OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Developing an Alternative Payment Methodology Plan

Rhode Island Alternative Payment Methodology Advisory Meeting
March 5, 2015

Presentation Outline

1. Background
2. Current Payer Payment Methodologies
3. Definition of Alternative Payment Methodologies (APMs)
4. Discuss Possible Facilitators of APM Adoption
5. Discuss APM Targets for 2016
6. Next Steps

1. Background: SIM Grant

- Rhode Island health care leaders and policymakers recognize the importance of moving from FFS volume incentives that lead to overuse, misuse and fragmented care to value-based incentives that promote improved quality and efficient care delivery

- The SIM grant promotes adoption of Alternative Delivery System and Payment Methodologies
  - Funds new models of care or enhancements of existing models that are alternative to volume-based delivery of care models

Background: Health Care Compact

- Health Care Compact signed by leading payers and providers in December 2014 includes as key recommendations:
  - the expanded use of APMs to reward value and patient-centric care delivery
  - that state and health care sector leaders should set an aggressive target and timetable to reduce traditional FFS use in Rhode Island
  - that a stakeholder group be formed immediately to work collaboratively with the Administration to transform RI's health care payment system

Background: Affordability Standards

- Section d(2) of the revised OHIC Affordability Standards recognizes the need to
  - reduce the power of FFS volume incentives, and
  - move to APMs that provide incentives for better quality and efficient service delivery
- Regs require each health insurer to submit a schedule to increase annually its use of APMs for:
  - Hospital services
  - Medical and surgical services
  - Primary care services

Background: APM Committee

- OHIC Commissioner to convene multi-stakeholder APM Committee annually to develop annual APM targets and APM plan
- First set of meetings in March and April 2015 to develop a plan and targets for 2016
- October 2015 meetings tasked with developing APM plan and targets for 2017, including addressing medical and surgical specialty professional providers.
- Committee to meet October 1 and complete work before January 1, annually thereafter.

Background: APM Plan

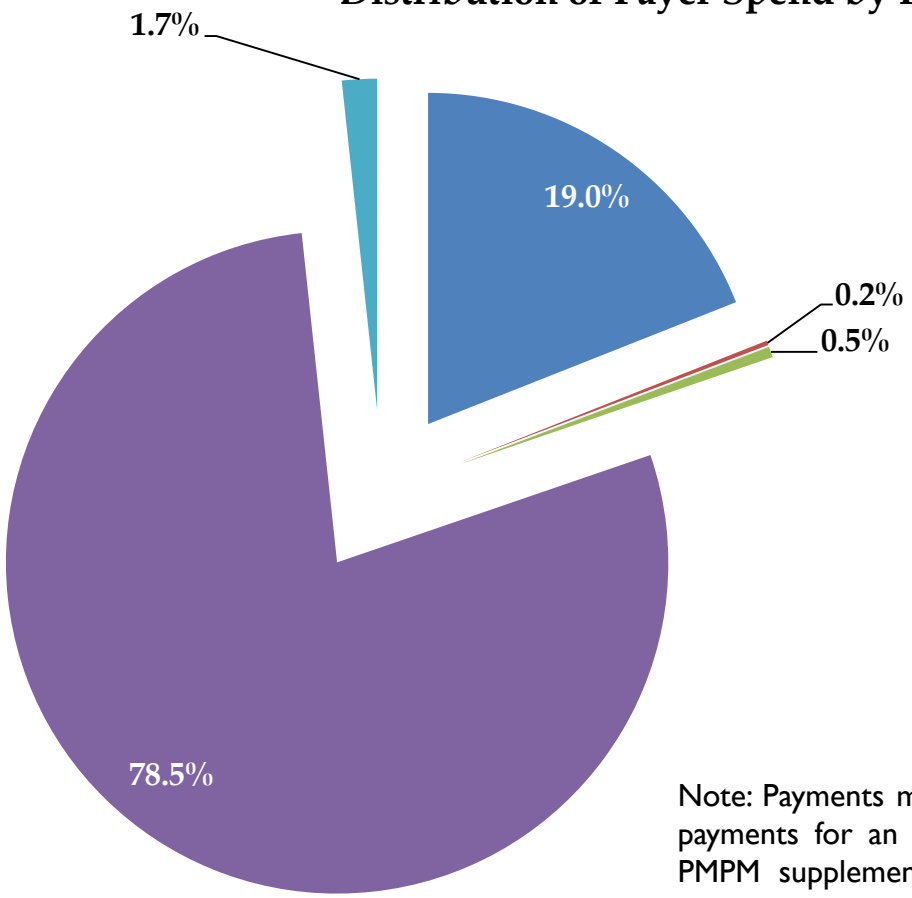
- The APM plan is to include:
  - Annual targets
  - Types of payments that qualify as APM payments
  - Steps payers will take to achieve APM targets
- The 2015 APM plan must be submitted to the Commissioner by May 1
- If the plan is not developed, or is viewed as inadequate by the Commissioner, the Commissioner may require a plan to be implemented by insurers

