State of Rhode Island Office of the Health Insurance Commissioner
Alternative Payment Methodology Advisory Committee
Meeting Agenda
November 30, 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) **Review Draft 2017 APM Plan**

3) **Next Steps**

4) **Public Comment**

State of Rhode Island Office of the Health Insurance Commissioner
Alternative Payment Methodology Advisory Committee
Meeting Minutes
November 30, 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: Pat McGuigan, Mary Craig, Sam Salganik, Todd Whitecross, Chris Dooley, Alok Gupta, Dan Moynihan, Tom Breen, Patrick Tigue, Mike Souza, William Cioffi, Al Charbonneau, Weber Shill, David Paller, Pano Yeracaris, Jeanne LaChance (for Chuck Jones), Lou Rice, Pat Flanagan, Grant Porter.

Review of Draft 2017 APM Plan

Cory King, Principal Policy Associate for OHIC, welcomed the Committee members and opened the meeting by stating that he would summarize each section of the draft 2017 APM plan and ask members of the Committee for feedback and suggested modifications.

Under the Definitions from the 2016 Plan, section c(2), Cory King noted that the term "shared risk" had been added to the first bullet "Episode-based (bundled) payments with shared risk."

Some members of the Committee expressed reservations about the ability of disparate groups of providers to assume risk under a bundled payment approach.

Al Charbonneau requested that the minutes reflect the reservations that have been expressed.

Before moving to Section III of the draft plan, which contains the proposed APM targets, Cory King summarized how the APM targets are defined and calculated. He noted that during the November 20th meeting the question of whether certain infrastructure payments could be credited toward meeting the targets was asked. Cory King restated that the nature and purpose of the infrastructure payments would need to be reviewed by the Commissioner before a determination could be made.

Next Cory King stated that the Office of the Health Insurance Commissioner takes the APM targets very seriously. OHIC will issue a final APM reporting template to insurers, which OHIC has already received comment on. OHIC will periodically monitor insurer progress toward meeting the targets and expects insurers to monitor their progress internally throughout the year.

If, despite good faith efforts to comply with the APM targets, the insurer finds it impossible to comply, they are obligated to notify the Commissioner as soon as those circumstances become apparent. The

Commissioner may grant a waiver in these circumstances and require development and implementation of a corrective action plan from the insurer. If an insurer does not demonstrate, to the satisfaction of the Commissioner, that they made good faith efforts to comply with the targets, then the insurer may face penalties ranging from a fine to an impact on their ability to market plans.

Next, the proposed APM and Non-FFS targets were reviewed. There were no comments on the aggregate APM targets of 40% for 2017 or 50% for 2018. The proposed Non-FFS targets for 2017 and 2018, 6% and 10% respectively elicited the following comments.

Lou Rice stated that the targets seemed doable, but no one is currently capable of doing effective bundles. Achievement of the targets would be driven by quality incentives, supplemental payments, and shared savings since there are currently no bundles or capitation.

Weber Shill asked whether the risk under a bundled payment would apply to the total cost of the episode, or just the professional fee. Our fee may be only $3,000 of a $30,000 bundle.

William Cioffi remarked that 6% and 10% will be difficult to get to when you only have two or three of the bullets listed under section c(2) to work with.

Pano Yeracaris stated that providers have several years to plan for risk assumption.

Todd Whitecross commented that capitation is ultimately a lot of risk for whoever is involved. People were pretty reticent to jump into downside risk at all. Downside risk is a precursor to capitation.

Mary Craig stated that primary care capitation is not going to hit the targets. She worries about bundles with United's small market share.

Cory King reminded the Committee that P4P distributions count only for 2016 and 2017. He asked if the Committee would like to revisit that decision from the spring.

Todd Whitecross commented that 10% for 2018 feels aggressive. To get to 10%, not enough room from a trend standpoint.

Pat McGuigan stated that we are doing this exercise to change behavior. If the targets are lower, it feels like we're going to "keep on keeping on." Pushing people to do something different is a good thing.

