**State of Rhode Island Office of the Health Insurance Commissioner**
**Alternative Payment Methodology Advisory Committee**
**Meeting Agenda**
**November 20, 2015, 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**

1) **Introductions & Review of Agenda**

2) **Presentation & Discussion: Goals and Activities for the 2017 APM Plan & Draft Recommendations**

3) **Next Steps**

4) **Public Comment**

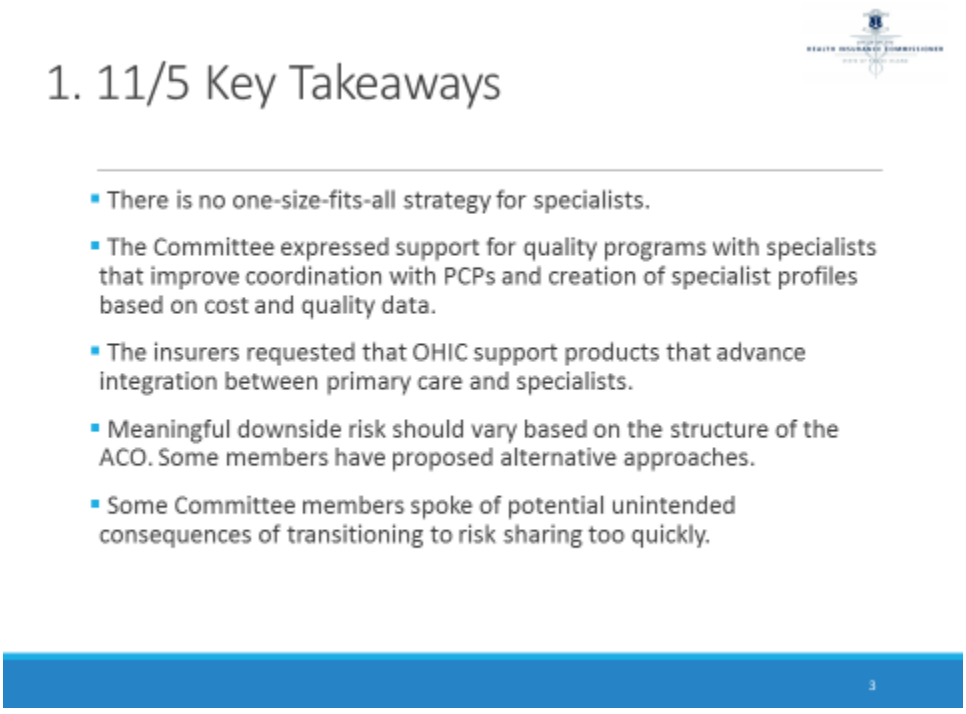
**State of Rhode Island Office of the Health Insurance Commissioner**
**Alternative Payment Methodology Advisory Committee**
**Meeting Minutes**
**November 20, 2015, 8:00 A.M. to 11:00 A.M.**
**State of Rhode Island Department of Labor and Training**
**1511 Pontiac Avenue, Building 73-1**
**Cranston, RI 02920-4407**

**Introductions & Review of Agenda**

Members in Attendance: Erik Helms, Pat McGuigan, Billy Almon Jr., Mary Craig, Al Kurose, Sam Salganik, Todd Whitecross, Chris Dooley, Alok Gupta, Ted Long (DOH), Domenic Delmonico, Dan Moynihan, Tom Breen, Patrick Tigue, William Cioffi, Mike Souza, Al Charbonneau, Weber Shill, Pano Yeracaris, Noah Benedict, Jeanne LaChance (for Chuck Jones), Lou Rice.

**1) Recap of 11-5-2015 Meeting and Follow Ups**

Cory King, Principal Policy Associate for OHIC, opened the meeting with a review of the key takeaways from the 11-5 meeting.




Next Mr. King informed the Committee that OHIC's Administrative Simplification Work Group is considering options around plan design. Members of the Administrative Simplification Work Group expressed interest in requiring PCP selection in all commercial products. During the 11-4 meeting of the Work Group, some members asked how "primary care provider" should be defined. Should it be defined

based on specialty or whether the provider is the patient's "center of care?" This question led to some debate among the Administrative Simplification Work Group.

Dr. Ted Long noted that CMS and HRSA have standard definitions of primary care.

Members of the APM Committee expressed continuing support for PCP selection.

**2) Draft APM Targets for 2017 and 2018**

Next Mr. King reviewed the proposed Alternative Payment Methodology and Non-Fee for Service Targets for 2017 and 2018. OHIC is proposing the following targets:

APM Targets: 2017: 40% and 2018: 50%
Non FFS Targets: 2017: 6% and 2018: 10%

Mr. King noted that the aggregate APM target for 2018 aligns with CMS's targets for Medicare and RI's Reinventing Medicaid goals. This alignment will ensure convergence around common goals.

Erik Helms asked that we evaluate the directionality of the OHIC hospital contracting conditions with the targets.

The hospital contracting conditions require insurers to have quality improvement programs in place with hospitals and to tie at least half of the annual fee increase for hospital inpatient and outpatient services to performance on quality.