Goals for Today's Meeting

1. Establish a baseline understanding by reviewing summary of current APM use by health insurers
2. Discuss criteria for determining which payment methodologies qualify as APMs
3. Discuss steps, programs, initiatives to facilitate use of APMs by RI insurers and providers
4. Discuss the target for 2016
5. Delineate next steps

2. Summary of Current APM Activity in RI

RI Commercial Market (July 2013 – June 2014)
Distribution of Payer Spend by Payment Methodology

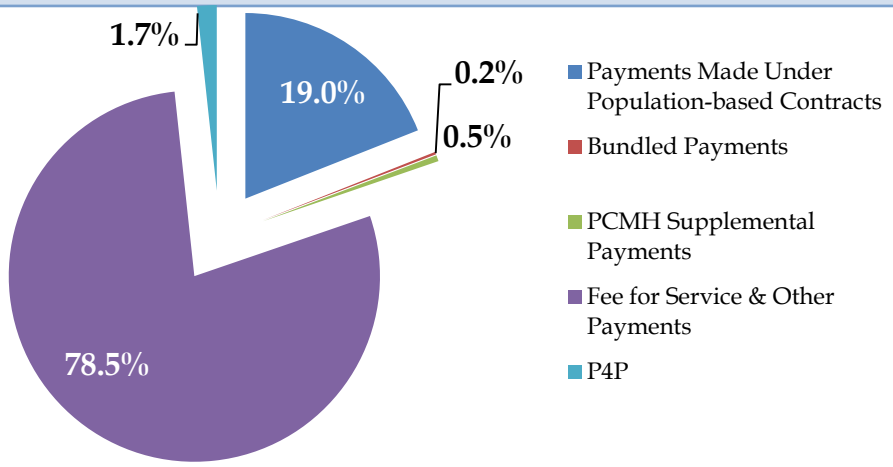


Note: Payments made under population-based contracts include fee-for-service payments for an identified covered lives population, shared savings payments, PMPM supplemental payments, targeted infrastructure payments, and quality incentives.

2. Summary of Current APM Activity in RI

Distribution of Payer Spend by Payment Methodology

	Payments Made Under Population-based Contracts	Bundled Payments	P4P	PCMH Supplemental Payments	Total Medical Expense
Fully Insured	$ 188,818,574	$ 2,424,403	$ 18,080,223		$ 1,066,311,117
Self Insured	$ 231,811,235	$ 2,418,458	$ 19,242,913		$ 1,121,089,098
Commercial Market Total	$ 415,633,600	$ 4,842,862	$ 37,323,136	$ 11,459,885	$ 2,187,400,215
Percent of Total Commercial Medical Expense	19.0%	0.2%	1.7%	0.5%	



