its recent application), and would need to amend its State Plan as well. Additionally, the state would need to apply to CMS for a Medicare waiver (similar to that in Maryland). This approach could be combined with global or alternative payment methods/global budget targets and/or ACO initiatives.

The indirect legal risks include the following: The state could face challenges (including litigation) from providers objecting to the rates, if they are not adequate either as is or in connection with other health reform initiatives the state may seek to implement contemporaneously.

Additionally, the state would need to obtain authorization from CMS to include Medicare, and would need a Medicaid waiver and an amendment to the state plan currently in effect. The legislation would also need to identify or create the government entity charged with setting and reviewing these rates.

(6) **Voluntary Participation by Self Insured:** The rates and contracts negotiated by self-insured employers may not be within the jurisdiction of NHID or other state authorities, due to possible pre-emption by federal ERISA provisions. Therefore, while their participation in the commission could be compelled, it is less clear whether their use of any Model Contract could be, and may need to be voluntary.[110] Nonetheless, as the market shifts towards use of the Model Contract, employers may make that transition on their own-and may face pressure from providers and ACOs to do so, as well.

(7) **Regulation of Provider Risk:** As contracting under Model Contract arrangements increase, and more ACOs and other integrated organizations seek to take on risk based contracting, the state should consider regulating provider risk. This shift toward risk bearing contracts would need to be accompanied by contemporaneous regulation of provider risk, to protect provider solvency and minimize system and care delivery disruption and dysfunction. The state already has several ACOs and carrier-provider contracts utilizing alternative

[109] See Manatt report at 22-24 for further discussion of, and potential solutions to, fraud and abuse issues, and Manatt report at 25-28 for discussion of antitrust issues and potential solutions.
[110] See Manatt report at 8-9 for further discussion of ERISA, potential New Hampshire regulatory authority over employer risk based contracting, and related solutions; see also p. 19 of Manatt report for discussion of difficulty predicting judicial rulings in the ERISA context.

payment methods, so it will be important to pair a shift toward new contract models with provider risk regulation.[111] Regulating provider risk also aligns with the federal interest in limiting provider risk, even where the insurer maintains full financial responsibility (and specifically aligns with MSSP, Pioneer ACO, as well as Medicare Advantage program requirements). See infra at Section IV.2.d) for additional discussion of provider risk.

[111] See p. 15 of Manatt report for detailed reasons that this is desirable/advisable, and risks of failing to do so (provider solvency, lack of capacity to absorb risk, insurer solvency, consumer access).

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