There was some discussion of how hospital facility payments would be counted toward the APM and non-FFS targets when those payments were linked to quality performance. The following example illustrates how they will be counted. If a hospital service fee is $100 today, assuming a cap on fee increases of 3%, half of which increase must be earned by performance on quality measures, then of the resulting $103, $1.50, if earned, would be counted as a pay for performance distribution. The pay for performance distribution would be included in the APM target and the non-FFS target. The $103 in its entirety would only count toward the aggregate APM target if it was paid under a population-based contract or a bundled payment.

Erik Helms asked if Blue Cross paid a hospital system to fund an infrastructure project, would that count toward meeting the targets. Cory King responded that infrastructure payments to ACOs may count in some instances, but insurers should approach the Commissioner for approval before OHIC would credit the payment toward the targets.

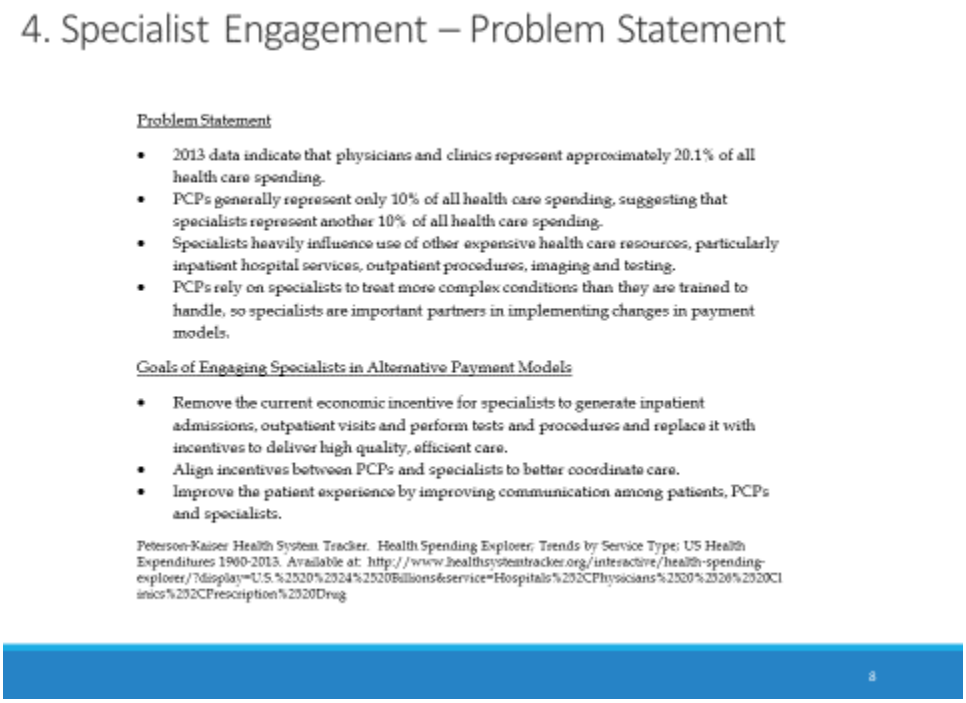
### 3) Follow up on Oncology Bundles

Next Marge Houy of Bailit Health Purchasing gave a brief presentation on examples of oncology bundles. The presentation covered UnitedHealthcare's Pilot for Breast, Colon and Lung cancers, MD Anderson's Pilot for Head and Neck Cancers, and examples from CMS.

Work group members had clarifying questions about the examples.

### 4) Recommendations: Engaging Specialists in APM Strategies

Next Mr. King presented the draft problem statement and goals for specialist engagement. The Committee asked for a problem statement and written goals during the 11-5 meeting. Some committee members stated that we should focus on unwarranted utilization and variations in treatment. Mary Craig asked if we could quantify what percentage of spending is unnecessary. Another committee member remarked that lack of access to specialists can be a problem that should be added to our problem statement.




Next Mr. King drew Committee members' attention to the six options for engaging specialists that were discussed during the 11-5 meeting. He noted that the Committee expressed support for options that would require insurers to develop quality incentive programs for specialists that focus on improved coordination with PCPs and developing specialist profiles on cost and quality measures using APCD data.

Alok Gupta noted that the TCPI grant could be part of programs to engage specialists.

Domenic Delmonico stated that CNE is developing a program to engage hospitalists to work on effective patient discharges to post-acute services. Mr. Delmonico would like OHIC to maintain flexibility for others to try different options.

Erik Helms asked for clarification around how OHIC would potentially consider rate increases for specialists in conjunction with the rate review process. Cory King stated that OHIC could contemplate something similar to the hospital contracting conditions, but for specialists.

Al Kurose asked that OHIC explicitly say that the state would work with specialists to create the specialist profiles contemplated under option 6.

Mary Craig stated that creating the specialist profiles contemplated under option 6 may take two years or longer.

The Committee discussed whether "new" money would be needed to advance programs with specialists that encourage coordination with PCPs and quality improvement.

Dr. Cioffi stated that we need to consider new money. EHR connections cost between $15 and $50 thousand dollars. Specialist working in small group practices can't bear that expense easily.

Sam Salganik stated that new money can lead to return on investment, naming patient centered medical homes as an example.

**5) Recommendations: Consumer Safeguards**

Next Mr. King introduced the draft recommendations around consumer safeguards. In previous meetings, some members of the Committee have expressed concerns that the transition to alternative payment models may have the unintended consequence of limiting patient access to care through such practices as cherry picking patients and skimping on care.

Sam Salganik expressed support for the recommendations.