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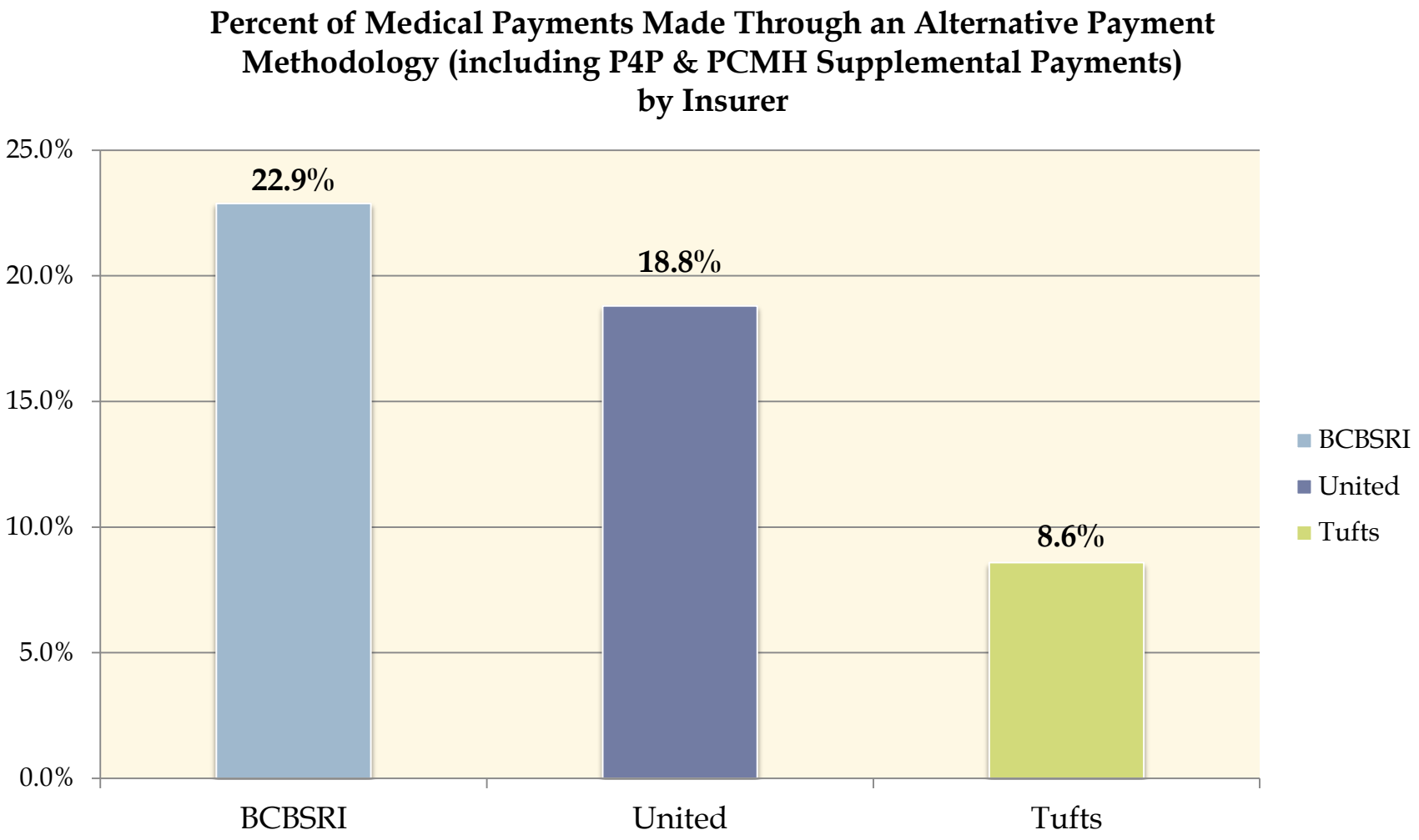

3. Draft Definition of APMs

- Payment methodologies structured such that predominant provider economic incentives are refocused from volume of services provided to delivering care in a manner that:
  - Improves quality of care
  - Improves population health
  - Reduces cost of care growth
  - Improves patient experience

Draft Definition of APMs (cont'd)

- APMs must measure *cost performance relative to a "budget"* that may be prospectively paid or retrospectively reconciled, and must include meaningful downside risk over time

- APMs include:
  - Total Cost of Care budget models
  - Limited scope-of-service budget models (e.g., primary care capitation)
  - Episode-based payments (procedure or condition)
  - Other non-FFS payments that meet the definition of an APM (e.g., Maryland's global budgets)

APM Exclusions

- APMs do NOT include pay-for-performance models or quality bonuses alone, although these models can complement APMs.

Discussion

- Are these the appropriate criteria?
- What other criteria should be added?
- Are there any criteria that should be modified?

4. Possible Facilitators of APM Adoption

- Implement consistent models across payers by developing selected common elements of APMs, e.g., common set of episodes for multi-payer use, common patient attribution methodology
- Develop common measures and reports to track provider success in improving quality and efficiency; share results publicly

Possible Facilitators of APM Adoption (cont'd)

- Build provider capacity to assume risk by:
  - Providing targeted learning collaboratives by type of APM
  - Holding seminars for provider leaders considering entering into APM agreements
  - Supporting expansion of community health teams to support small practices
  - Providing technical assistance to providers with identified need for support, e.g., safety net providers (new RWJF grant program)
  - Providing "exoskeleton" for a virtual ACO (reporting, funds management, etc.)

Possible Facilitators of APM Adoption (cont'd)

- Create momentum for change by lowering or freezing fee schedules for PCPs not in an ACO
  - Strategy used by BCBSMA to move providers into its Alternative Quality Contract
- Create tiered products that introduce incentives for enrollees to use highly efficient and high quality providers

Discussion

- Would one or more of these approaches encourage small practices to transform?
- Are these options viable?
- What other considerations should be on the table?

5. 2016 Targets

- For the baseline period (July 2013 – June 2014) **19.7%** of medical payments were made through APMs.

- Proposed 2016 Target:
  - 40% of medical payments shall be made through APMs.

6. Next Steps

- OHIC will draw upon discussion to perform any indicated research and to develop a first draft of recommendations
- Draft recommendations will be circulated in advance of next meeting
- OHIC may reach out to discuss particular issues with some advisory committee members