OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Alternative Payment Methodology Plan: Proposed Recommendations

Rhode Island Alternative Payment Methodology Advisory Committee Meeting
April 2, 2015

Presentation Outline

1. Update on Care Transformation Advisory Committee
2. Key Take-Aways from March 5th Meeting
3. Discuss Recommendations for APM Plan
   a. Revised APM Definition & Criteria
   b. Structure of APM Targets
   c. Proposed APM Targets
   d. Facilitators of APM Adoption
4. Next Steps

1. Update on Care Transformation Advisory Committee Activity

- Committee charge:
  - The Care Transformation Committee will annually develop a care transformation plan.
- The Care Transformation Plan is to include:
  - Annual care transformation targets;
  - Specific health insurer activities, resources, and financial supports needed by providers to achieve the targets (Including community health teams and practice coaches); and
  - Common standards and procedures governing health insurer-primary care provider contractual agreements, such as, alignment of performance measures and insurer provision of this information to the practice.

1. Update on Care Transformation Advisory Committee Activity (cont'd)

- First Meeting:
  - The Committee considered alternative definitions of PCMH that include requirements for performance.
  - Care transformation challenges were considered from the provider and insurer perspectives.
- Second Meeting:
  - The Committee reviewed a three-part definition of PCMH which relies on NCQA Level 3 attainment, implementation of cost containment strategies, and demonstration of improvement on key utilization measures.
  - Care transformation supports and a sustainable funding model were reviewed by the Committee.

2. Key Take-Aways from March 5th Meeting

- APM Definition & Criteria:
  - Agreement on APM definition, except that some modifications to language were necessary to support inclusion of population-based payment models where FFS remains the underlying payment methodology.
  - Support for inclusion of "increased access" and "patient engagement" as goals of APMs.
  - Recognition that assumption of "meaningful downside risk" is conditioned by provider competency and financial strength to manage risk.
- Specific Payment Methodologies:
  - General consensus on the types of payment models that should count as APMs.
  - Support for including P4P as an APM, at least in the short-term.

2. Key Take-Aways from March 5th Meeting

- Possible APM Facilitators:
  - Benefit design plays an important role.
  - Need for prospective attribution and PCP selection to give providers the tools and information to manage risk. It is difficult to measure performance with retrospective information around patients and budget targets.
  - Concerns expressed about freezing fee schedules included:
    - 1) driving lower cost independent providers to higher cost systems, and
    - 2) driving more doctors to border states with higher fee schedules.

2. Key Take-Aways from March 5th Meeting

- APM Targets:
  - Support for inclusion of FFS payments made under population-based contracts with shared savings or shared risk as part of the APM target calculation.
  - Strong support that the composition of the "payment under the payment" must move away from FFS.
- Existing Population-based Contracting Targets (Reg. 2 Section 10(d)(1)):
  - 2015: 30% of insured covered lives
  - 2016: 45% of insured covered lives

3.a. Revised APM Definition & Criteria

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

3.a. Revised APM Definition & Criteria (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)
  - PCMH Supplemental Payments and all P4P payments
  - Other non-FFS payments that meet the definition of an APM (e.g., Maryland's global budgets)

3.b. Structure of APM Targets

- Two sets of targets are proposed:
  - **APM Target**: Use of APM payments as a percentage of commercial insured medical spend.
  - **Non-FFS APM Target**: Use of non-FFS APM payments as a percentage of commercial insured medical spend.

3.b. Structure of APM Targets (cont'd)

- The APM Target shall include:
  - All FFS payments under a Total Cost of Care contract with shared savings or shared risk.
  - Episode-based payments, primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments.
  - Supplemental payments to PCMHs (e.g., for infrastructure development or Care Manager services), shared savings distributions, and all pay-for-performance payments for years 2015 through 2017.

3.b. Structure of APM Targets (cont'd)

- The Non-FFS APM Target shall include:
  - Episode-based payments
  - Limited scope-of-service capitation payments, e.g., for primary or specialty care services
  - Supplemental payments for infrastructure development or Care Manager services for years 2015 through 2017.

Discussion

- Do you agree with the definition of APM?
- Do you agree with the inclusion of two targets?
- Are there any changes to either target that you would like to propose?

3.c. Proposed Targets

- Proposed Aggregate Targets:
  - Baseline: ≈20%
  - 2016: 45%
  - 2017: 60%
  - 2018: 70%
  - 2019: 80%
- Proposed Non-FFS Targets:
  - Baseline: ≈2%
  - 2016: 8%
  - 2017:16%
  - 2018: 24%
  - 2019: 32%

Discussion

- Can your organization support these targets?
- Are there any changes or modifications that you would like to propose?

3.d. Facilitators of APM Adoption

- 2016 support includes:
  - Holding learning collaborative for unaffiliated providers to build total cost of care management skills and inform them about ACO options.
  - Promoting development of a standard core set of ACO performance measures.
- 2017 support includes:
  - Requiring all enrollees in all products to select a PCP, which will be used for attribution purposes.
  - Offering tiered products that align provider and enrollee incentives to promote highly efficient, high quality networks.
  - Freezing fee schedules of PCPs who do not participate in an ACO.

Discussion

- Are there any modifications you would like to make to these recommendations?
- Are there additional support activities that you would like to include?

4. Next Steps

- Draft APM Plan will be circulated in advance of the next meeting
- OHIC may reach out to discuss particular issues with some Advisory Committee members