Patrick Tigue remarked that where cherry picking is the result of provider actions it would be inappropriate for OHIC to hold in insurer responsible.

**6) Revised Draft Definition of "Meaningful Downside Risk"**

Next Mr. King introduced the revised definition of "meaningful" downside risk.

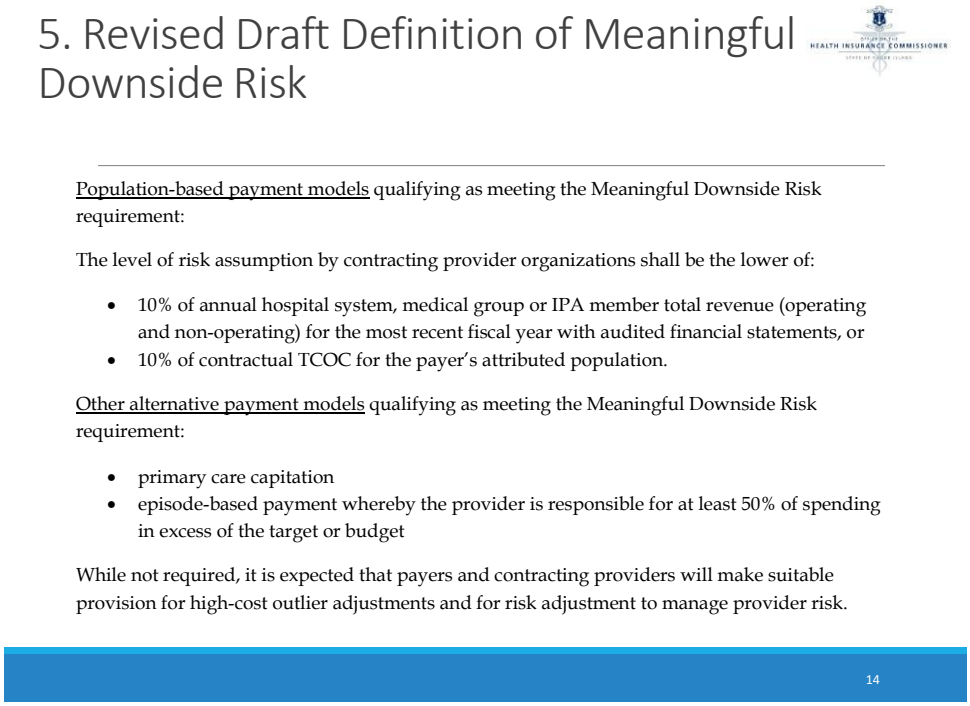
Some members of the Committee expressed that the risk should be linked to revenue generated under the contract, not total cost of care, and that 5% would be a reasonable starting point.

Al Kurose stated that we may consider asking the question: "What is a reasonable panel size for these types of contracts to be feasible?"

Tom Breen stated that hospitals are accountable to their Board of Directors, which have fiduciary responsibility.

Cory King stated that since there was still disagreement and lack of complete understanding around these definitions, OHIC would essentially hold this topic for further study.

Erik Helms stated that Blue Cross was moving forward regardless of whether or not OHIC set a target.




The meeting was concluded with no public comment.

The next meeting will be Monday November 30th at 8 a.m. at the same location.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

# Goals and Activities for the 2017 Alternative Payment Methodology Plan & Draft Recommendations

RHODE ISLAND ALTERNATIVE PAYMENT METHODOLOGY ADVISORY COMMITTEE MEETING

NOVEMBER 20, 2015

# Agenda

1. Key Takeaways from the 11-5 Meeting / Follow ups
2. Draft APM Targets for 2017 & 2018
3. Follow up on Oncology Bundles
4. Recommendations: Engaging Specialists in APM Strategies
5. Recommendations: Consumer Safeguards
6. Revised Draft Definition of “Meaningful” Downside Risk
7. Next Steps

