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Regulatory Barriers to Value Based Payment Reform in NH: Stage 1

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Regulatory Barriers to Value Based Payment Reform in NH: Stage 1

Lucy Hodder, JD

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Regulatory Barriers Stage 1

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Regulatory Barriers to Value Based Payment Reform in NH: Stage 1 Executive Summary

New Hampshire has struggled with how to pay for health care and how to set policies that support a health care system¹ that is accessible, affordable and effective for its residents. New Hampshire individuals, businesses and governments all depend upon accessible health care yet are burdened collectively and individually with costs consistently higher than bordering states. The health care system is notoriously inefficient and costly, built upon meteoric medical progress and clinical innovation.

As New Hampshire enters 2017, health care policy once again dominates the public discourse. Policy makers debate how to pay for insurance, who should have insurance, and what insurance should look like. Policy makers have even questioned whether individuals should rely on health insurance at all to pay for health care costs.

There are two events that have precipitated this discussion in earnest: 1) the near collapse of the U.S. economy in October 2008; 2) the epic rise of health costs and expenditures. The health care system now makes up nearly one-fifth of the US economy. The overall share of the U.S. economy devoted to health care spending was 17.8 percent in 2015, up from 17.4 percent in 2014.² New Hampshire has seen similar growth, and health care spending grew to 21% of New Hampshire's Gross State Product in 2015.³

In 2013, the U.S. spent far more on health care than other high income countries. This appears to have been largely driven by greater use of medical technology and higher health care prices, rather than more frequent doctor visits or hospital admissions. Despite spending more on health care, Americans had poorer health outcomes than most industrialized nations, including shorter life expectancy and greater prevalence of chronic conditions.⁴ If all community stakeholders benefit from good health, why are we spending more on health care without corresponding outcomes to justify the increased costs?

¹ The term "health care system" is a general term intended to broadly reference the system we rely upon in New Hampshire to deliver and pay for care to our citizens.

² Centers for Medicare & Medicaid Services, National Health Expenditure Data, (2016), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf>.

³ New Hampshire Center for Public Policy Studies, Health Care Score Card and New Hampshire's Silver Tsunami: Aging and the Healthcare System, (September 2011), available at http://www.nhpolicy.org/UploadedFiles/Reports/aging_and_the_healthcare_system_final.pdf; see also, New Hampshire: Demographics and the Economy, KFF.org, (February 21, 2017, 3:18 pm), <http://kff.org/state-category/demographics-and-the-economy/?state=NH>.

⁴ The Commonwealth Fund, U.S. Healthcare from a Global Perspective (2013) available at <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>

The United States electorate focused on health care reform in 2008, resulting in the historic passage of the Patient Protection and Affordable Care Act (the ACA) in March 2010. The ACA imposed sweeping health insurance reforms, with key reforms effective in January 2014.

Health care is a quasi-regulated system at both a federal and state level. It is not a purely public system, yet the purchase of health insurance is subsidized by the federal government either directly or through tax credits/incentives at almost every income level and by the state for those with the lowest income. Federal and state regulation impact every aspect of health care delivery from licensure to payment to business structure, yet few states have treated health care services like a utility and gone so far as to assume active regulation of health care delivery. Therefore, the health care system remains in an uncomfortable and inefficient space between a free market, an actively supervised market and a publicly operated system.⁵ Akin to a utility, all citizens will need health care supports and services at some time in their life. The extent of our needs, however, is neither predictable nor constant.

Medicare (our federal health insurance for the elderly and disabled) and Medicaid (our federal-state health insurance program for poor adults)⁶ insure a significant number of New Hampshire residents. In total, 25% of New Hampshire residents were covered by Medicare, Medicaid, or Tricare/VA coverage in 2015.⁷

The majority of New Hampshire residents have health insurance through employer based plans. See 2015 coverage allocation chart below.⁸

