OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

Alternative Payment Methodology Advisory Committee
Meeting Minutes
October 18, 2016, 8:00 A.M. to 11:00 A.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Introductions

APM Data Review and Discussion

Cory King of OHIC asked the Committee whether OHIC should consider revising the way it measures payments made under APMs. The existing measure specifications are based on payments for all fully insured covered lives, regardless of their state of residence. Cory asked if it would be more appropriate to narrow the focus to RI resident covered lives since health plan members who reside out of state will likely be attributed to providers in their state of residence, and RI payers will likely not have sufficient membership volume with these providers to execute APMs.

Tom Cabral of BCBSRI confirmed that Blue Cross cannot execute APMs with out of state providers due to lack of member volume. Mr. Cabral suggested that OHIC should measure for RI resident covered lives and RI providers.

Cory King responded that OHIC needs to include payments to out of state providers because these costs are captured in total cost of care payment models executed with RI ACOs.

Mary Craig of United suggested we consider individuals with RI provider attribution, and not state of residence.

Dr. Peter Hollmann remarked that costs associated with non-attributed patients are captured in the OHIC APM measure denominator.

Cory King concluded the discussion by saying that OHIC would take this back and think it over.

Presentation & Discussion: Goals and Activities for the 2017-18 APM Plan – Minimum Downside Risk

Cory King introduced the minimum downside risk topic by reviewing relevant sections of OHIC Regulation 2 and the 2016 and 2016-17 Alternative Payment Methodology Plans which reference a to-be-defined percentage of APMs including "meaningful downside risk" by 2017.

OHIC asked Bailit Health Purchasing to research national and regional risk contracting models, with a focus on the Massachusetts market, and to make recommendations to the OHIC around minimum risk thresholds in population-based contacts that would be meaningful enough to focus provider behavior to improve high risk care management and improve performance on cost. Cory then turned the presentation over to Michael Bailit, of Bailit Health Purchasing, to review the Downside Risk Study and the proposed recommendations for minimum downside risk in contracting.

Minimum Downside Risk Report: Study Recommendations

ACOs including Hospital Systems	Physician-based ACOs
Between 10,000 and 20,000 commercial lives, as % of projected total cost of care: Year 1: net risk >/= 1% By Year 5: net risk >/= 5%	Between 10,000 and 20,000 commercial lives, as % of physician org's ACO contract revenue: Year 1: net risk >/= 3% By Year 5: net risk >/= 10%
Over 20,000 commercial lives, as % of projected total cost of care: Year 1: net risk >/= 2% By Year 5: net risk >/= 6%	Over 20,000 commercial lives, as % of physician org's ACO contract revenue: Year 1: net risk >/= 10% By Year 5: net risk >/= 20%

Dr. James Fanale of Care New England/Integra asked why there were different requirements for hospital and non-hospital-based ACOs. Dr. Fanale remarked that hospital-based ACOs don't control all of the spending. Dr. Fanale expressed concern at the potential for 5% losses on total cost of care because these losses are significant enough to cause the system to stop operating, in his view.

Tom Breen of South County Hospital stated that hospital boards, which have fiduciary responsibility, would express concern over contracts with the potential to expose hospitals to significant losses.

Dr. Al Kurose stated that he disagrees with the recommendations. 20% for provider ACOs is too high. It should be 8% like the federal government will be doing. Also, don't make hospital-based ACOs working with medical groups assume the hospital-based risk level; if you do so those agreements won't happen - it will be a huge mistake.

Chuck Jones of Thundermist recommended that the requirements be based on ACO contract revenue, instead of total cost of care.

Other members of the Committee remarked that the Massachusetts market, on which the downside risk recommendations are largely based, has a longer experience under risk contracting. Todd Whitecross of Tufts Health Plan shared Tufts experience phasing in downside risk in provider contracts. Dr. Fanele noted that in the BCBSMA Alternative Quality Contract there was a great deal of infrastructure support up front. Todd Whitecross commented that this was true, but there was less primary care provider support than in Rhode Island.

Dr. Kurose said that Coastal Medical is assuming significant investment risk to do population-health management, but that risk is not accounted for in these recommendations.

Sam Salganik of RIPIN stated that there should be state certification of provider capacity to assume downside risk.

Dr. Bradley commented that the Committee seems to be focused on the outer year risk thresholds within the 5 year time horizon. There does not seem to be as much concern around year 1.

Todd Whitecross asked if we should lower the covered lives thresholds for the downside risk recommendation below 10,000.

Cory King reminded the Committee that OHIC is not requiring that 100% of attributed commercial members have their care reimbursed under a risk contract. The regulation only require 10%.