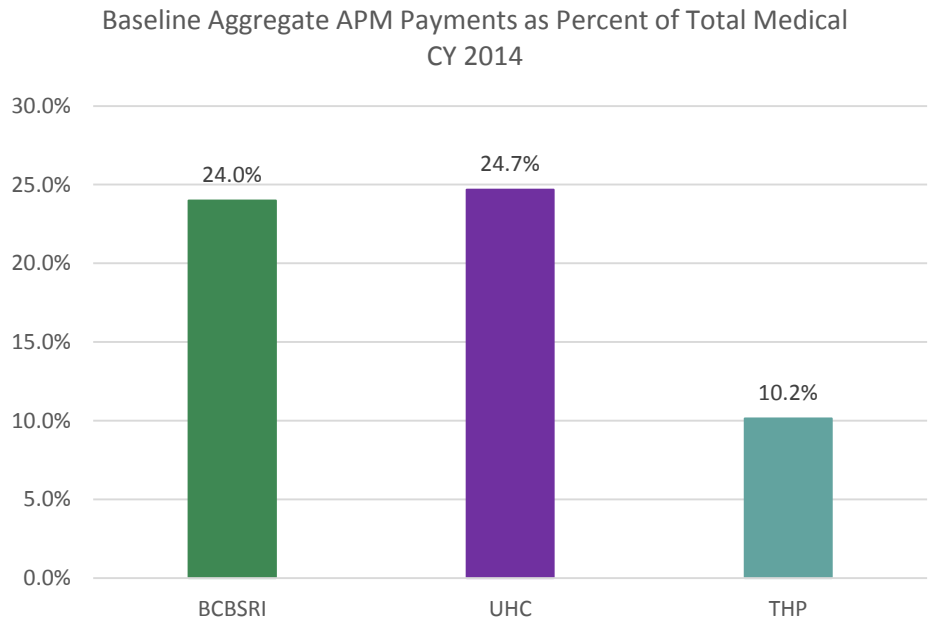
# 1. 11/5 Key Takeaways

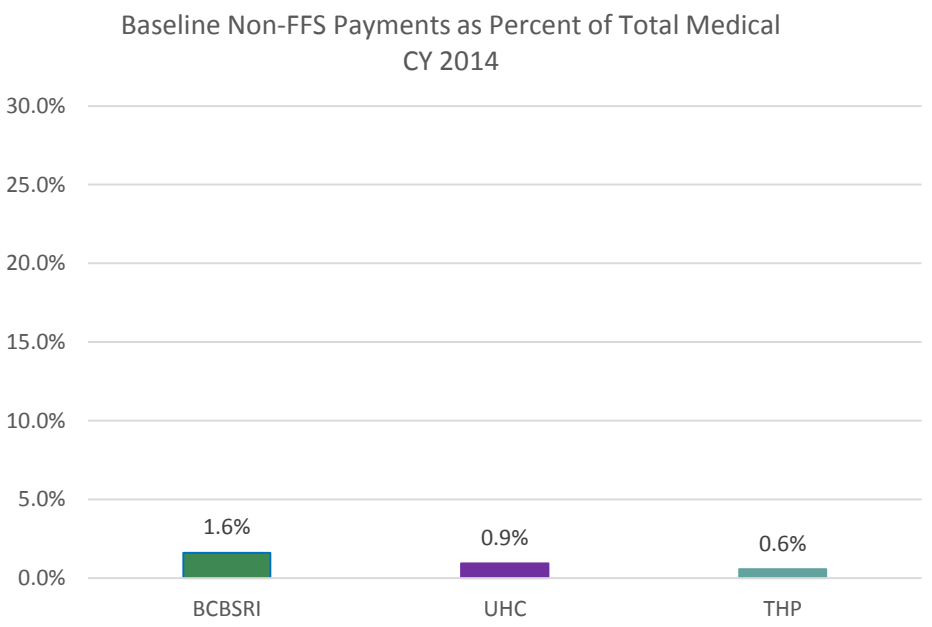
- There is no on-size-fits-all strategy for specialists.
- The Committee expressed support for quality programs with specialists that improve coordination with PCPs and creation of specialist profiles based on cost and quality data.
- The insurers requested that OHIC support products that advance integration between primary care and specialists.
- Meaningful downside risk should vary based on the structure of the ACO. Some members have proposed alternative approaches.
- Some Committee members spoke of potential unintended consequences of transitioning to risk sharing too quickly.

# 1. Follow ups

- OHIC's Administrative Simplification Work Group is considering options around plan design.
- Work Group members have expressed interest in requiring PCP selection in all commercial products.
- Questions?

# 2014 APM & Non-FFS Baselines



# 2. Draft APM Targets for 2017 & 2018

Proposed targets align with Medicare and Medicaid:

- Aggregate Targets:
  - 2017: 40%
  - 2018: 50%
- Non-FFS Targets
  - 2017: 6%
  - 2018: 10%

# 3. Specialist Engagement – Problem Statement

Problem Statement

- 2013 data indicate that physicians and clinics represent approximately 20.1% of all health care spending.
- PCPs generally represent only 10% of all health care spending, suggesting that specialists represent another 10% of all health care spending.
- Specialists heavily influence use of other expensive health care resources, particularly inpatient hospital services, outpatient procedures, imaging and testing.
- PCPs rely on specialists to treat more complex conditions than they are trained to handle, so specialists are important partners in implementing changes in payment models.

Goals of Engaging Specialists in Alternative Payment Models

- Remove the current economic incentive for specialists to generate inpatient admissions, outpatient visits and perform tests and procedures and replace it with incentives to deliver high quality, efficient care.
- Align incentives between PCPs and specialists to better coordinate care.
- Improve the patient experience by improving communication among patients, PCPs and specialists.

Peterson-Kaiser Health System Tracker. Health Spending Explorer; Trends by Service Type; US Health Expenditures 1960-2013. Available at: http://www.healthsystemtracker.org/interactive/health-spending-explorer/?display=U.S.%2520%2524%2520Billions&service=Hospitals%252CPhysicians%2520%2526%2520Clinics%252CPrescription%2520Drug

# 3. Options for Engaging Specialists in APM Strategies

**1.** OHIC requires plans to pay specialists involved in APMs more than those who are not involved in APMs.

**2.** OHIC considers level of specialists' rate increases in approving insurer rates.

**3.** OHIC requires plans to implement specialist APM pilots for at least two high volume or high cost specialties such as oncology bundle or joint replacement bundle.

**4.** OHIC facilitates multi-payer APM initiative targeted at high volume/high cost specialists such as oncology bundle or joint replacement bundle.

**5. OHIC requires plans to develop quality incentive programs for specialists that focus on improved coordination with PCPs.**

**6. OHIC works with payers and the APCD to create specialist profiles based on "potentially avoidable complications" or other measures of cost and quality.**

# Discussion

Can the Committee agree to move forward on options 5 and 6?