William Cioffi stated that polite discussion doesn't mean there isn't angst. To have a specialist live in both worlds is hard. We're at 100% fee for service today. It's hard if there's no new money for this for specialists.

Al Charbonneau commented that there is no discussion about how to make premiums more affordable. If we have practitioners making the transition, but it's not enough to help premiums, we need to look for

something else. Bundles and PCMHs are small changes. For businesses and consumers we need to focus on overhead.

Commissioner Hittner commented that these targets may be what spurs advocacy to change the system.

Lou Rice commented that there are a lot of different specialists out there. It's hard to measure quality, and there is not agreement on what quality is for those specialists.

David Paller asked about data infrastructure. It's daunting to go into a bundle as a surgical practice if you don't have access to timely claims data.

Al Charbonneau stated that this model will drag people along in the market. How do you set the expectation that it's working? Is this leading to premium changes? We don't know that. Evaluation should be a part of this plan.

Cory King responded that evaluation is a component of the Affordability Standards. In 2018 OHIC has to do a comprehensive evaluation. We can look at how much premiums have increased and whether they have become less volatile. Drawing causality between OHIC's standards and premium trends is tough to do scientifically.

Cory King stated that we can leave the non-FFS targets as they are and revisit the 2018 target in the fall of 2016.

Next Cory King reviewed section 4 of the draft 2017 APM Plan. Section 4 deals with programs to engage specialists in payment reform activities.

Alok Gupta of the Rhode Island Quality Institute was asked to provide an overview of the TCPI grant. TCPI focuses on practice transformation. Quality improvement is the main focus of the grant; it is not a technology grant. Pano Yeracaris remarked that practice transformation is about culture change, which means leadership training, use of data to drive change, patient engagement, specialist coordination with PCPs, reductions in unnecessary testing and avoidable hospitalization.

Cory King asked whether the draft language under requirements 1 and 2 provide enough direction to payers.

Pat McGuigan asked: operationally what does this mean? It feels squishy as a non-health care person. It needs more detail.

Peter Hollmann commented that the first requirement reads fine. Don't need to get more specific. On the second requirement, OHIC could create a vehicle for people to come together by using the state action exemption for anti-trust to do something like CTC. Don't want to leave this to each insurer talking to each specialty group.

Sam Salganik recommended that the Plan specifically state that supplemental payments for care management services paid to specialist practices count toward meeting the APM targets.

Todd Whitecross stated that success in moving to bundled payment will rely on good data.

Alok Gupta stated that the Plan should capture specialist practice transformation explicitly in requirement 1.

Lou Rice asked if we were assuming that primary care practice transformation is the same for specialists.

Peter Hollmann stated that transformation is a meaningless term. The language in the plan should not imply NCQA accreditation.

Next, Cory King summarized the consumer safeguard requirements in the draft Plan.

Sam Salganik voice approval for the content of the consumer safeguards section. He asked whether ACO was defined and suggested that OHIC use a more general term. Mr. Salganik also suggested that OHIC should retain the authority, such that, if OHIC finds improper conduct through an ACO, OHIC should retain the authority to withhold credit of the dollars under that contract from the insurer's APM calculation.

Finally, Cory King stated that OHIC would conduct a study of options around setting a minimum downside risk threshold for ACO contracts.

The next steps are for OHIC staff to make redline edits based on feedback during today's meeting and to distribute to the Committee. A two week comment period will open and the draft Plan will go to the Commissioner by January 1st. 2016.

The meeting was concluded with no public comment.

The Committee will reconvene in the fall of 2016.

Draft Rhode Island 2017 Alternative Payment Methodology Plan Recommended to Health Insurance Commissioner Kathleen C. Hittner November 30, 2015

The Alternative Payment Methodology Advisory Committee recommends that Health Insurance Commissioner Kathleen C. Hittner adopt the following Alternative Payment Methodology Plan for 2017.

I. Background and Purpose

{Example Introductory Language}

This 2017 Alternative Payment Methodology Plan is adopted pursuant to Section 10(d)(2) of Regulation 2: Powers And Duties of the Office of the Health Insurance Commissioner, by Kathleen C. Hittner, Health Insurance Commissioner.