In regards to the question of how much risk is meaningful for a provider group to change behavior, Dan Moynihan of Lifespan stated that "meaningful" is different for every provider. It's hard to look at a percentage and say that is right.

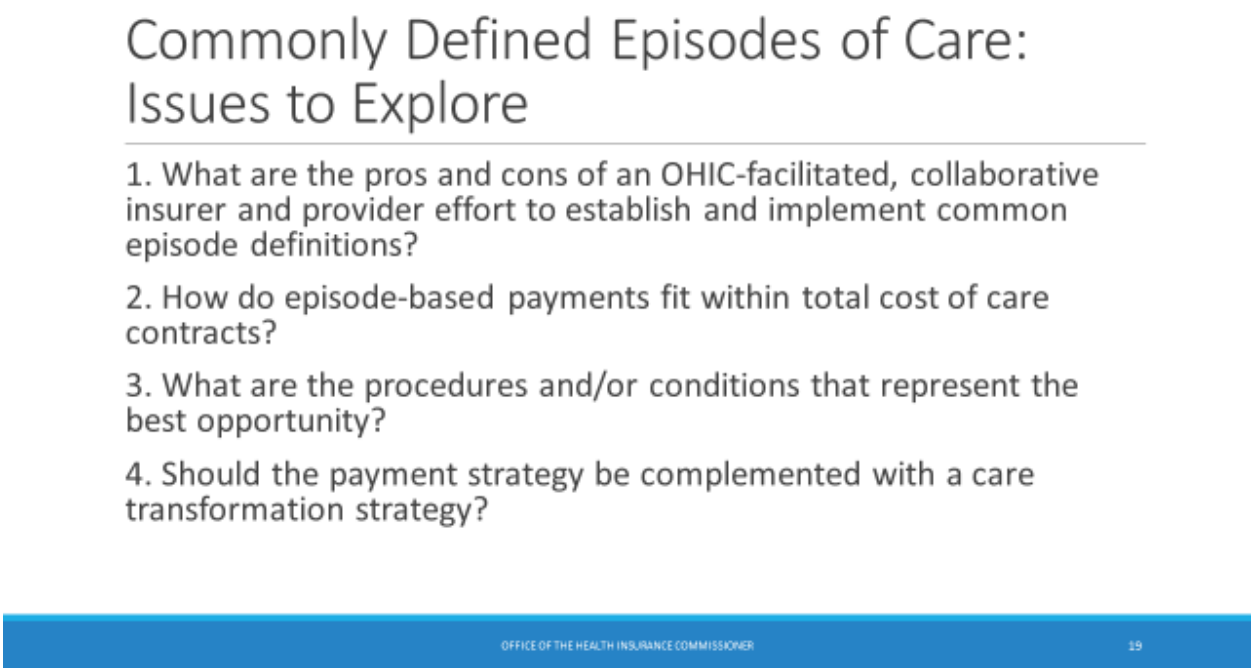
Overall, the Committee expressed general agreement that provider payment should move toward more risk sharing, however, the current recommendations may be too aggressive.

OHIC agreed to consider all of the feedback and modify the proposal for presentation at the next meeting.

Presentation & Discussion: Goals and Activities for the 2017-18 APM Plan – Episodes of Care/Specialist Engagement

Cory King opened the discussion by referencing the insurer Specialist Engagement Plans submitted to OHIC in June. Except for one insurer, there hasn't been much work done on specialist APM strategies to date, and most insurer plans are vague. OHIC proposed to lead a

process to define common episodes of care. Cory then turned it over to Michael Bailit to review the concept and facilitate a discussion of pros and cons.



Dan Moynihan commented that it's great to have a standardized transparent approach to episode-based payment.

Todd Whitecross remarked that it tends to be a good idea – but don't require purchase of a specific software package that not everyone possesses - becomes expensive.

Commissioner Hittner commented that OHIC has experience with standardization, referring to the SIM measure alignment process. Many physicians have come to me and said they want to be involved in discussions.

Kevin Callahan of United stated that United has developed these programs across the country. I don't want something prescribed to us that we can't support.

Tom Cabral commented that we should talk about episode definition, but not payment arrangement.

Sam Salganik remarked that he likes idea of a unified approach to quality measurement that addresses the small numbers problem. Mr. Salganik likes idea of consumers having data on who is best quality.

In the Joint Advisory Committee meeting members commented on the operational difficulties of reconciling episode-base payments and population-based payments. Insurers want to avoid paying for the same savings twice.