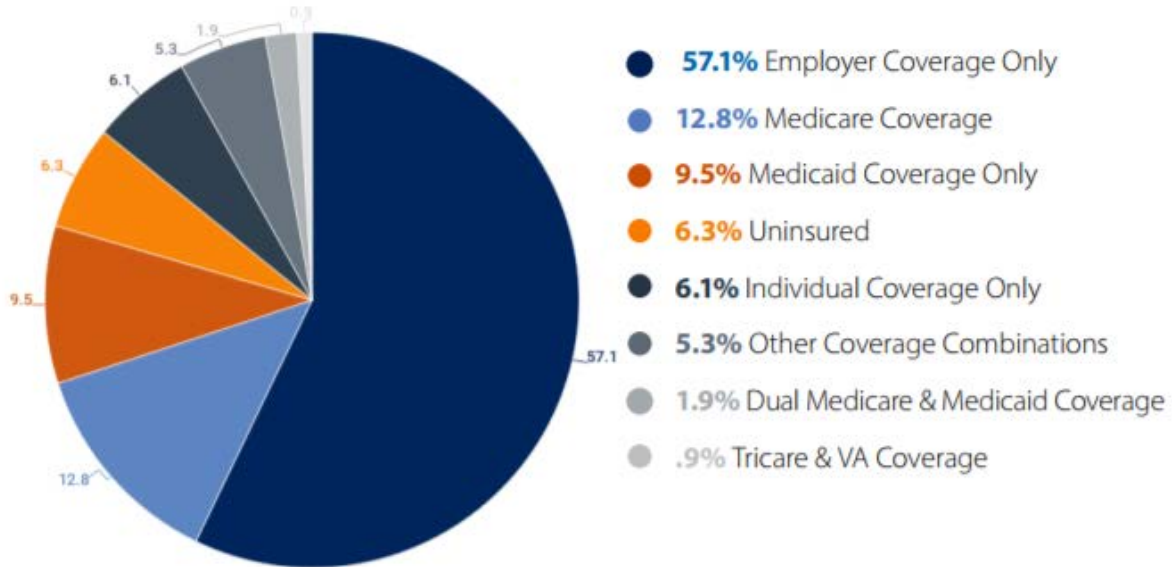
⁵See North Carolina State Board of Dental Examiners v. FTC, 574 U.S. ____ (2015)(SCOTUS analyzes state action immunity doctrine and what it means to be actively supervised by the state).

⁶ Medicaid in New Hampshire traditionally covered certain low income pregnant women, children, elderly, developmentally disabled and severely mentally ill. Medicaid additionally now covered certain low income able body adults through the New Hampshire Health Protection Program, funded substantially by the federal government.

⁷ Gorman Actuarial, Inc (“NHID Gorman”), New Hampshire Insurance Department 2015 Medical Cost Drivers – Final Report, (November 2016), available at <https://www.nh.gov/insurance/reports/documents/nhid-2015-medical-cost-drivers-final-report.pdf>.

⁸ From Covering the Care: Health Insurance in New Hampshire, a data brief released by the Institute for Health Policy and Practice in June, 2017.

2015 NEW HAMPSHIRE RESIDENTS



Additionally, approximately 10% of New Hampshire’s residents receive health insurance benefits through a public employer, including the State of New Hampshire or municipal government. Thus, high healthcare expenditures place a particularly acute burden on government budgets at the federal, state and municipal level. Businesses and individuals are also impacted when risk shifts to employees evidenced by the increasing number of individuals with employer sponsored or health exchange-purchased coverage who are enrolled in high deductible health plans.⁹ Governments at all levels, not surprisingly, are trying to control expenditures and costs due to consumer and tax-payer concerns, at times with careful planning and at times without.

The State of New Hampshire (and many New Hampshire providers), following the steps of the federal government and many health care delivery reform leaders, has adopted the goals of the “triple aim” as a way to reshape our health delivery system.¹⁰ The triple aim has many converts as it makes sense – better quality, better access and lower costs by paying for “value instead of volume”.¹¹ Over the past eight years, the federal government has tried to plan for a transition of the U.S. health care system away from fee for service payments (FFS) and towards shared risk and population based payment models that rewards value as opposed to volume.¹² The Health Care Payment Learning Action Network (HCPLAN) set forth principles

⁹ *Id.* at 20-21.

¹⁰ *E.g.*, New Hampshire Health Innovation through SIM. <https://www.dhhs.nh.gov/ocom/documents/about-sim.pdf>

¹¹ The Center for Evidence-Based Policy, ECONorthwest, supported by State Innovation Models (SIM) Initiative, US DHHS-CMS, *State of Health Care Transformation in New Hampshire 2015*, (“SIM 2 Report”), 4 (2015), available at <http://www.newhampshirehealthinnovation.org/wp-content/uploads/2015/10/State-of-Health-Transformation-New-Hampshire-SIM.pdf>.

¹² Health Care payment Learning & Action Network, *Alternative Payment Model (APM) Framework, Final White Paper*, (January 2016), available at <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>.

on which to base an alternative payment model, which can be summarized as follows: empowering patients to be partners in health care transformation, shifting spending towards population based payments, ensuring value based incentives reach providers that deliver care, taking quality into account and motivating providers to invest in and adopt new approaches to care delivery through value based incentives.