Are there modifications to the options that you would like to propose?

Which of the other options would you like the Commissioner to consider?

# 4. Recommendations: Consumer Safeguards

## Recommendations to Safeguard against ACO Cherry Picking as a Risk Management Strategy

Problem Statement

A member of the Alternative Payment Methodology Advisory Committee expressed concern about accountable care organizations having a financial incentive to exclude high-cost patients from their attributed patient population ("cherry picking"). These same members have asked that OHIC adopt a strategy for preventing cherry picking by ACOs and their providers.

Recommendations

1. OHIC requires that all insurer contracts that transfer financial risk to ACOs include as part of the reimbursement model requirements that link performance on quality measures to reimbursement levels, such that ACOs will be penalized financially for poor quality performance and rewarded for high levels of quality performance.
2. OHIC requires that all insurer contracts that transfer financial risk to ACOs include clinical risk adjustment as part of the payment model.
3. OHIC collects and analyzes financial and quality performance data that Rhode Island insurers generate or collect from ACOs, as well as member complaints regarding ACOs submitted to insurers and to OHIC.
4. If OHIC analysis of ACO-related data raises questions about possible cherry picking, OHIC is to conduct an audit of ACO activities and take appropriate regulatory action with respect to Rhode Island plans who have contractual arrangements with the concerning ACO.

# Discussion

Are there modifications to the options that you would like to propose?

Do you have alternative ideas that the Commissioner should consider?

# 5. Draft Definition of Meaningful Downside Risk

- Since the last meeting OHIC has received feedback from some Committee members and has drafted a revised definition.

# 5. First Draft Definition of Meaningful Downside Risk

"Meaningful Downside Risk" means the potential financial loss a provider must accept in order to have sufficient incentive to undertake significant care delivery transformation that will result in improved quality of care and reduced total cost of care.

For the purposes of the Rhode Island 2016 Alternative Payment Methodology Plan, Section II Definitions, "Meaningful Downside Risk" is present when a contract between a provider entity and an insurer specifies that the provider assumes risk of loss that is equal to at least fifteen percent (15%) of the total cost of care incurred by the population for which the provider entity is responsible. The 15% risk assumed by the provider entity is net of any risk-sharing arrangements it has with the insurer. For example, a 50/50 risk sharing arrangement would meet the definition of "Meaningful Downside Risk" if the provider has 30% of total cost of care at risk (i.e., 50% x 30% = 15%). However, a 50/50 risk sharing arrangement that has 20% of total cost of care at provider risk would not meet the definition of "Meaningful Downside Risk" (i.e., 50% x 20% = 10%).

# 5. Revised Draft Definition of Meaningful Downside Risk

Population-based payment models qualifying as meeting the Meaningful Downside Risk requirement:

The level of risk assumption by contracting provider organizations shall be the lower of:

- 10% of annual hospital system, medical group or IPA member total revenue (operating and non-operating) for the most recent fiscal year with audited financial statements, or
- 10% of contractual TCOC for the payer's attributed population.

Other alternative payment models qualifying as meeting the Meaningful Downside Risk requirement:

- primary care capitation
- episode-based payment whereby the provider is responsible for at least 50% of spending in excess of the target or budget

While not required, it is expected that payers and contracting providers will make suitable provision for high-cost outlier adjustments and for risk adjustment to manage provider risk.

# Discussion

Is there anything about the revised draft definition of “meaningful” downside risk that you would like to modify?

Are there alternative approaches to defining “meaningful” downside risk that you would like to propose?

# 6. Next Steps

OHIC will distribute a draft APM Plan in advance of the next meeting.

OHIC may reach out to discuss particular issues with some Advisory Committee members.

Next Meeting: Monday November 30th at 8 AM.

# Oncology Episode of Care Payment Models

OHIC APM Advisory Committee Meeting

*November 20, 2015*

bailit health

# Three Examples

1. UnitedHealthcare's Pilot for Breast, Colon and Lung Cancers
   - Initiated October 2009 with first oncology group; fifth group enrolled in Fall 2010
   - Evaluated 2014
   - Expanded to five new oncology groups in 2015
2. MD Anderson Pilot for Head and Neck Cancers
   - Pilot launched April 1, 2014
   - Enrollment to end October 31, 2016
   - Pilot to end October 31, 2017
3. CMS
   - Applications to participate due June 30, 2015

# UnitedHealthcare: Scope of Pilot

- Five oncology groups covering 1024 patients
- Covers breast, lung and colon cancer patients with one of 19 clinical conditions, such as:
  - Breast: stages 0,I; no chemotherapy
  - Breast: stages I, II; HER2 overexpression, ER/PR positive
  - Colon: stages II, III
  - Colon: stage IV
  - Lung: small-cell, any stage
  - Lung: non-small-cell, stages IV, nonsquamous histology

# UnitedHealthcare: Payment Model

| Service Type | Payment Methodology | |
|---|---|---|
| | Episode Model | Standard Model |
| Physician office visit | FFS | FFS |
| Chemo administration | FFS | FFS |
| Chemo medications | Average Sale Price (ASP) | ASP + contracted % |
| Diagnostic radiology | FFS | FFS |
| Laboratory | FFS | FFS |
| Physician hospital care | Episode | FFS |
| Hospice management | Episode | FFS or none |
| Case management | Episode | None |