The purpose of Section 10(d)(2) of Regulation 2 is to "significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.[1]"

The APM Plan components, detailed below, are designed to provide incentives to move the Rhode Island marketplace away from the fee-for-service payment model and towards payment models that encourage high quality and lower cost of care.

II. Definitions from the 2016 Plan

(a) "Alternative Payment Methodology" means a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:

- Improving quality of care; and
- Improving population health; and
- Reducing cost of care growth; and
- Improving patient experience and engagement, and
- Improving access to care.

To qualify as an APM, the payment methodologies must define and evaluate cost performance relative to a "budget" that may be prospectively paid or retrospectively reconciled. Providers are rewarded for managing costs below the budget, should quality performance be acceptable, by retaining some or all of the savings. Providers may also be responsible for some or all of the costs that exceed the budget.

[1] OHIC Regulation 2 Section 10(d)(2)(A)

While generally not employing the aforementioned budget methodology, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to PCPs or to ACOs will be included in the calculation of an insurer's APM target for calendar years 2016 and 2017.

(b) "Approved Alternative Payment Methodologies" include:

- Total cost of care budget models;
- Limited scope of service budget models;
- Episode-based (bundled) payments;
- Infrastructure payments and pay-for-performance payments for 2016-2017, and
- Other non-fee-for-service payments that meet the definition (a) above as approved by OHIC.

(c) The Alternative Payment Methodology Plan specifies two targets for insurers to achieve.

(1) "Alternative Payment Methodology (APM) Target" means the aggregate use of APMs as a percentage of an insurer's annual commercial insured medical spend. The APM Target shall include:

- All fee-for-service payments under a population-based total cost of care contract with shared savings or shared risk;
- Episode-based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments;
- Supplemental payments for infrastructure development and/or Care Manager services to patient-centered medical homes and to accountable care organizations, and all pay-for-performance payments for years 2016 and 2017, and
- Shared savings distributions.

(2) "Non-Fee-for-Service (FFS) Target" means the use of strictly non-fee-for-service alternative payment methodology payments as a percentage of an insurer's annual commercial insured medical spend. The Non-FFS target defined in this subsection (2) is a subset of the APM Target defined in subsection (1), above. The Non-FFS Target shall include:

- Episode-based (bundled) payments with shared risk;
- Limited scope-of-service capitation payments and global capitation payments;
- Quality payments that are associated with a non-fee-for-service payment (e.g., a quality payment on top of a bundled payment or PCP capitation);
- Shared savings distributions, and
- All supplemental payments for infrastructure development and/ or Care Manager services to patient-centered medical homes and to accountable care organizations, for years 2016 and 2017.

III. Alternative Payment Methodology Targets

For purposes of meeting the "Alternative Payment Methodology Target" for calendar years 2017 and 2018, health insurers subject to the Affordability Standards shall take such actions as necessary to have 40% of insured medical payments made through an alternative payment

methodology throughout the entirety of calendar year 2017 and 50% of insured medical payments made through an alternative payment methodology throughout the entirety of calendar year 2018.

For purposes of meeting the "Non-Fee-for-Service Target" for calendar years 2017 and 2018 health insurers subject to the Affordability Standards shall take such actions as necessary to have 6% of insured medical payments made through non-fee-for-service models for the entirety of calendar year 2017 and 10% of insured medical payments made through non-fee-for-service models for the entirety of calendar year 2018.

IV. Identified Support for Value-Based Payment Reform

1. Specialist Engagement

Specialists play an important role within the health care system, influencing use of other expensive health care resources, particularly inpatient hospital services, outpatient procedures, imaging and testing. Primary care providers (PCPs) rely on specialists to treat more complex conditions than they are trained to care for, therefore specialists are important partners in implementing changes in payment models.

To ensure that specialists are engaged in initiatives to transform health care payment to support improved quality and increased efficiency through coordinated care, Rhode Island's health insurers shall take such actions as necessary to develop programs with specialist providers that meet the following requirements.