Dr. Kurose commented that Atrius says that episodes have hurt them financially. All payer bundle price raised the price for Atrius. The question is "who is the bundler" and "how does the price get set"?

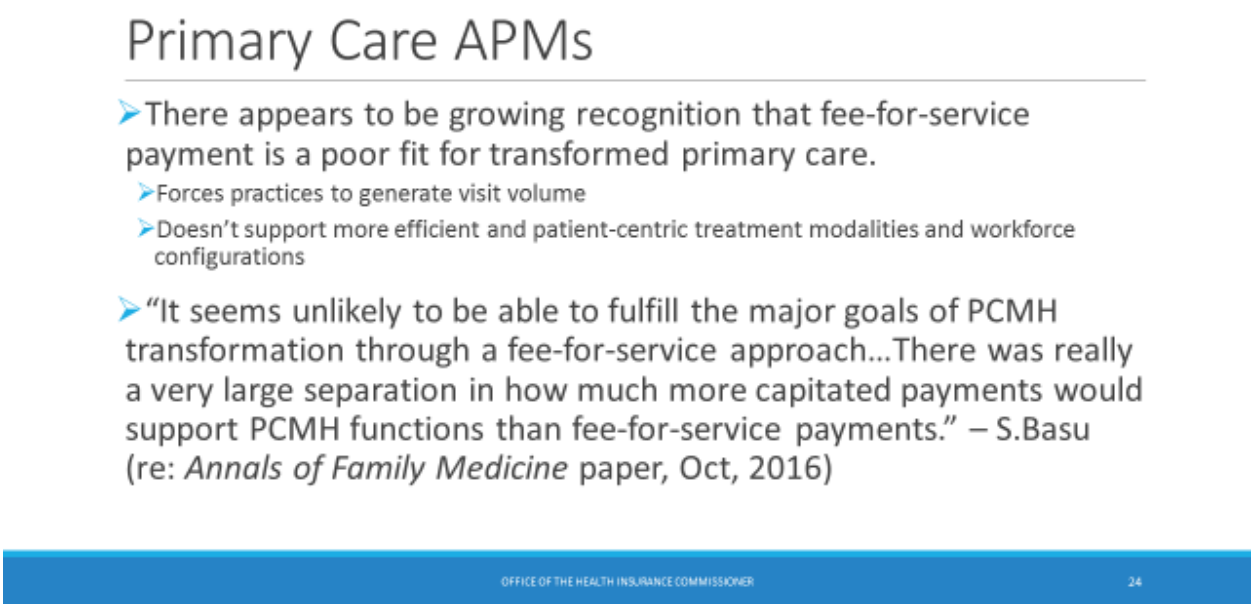
Todd Whitecross identified two issues: a) how to deal with savings and deficits and b) do bundles obscure information from primary care physicians.

Dr. Fanale commented that it is hard to take episodes out of total cost of care. I think ACOs should decide what to do with episodes outside of their organization.

OHIC identified next steps: survey Committee for ideas of conditions/procedures; flesh out what it means for the ACO to be the responsible party; solicit a guest speaker

Presentation & Discussion: Goals and Activities for the 2017-18 APM Plan – Primary Care APMs

Michael Bailit introduced the next topic on primary care alternative payments models.



Michael Bailit reviewed two types of primary care APMs: primary care capitation and a fee for service plus PMPM hybrid modeled on CPC+ Track 2.

Deb Hurwitz commented that primary care payment reform has been a goal of CTC since the beginning. The most exciting part of CPC+ is Track 2's payment model.

Dr. Kurose commented that primary care capitation is a smart idea. I'm in favor of the hybrid approach. Helps give people time to adapt.

Sam Salganik also expressed support for a hybrid approach. Helps mitigate risk of abuse. Public approach through OHIC or CTC is a good idea.

Dr. Pat Flanagan also expressed support for a hybrid approach. Need to protect the special needs of kids, EPSDT needs. Incrementalism is good.

Pano Yeracaris remarked that the hybrid approach is consistent with but not identical to CPC+. Include some centralized practice supports.

Mary Craig of United commented that United is struggling operationally with the hybrid method for CPC+ and the risk stratification. United corporate is talking with CMS about this.

Todd Whitecross commented that we [Tufts Health Plan] struggle with explaining capitation payments to practices. We also need to discuss risk adjustment and study it, as we have not done it in the past. Generally, a good idea.

Charlotte Crist commented that this discussion requires an assessment of where each practice is. We are unclear how we measure the impact of the new payment model.

Sam Salganik stated that we need to integrate Medicaid into this conversation. [Medicaid representation was not present].

The meeting concluded with no public comment.