Significantly, the U.S. Department of Health and Human Service's former Secretary, Sylvia M. Burwell, announced a Medicare goal to move 30% of Medicare payments to alternative payment models by the end of 2016 and 50% into alternative payment models by the end of 2018. Similarly, New Hampshire, as part of its Section 1115 Delivery System Reform Incentive Program (DSRIP) waiver via the Centers for Medicare and Medicaid Services (CMS), has pursued innovation dollars to transform the delivery of integrated behavioral health and substance use disorder care. As part of the waiver, the state must develop a plan for sustaining the DSRIP investments beyond the life of the waiver and for moving at least 50% of payments to Medicaid providers into "Alternative Payment Models" (APMs). In general, the state has defined APMs as paying providers based on improving outcomes through prevention and effective treatment, not based on volume. Key elements of APMs include the use of risk-sharing to establish provider incentives to contain costs, robust quality metrics to ensure high-quality care, and re-allocation of saved funds to areas of need.¹³

So too, commercial payers, who provide fully-insured plans to employer sponsored groups as well as provide administrative services to self-insured plans, have moved towards alternative payment models. However, true value based payment models are elusive in the commercial market. Approximately 40% of members in self-insured and fully-insured plans had providers who were provided "up-side" incentives for meeting certain metrics in 2015, but the percentage of providers who are penalized for failure to meet incentives, i.e., exposed to "down-side" risk, is much lower.¹⁴ Overall, commercial payers have had limited success transitioning providers in the commercial market to value based payment models that move away from traditional fee-for-service as the underlying driver of revenue.¹⁵ Many providers, notably in primary care settings, have worked on a variety of efforts to transform practice delivery to more patient centered care, focusing on efforts to improve the patient experience and provider communication through effective technology.¹⁶

Collectively, the federal and state governments, as regulators of the Medicare and Medicaid programs as well as the payers of health care services, are using their authority to push the New Hampshire health care system towards meeting payment reform objectives and accomplishing what the health care system has not fully achieved when left to its own "market" forces. Progress is slow, and, without such a powerful force pushing the health care system towards value based payment reform with incentives and penalties, the system will not

¹³ New Hampshire Department of Health and Human Services, [Building Capacity for Transformation, New Hampshire's DSRIP Waiver Program](http://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrrip-waiver-overview-20160304.pdf), (March 2016), available at <http://www.dhhs.nh.gov/section-1115-waiver/documents/nh-dsrrip-waiver-overview-20160304.pdf>.

¹⁴ *Supra* note 6 at 39-40.

¹⁵ *Supra* note 8 at 54-62.

¹⁶ SIM 2 Report at 44-53.

move. Only with such a powerful push will stakeholders begin to take responsibility for upstream attention to social and environmental needs and not just to downstream treatments and interventions.

The failure to make significant progress towards alternative payment models and value based payment reform raises the question – *why is value based payment reform so slow and so difficult?* The Endowment for Health has asked for a deeper investigation into whether the way we regulate the health care system plays a part in our lethargy. If the answer is “yes”, *are there regulatory barriers to value based payment reform that can be eliminated to ease the transition?*

Stage 1: Survey of Legal Barriers and Identification of Existing Transformation Case Studies

Our health care system is highly regulated, however, many of the regulations were adopted to adjust for market forces and promote delivery system equities. To identify what barriers might be usefully modified to create avenues for value based payment transformation, it is important to first survey the ways our federal and state governments regulate health care and why. The New Hampshire Insurance Department (NHID) began this process in 2015, by looking at payment reform initiatives and their potential to work in New Hampshire.¹⁷ NHID also examined legal and regulatory obstacles to provider payment reform and discussed options for policymakers to facilitate reform.¹⁸ However, the NHID review focused on health care insurance, while the first step in this analysis takes a broader view.

Second, in order to better test how legal barriers encourage or oppress transformation, we have identified five current efforts at system transformation created without mandate (although some with incentives). These transformation models are not necessarily those typically identified as practice transformation or value based models but exist, may work, and were chosen by health care system stakeholders because of and despite regulatory barriers.

Step 1: As a first step in this project we surveyed the way health care is regulated in New Hampshire to inform the analysis and discussion of experimental value based payment case studies. Step 1 was accomplished by:

- 1) Identifying a definition of “value based payment reform” through interviews with subject matter experts;

¹⁷ Compass Health Analytics, Health Care Payment Reform: Options and Recommendations, (April 2015), available at https://www.nh.gov/insurance/reports/documents/compass_umass_pmt_rfm_rpt.pdf; see also, Harold D. Miller, Center for Healthcare Quality & Payment Reform, Ten Barriers to Healthcare Payment Reform and How to Overcome Them, (December 2012), available at <http://64.64.16.103/wp-content/uploads/2012/12/overcomingbarrierstopaymentreform.pdf>.

¹⁸ Ario, Joel et al, Manatt, Provider Payment Reform in New Hampshire: Legal Considerations for Policymakers, (June 2014), available at https://www.nh.gov/insurance/reports/documents/prov_payref_lgl_cons_plcymkrs.pdf.