Requirements:

1. Align incentives between PCPs and specialists to better coordinate care and improve the patient experience by improving communication among patients, PCPs and specialists, and
2. Develop and implement alternative payment methodologies with high volume specialties and/or specialty care practices consistent with definitions under Section 2 above.

By June 1st, 2016 health insurers shall submit to OHIC, for approval by the Commissioner, a plan to carry out requirements 1 and 2 above. The plan should detail the specific programs and how they will advance the goals articulated in this 2017 APM plan.

Consistent with requirement 1 above, health insurers may also apply financial incentives for specialists to participate in practice transformation. An example would be RIQI's TCPI grant.

Finally, OHIC shall work with payers, providers, and consumers to develop publicly available measures of specialist cost and quality.

2. Consumer Safeguards

Consumers have an interest in high quality patient-centered care that is organized around the needs and goals of each patient. Consumer advocates have expressed concerns that some APMs may encourage providers to cherry-pick patients based on health status, skimp on care, and engage in other practices that impede access to high quality patient-centered care. In response to these concerns, the following insurer-provider contracting standards shall take effect.

A. Contracting Requirements:

1. All insurer contracts that transfer financial risk to ACOs shall 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. Quality measures should include at least one measure that assesses patient experience and/or access to referral services.

2. All insurer contracts that transfer financial risk to ACOs shall include clinical risk adjustment as part of the payment model.

B. OHIC Monitoring and Review of Information:

OHIC may collect and analyze 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.

OHIC may review any ACO contract to ensure compliance with the contracting requirements above.

3. Downside Risk

OHIC shall study options around setting a minimum downside risk threshold for ACO contracts. OHIC shall issue a report by June 1, 2016 detailing these options and open a 30-day public comment window. After public comment, the Commissioner may adopt standards in conjunction with the approval of insurer rate filings.

V. Conclusion

{Example Conclusion Language}

This 2017 Alternative Payment Methodology Plan is derived from the draft recommendations of the Alternative Payment Methodology Committee.

Rhode Island 2016 Alternative Payment Methodology Plan
As Adopted by Health Insurance Commissioner Kathleen C Hittner
July 9th, 2015

I. Background and Purpose

This 2016 Alternative Payment Methodology Plan is adopted pursuant to Section 10(d)(2) of Regulation 2: Powers And Duties of the Office of the Health Insurance Commissioner, by Kathleen C Hittner, Health Insurance Commissioner.

The purpose of Section 10(d)(2) of Regulation 2 is to "significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services."[1] To carry out the purposes of this subsection a plan was developed over the course of four Committee meetings by the Committee members, who are listed in Appendix A. The Committee's plan was then adopted by the Commissioner.

The 2016 APM Plan sets forth:

1. A definition of Alternative Payment Methodologies (APMs);
2. Specification of the types of payments that shall be considered APM payments;
3. Specification of 2016 APM targets for Rhode Island's health insurers, and;
4. Identified support for value-based payment reform in 2016.

The APM Plan components, detailed below, are designed to provide incentives to move the Rhode Island marketplace away from the fee-for-service payment model and towards payment models that encourage high quality and lower cost of care.

II. Definitions

(a) "Alternative Payment Methodology" means a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:

- Improving quality of care; and
- Improving population health; and
- Reducing cost of care growth; and
- Improving patient experience and engagement, and
- Improving access to care.

To qualify as an APM, the payment methodologies must define and evaluate cost performance relative to a "budget" that may be prospectively paid or retrospectively reconciled. Providers

[1] OHIC Regulation 2 Section 10(d)(2)(A)

are rewarded for managing costs below the budget, should quality performance be acceptable, by retaining some or all of the savings. Providers may also be responsible for some or all of the costs that exceed the budget.

A to-be-defined percentage of APMs must include meaningful downside risk by the end of calendar year 2017.[2]

While generally not employing the aforementioned budget methodology, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to PCPs or to ACOs will be included in the calculation of an insurer's APM target for calendar years 2016 and 2017.