Duration of bundles: 19 Adjuvant episodes -- length of therapy plus 2 months
Metastatic episode -- 4 months

# UnitedHealthcare: Delivery Model

- Each oncology group selected a single chemotherapy regimen for each of the 19 adjuvant therapy episodes
  - National Comprehensive Cancer Network (NCCN) Guidelines
  - Preferred regimen could be changed by group at any time
  - Patients could be enrolled in clinical trials
- No standardization of regimens for metastatic disease
- Providers not locked in if patients needed other treatments
  - Participants estimated that selected regimens would work for 80% to 85% of all patients

# UnitedHealthcare: Financial and Analytic Support

- Oncologists submitted clinical data to United to determine correct episode
  - Episode fee paid immediately
  - All services billed to UHC on FFS basis
- Oncologists and UHC developed over 60 quality and cost measures
  - Reported regularly to groups

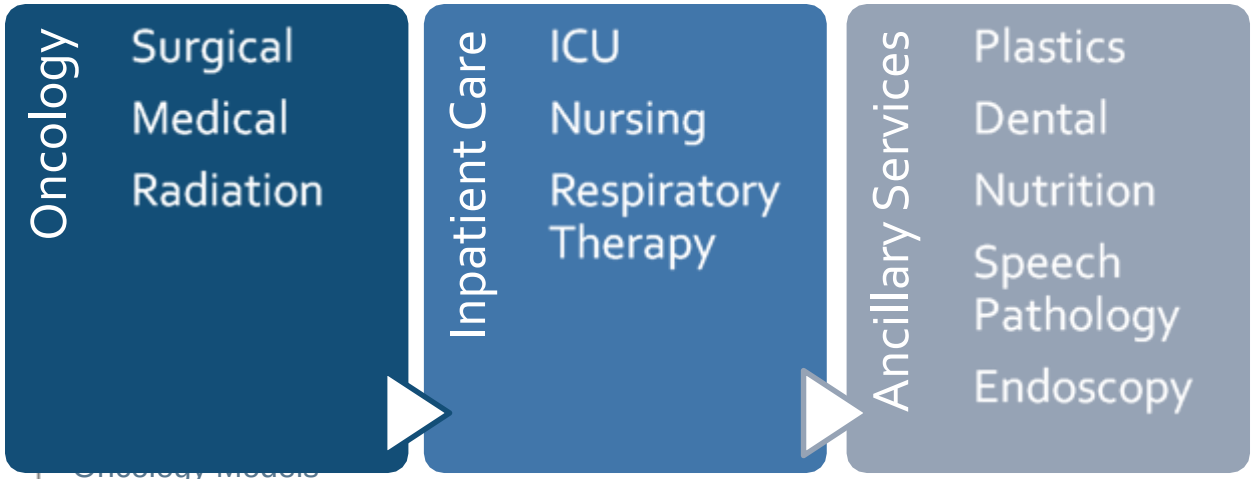
# UnitedHealthcare: Outcomes*

- Evaluated care for 810 patients
- Reduced TCOC by $40,000 per chemotherapy patient, *despite* 179% increase in chemotherapy spending
  - Represented $33.4 million in savings compared to control group
- Theories offered to explain reduced costs
  - Reduced inpatient and ED utilization
  - Fewer complications
  - Care delivery innovation (e.g., instituting pre-chemo education for patients)
  - Care management support

*L.N. Newcomer, MD et al. "Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Model." *American Society of Clinical Oncology*. July 18, 2014

# MD Anderson: Why Did They Start with Head and Neck?

- Lower financial risk for this population
  - Relatively low volumes, compared with breast, colon, etc.
- Highly coordinated care delivery model
  - Well-defined treatment endpoints
  - Multidisciplinary care routinely utilized



# MD Anderson Pilot Scope: Included Services and Payment Model

**Patient Population**

| |
|---|
| Lip & Oral Cavity |
| Larynx |
| Oropharynx |
| Salivary Gland |

- **Newly-diagnosed, untreated** patients
- Excludes patients with **concurrent** cancer, **recurrent** cancer, or cancer **treatment** in the preceding 12 months