- 2) Identifying perceived barriers to payment reform through interviews with subject matter experts;
- 3) Identifying case studies for further investigation because they: 1) offer existing examples of ways stakeholders are approaching value based payment reform; 2) reflect choices made by health care system stakeholders despite or because of regulatory barriers; 3) inform about trends, what's possible and what's probable by way of transformation efforts.

There is no quick fix or one size fits all approach to achieving the triple aim and health care system transformation. Many of those interviewed identified a multiplicity of barriers to achieving the triple aim that can be summarized as follows: our health care delivery system is riddled with misaligned incentives and multiple issues arising out of the fundamental premise that caring for our bodies and minds in the advanced world of technology and innovation circa 2017 is complex. Health care delivery is part science, part business, part public service, part benefit, part insurance, part government policy, part individual motivation, part social, and part wellness.

The regulatory survey identifies both federal and state regulation impacting the health care system. The legal regulations focus on the general regulation of insurance and health care providers¹⁹ and fall into the following general categories:

- Community Benefit Standards for Health Care Charitable Trusts
- Fraud and Abuse/Self-Referral Prohibitions
- Free Market Oversight
- Health Delivery Innovation
- Insurance Regulation
- Licensure
- Medicare/Medicaid Payment
- Privacy
- Provider Liability

The review of state and federal regulations reveal certain trends:

- 1) Provider payments and reimbursements are primarily controlled by federal and state regulations governing payment programs, such as Medicare and Medicaid.
- 2) Federal laws regulating self-referrals and kickbacks in the Medicare and Medicaid program influence the structure of the health delivery system.

¹⁹ The report focuses on the regulation of health service providers and insurance companies and does not include federal or state regulations impacting prescription drugs or the research, development, marketing and regulating of pharmaceuticals or durable medical equipment.

- 3) New Hampshire exerts little regulatory oversight over its health care providers except in the area of Medicaid payment, professional/facility licensure, privacy and medical negligence liability.
- 4) The NHID is the only state agency with legislative responsibility to examine commercial health care costs through an annual review of health insurance cost trends made public at an annual rate review/cost trend hearing.
- 5) The cost of and responsibility for medical error in New Hampshire's health system rests with the professionals providing care through medical malpractice statutes and jurisprudence.
- 6) For purchasers to understand whether they are purchasing value, the health care system must have a mechanism to translate costs and quality of care. Transparency of cost and quality is supported by New Hampshire's 'all payer claims database', the NH Comprehensive Health Care Information System (NH CHIS), which in turn supports the NH Health Cost website (www.nhhealthcost.nh.gov). The future of publicly available claims based cost and quality data is threatened by federal ERISA preemption, privacy laws at the state and federal level, and the economics that make data a valuable resource and thus likely to be kept as a proprietary resource, thus not in the public domain.
- 7) New Hampshire does not have a true health information exchange. The NH Health Information Organization (NHHIO) is a health information clearinghouse, which, while helpful, does not fully support patient-centered value based payment models.

Stage 2: Case Studies

Providers, payers and purchasers have developed models of payment and models of care in New Hampshire despite or because of our federal and state regulatory structures that change the way we purchase or access health care and are intended to reduce cost, improve access and/or improve quality. To assess the regulatory climate and potentially uncover opportunities for regulatory change, the following case studies have been chosen for analysis. These case studies have not been chosen because they represent ideal value based payment reform models, but because they are a feature of our health care system.

The analysis will include an assessment of the model's business structure, identification of the goals and intended impact on triple aim and an evaluation of whether and how regulatory structures impacted the choice of model.

The case studies to be analyzed include the following:

- 1) Jointly Venture Insurance/Medical Management Models:
 - Benevera Health
 - Tufts Freedom Plan

- 2) Collaborative Care Multispecialty- Integrated Behavioral Health
 - 1115 DSRIP Waiver
 - Citizen's Health Initiative – Behavioral Health Integration Learning Collaborative
- 3) Collaborative Care Primary Care
 - Anthem Enhanced Primary Care Model
 - Federally Qualified Health Centers Enabling Services
 - Direct Primary Care Models
- 4) Risk Based Models that Incorporate Population Health Goals
 - New Hampshire Accountable Partners
 - Cheshire Medical Center Population Health Based Reforms
- 5) Bundled Payments
 - Anthem – Specialty Care
- 6) High Deductible Health Plans
 - Commercial consumer driven health care options

Stage 2 will be completed through interviews of stakeholders participating in models. Summaries will be reviewed with advisory group to assess the need for more direct financial or claims analysis of case studies. Case study review will help inform recommendations for regulatory policy shifts.