**Included Services ***

**Diagnosis/ Workup**
- **Bundle:** RaTX Workup
- **FFS:** Other Covered Workup

**Treatment**
- **Bundle:** All Covered Services (1 yr)
- **FFS:** None

**Follow-Up/ Survivorship**
- **Bundle:** None
- **FFS:** All Covered Services

**** Bundle includes services at MD Anderson only***

# MD Anderson: Managing "Risk Transfer" Under the Pilot

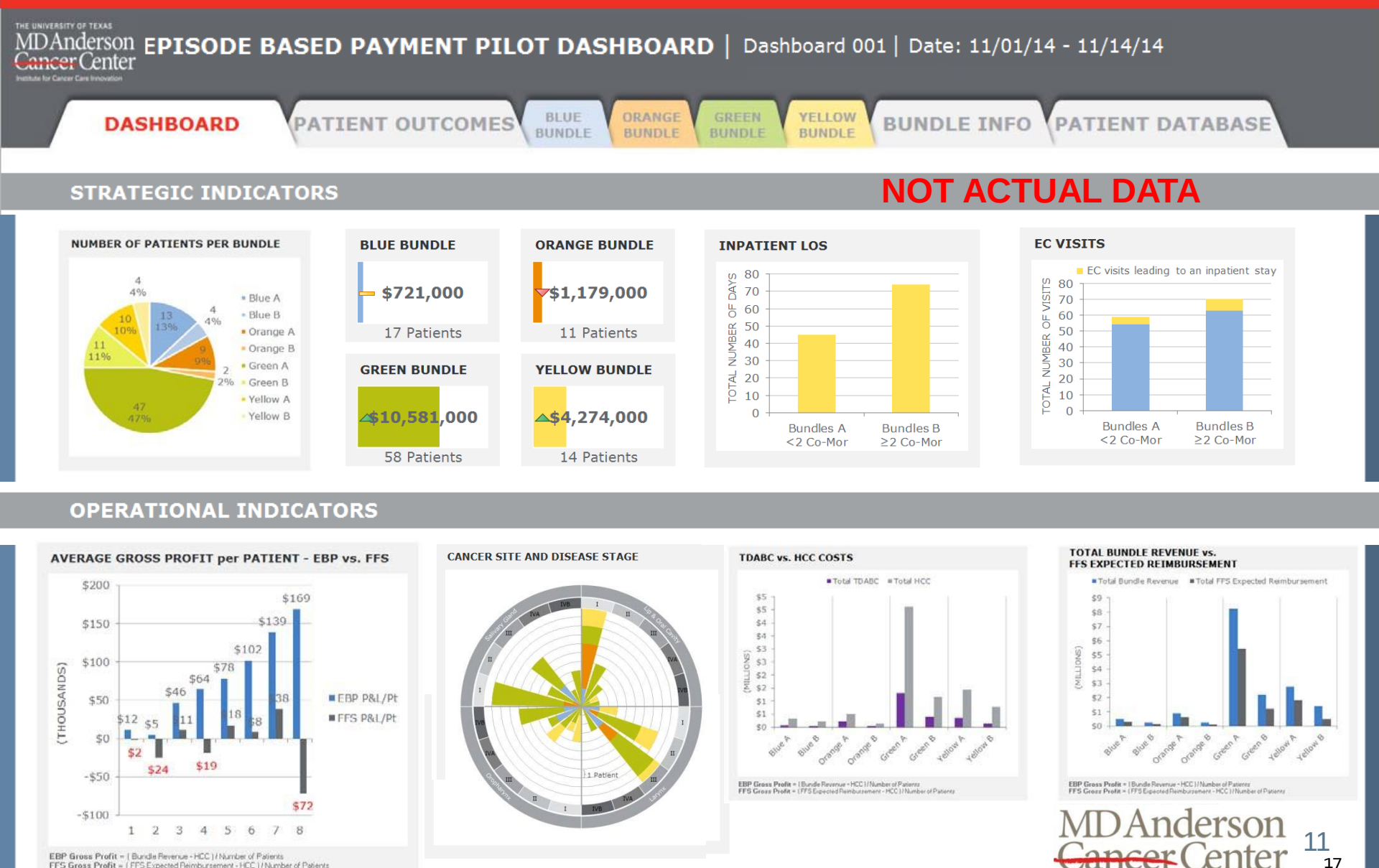
**Patient Risk**

- **Prospectively**—incorporate "**risk adjustment**" for patients with ≥ 2 comorbidities
  - Accounts for higher costs of care for more complex cases
- **Retrospectively**—include a **stop-loss provision** for unexpected complications

**Provider Risk**

- **Prospectively**—Leverage existing treatment and **continuity of care** pathways to standardize care
- **Retrospectively**—Near **real-time** financial performance and outcomes measurement to identify and mitigate unnecessary variations in care

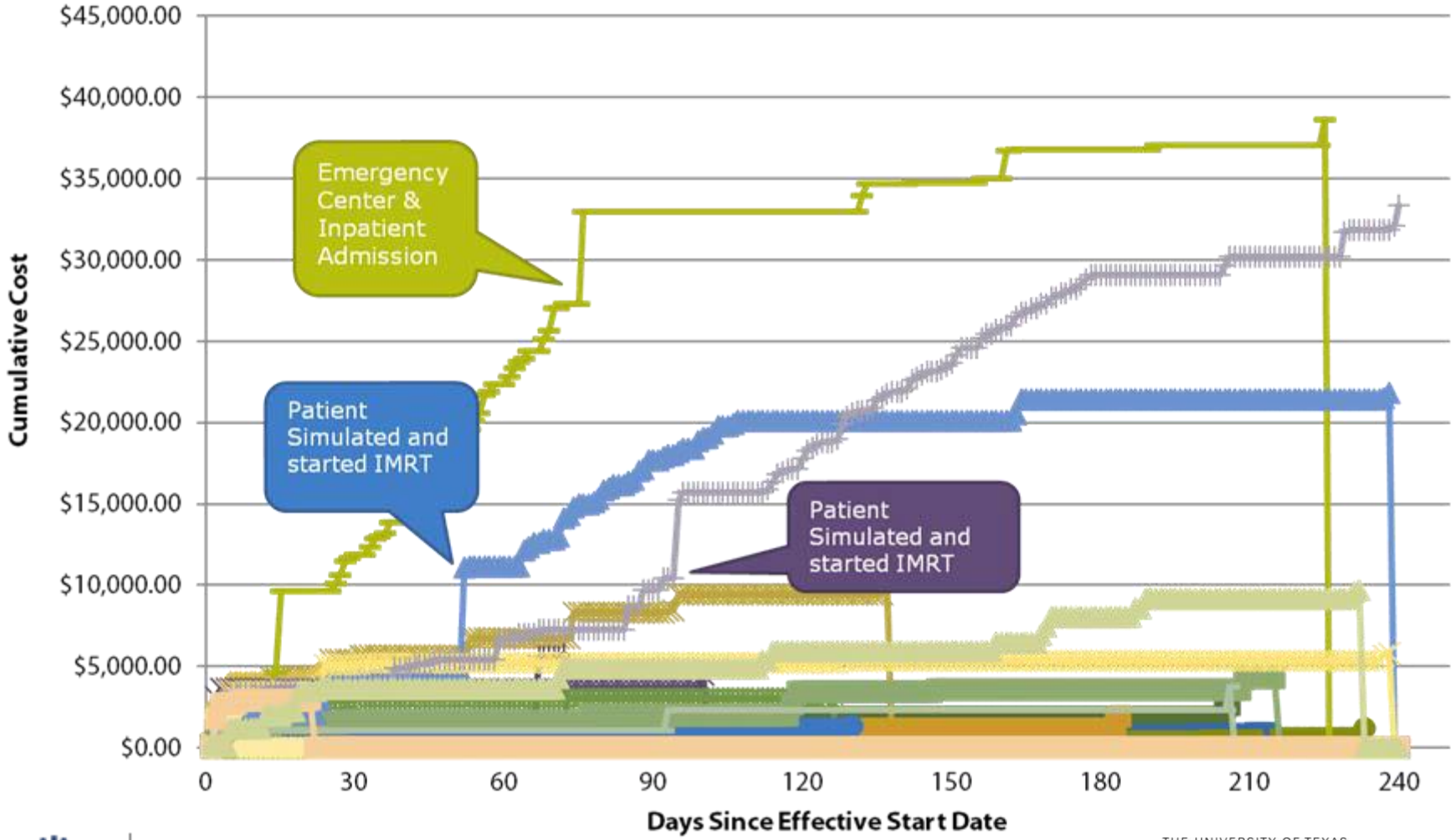
# MD Anderson: Patient Tracking Dashboard




MD Anderson Cancer Center

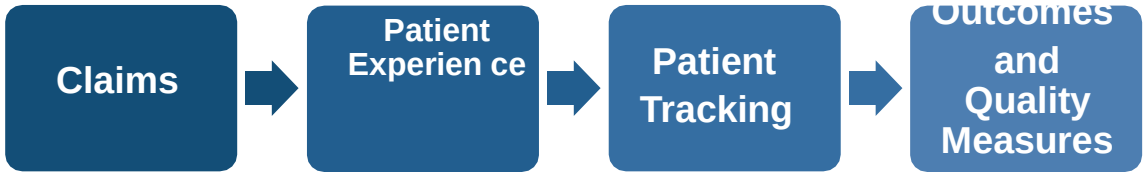
# MD Anderson:
# Sample Patient Cost Tracking

**NOT ACTUAL DATA**



# MD Anderson: Post-Implementation Project Support

- 4 Active Teams (nearly 30 participants, 40% from Head and Neck Center)




  - Time commitment varies (<1 hr to 20 hrs/wk)
- Dedicated Project Management Team and Analytical Support

# Bundle Design Considerations

1. Limit number of bundles to streamline administration
2. Ensure seamless patient experience and optimal outcomes
3. Blind physicians to patient eligibility/enrollment
   - Assign bundle after treatment plan is determined
4. Minimize disruption to provider workflow; build on existing use of care pathways
5. Develop methodology that is scalable and replicable
6. Treat pilot as a learning experience

# CMS Oncology Care Model: Overview

- Episode-based
  - Payment model targets chemotherapy and related care during a 6-month period following the initiation of chemotherapy treatment
- Emphasizes practice transformation
  - Based on OCM's 6 practice requirements regarding use of EMRs and data for CQI, patient navigation, follows nationally recognized clinical guidelines
- Multi-payer model
  - Includes Medicare FFS and other payers to leverage the opportunity to transform care for oncology patients

# CMS: Episode Definition

- Covers nearly all cancer types
- Episode initiates when a beneficiary starts chemotherapy
- Services included: all Medicare A and B services and certain Part D expenditures
- Episode duration is 6 months after chemotherapy has been initiated
  - Multiple episodes may be initiated during the 5-year model performance period

# CMS: Payment Model

- Participating practices will be paid “FFS Plus”
- Per-beneficiary-per month (PBPM) payment
  - $160 PBPM for enhanced services (primarily care management, care planning and 24/7 access)
  - PBPM is paid monthly during the 6-month episode, unless beneficiary enters hospice
- Performance-based payment
  - Based on meeting OCM’s 6 practice requirements and other quality measures, and
  - Reducing total cost of care below CMS-calculated, risk-adjusted benchmark minus discount
    - Payments may be reduced based on performance on quality measures
  - One-sided and two-sided performance-based risk options.

# Observations

- Delivery models focus on transforming care
  - Focus on standardized care and quality measures
  - Focus on improving coordination across providers
- Variation within episodes controlled by carefully defining patients covered by specific episode payment
- CMS is implementing an supplemental payment plus shared savings/risk assumption model, rather than an episode payment model.