(b) "Approved Alternative Payment Methodologies" include:

- Total cost of care budget models,
- Limited scope of service budget models,
- Episode-based (bundled) payments,
- Infrastructure payments and pay-for-performance payments for 2016-2017, and
- Other non-fee-for-service payments that meet the definition (a) above as approved by OHIC;

(c) The Alternative Payment Methodology Plan specifies two targets for insurers to achieve.

(1) "Alternative Payment Methodology (APM) Target" means the aggregate use of APMs as a percentage of an insurer's annual commercial insured medical spend. The APM Target shall include:

- All fee-for-service payments under a population-based total cost of care contract[3] with shared savings[4] or shared risk.[5]
- Episode-based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments.
- Supplemental payments for infrastructure development and/or Care Manager[6] services to patient-centered medical homes and to accountable care organizations, and all pay-for-performance payments for years 2016 and 2017, and;
- Shared savings distributions.

(2) "Non-Fee-for-Service (FFS) Target" means the use of strictly non-fee-for-service alternative payment methodology payments as a percentage of an insurer's annual commercial

---

[2] The 2017 target date was supported by a majority vote of the Committee. Four members abstained and one member voted "no".

[3] OHIC Regulation 2 Section 3(l)

[4] OHIC Regulation 2 Section 3(n)

[5] OHIC Regulation 2 Section 3(o)

[6] As stated within the 2016 Care Transformation Plan submitted by the Care Transformation Advisory Group, Care Manager can be interpreted to mean Care Coordinator for pediatric services. For a definition of pediatric care coordination, see R. Antonelli, J McAllister, J. Popp. "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework." The Commonwealth Fund, publication number 1277, May 2009.

insured medical spend. The Non-FFS target defined in this subsection (2) is a subset of the APM Target defined in subsection (1), above. The Non-FFS Target shall include:

- Episode-based (bundled) payments.
- Limited scope-of-service capitation payments and global capitation payments.
- Quality payments that are associated with a non-fee-for-service payment (e.g., a quality payment on top of a bundled payment or PCP capitation)
- Shared savings distributions, and
- All supplemental payments for infrastructure development and/ or Care Manager services to patient-centered medical homes or to accountable care organizations for years 2016 and 2017.

III. Alternative Payment Methodology Targets

For purposes of meeting the 2016 "Alternative Payment Methodology Target," health insurers subject to the Affordability Standards shall increase the percentage of insured medical payments that are made through alternative payment methodologies by 7.0 percentage points compared to the 2014 baseline percentage calculated by OHIC.

For purposes of meeting the 2016 "Non-Fee-for-Service Target," health insurers subject to the Affordability Standards shall increase the percentage of insured medical payments that are made through non-fee-for-service methodologies by 1.5 percentage points compared to the 2014 baseline percentage calculated by OHIC.

IV. Identified Support for Value-Based Payment Reform

(a) 2015/2016 Stakeholder Activities

The following activities shall be executed during the balance of 2015 and 2016 to advance value-based payment reform in Rhode Island.

1. Core Measure Set

The Committee recognizes the need to coordinate measures payers use to reward performance so that providers are receiving a consistent, coherent message regarding priorities for change. The Commissioner shall formally request that the SIM HIT and Measurement Work Group be convened and develop a core measure set for use by all Rhode Island public and private payers. The state shall actively engage payers and providers in the development of the core measure set and the core measure set developed shall offer payers and providers flexibility in choice of measures.

2. Purchaser and Consumer Engagement

The Committee also recognizes that purchaser (employer and consumer) engagement is essential to advancing value-based payment reform. Therefore, the Office of the Health Insurance Commissioner shall redouble its efforts to engage employers and consumers in health reform. OHIC shall put employer/consumer engagement in payment reform on the agenda of

its Health Insurance Advisory Council (HIAC). HIAC will be asked to design approaches to engaging and communicating with a diverse group of employers, including small and large employers and fully-insured and self-insured groups.

Furthermore, OHIC, or its community partners, shall work to identify funding to support consumer/employer engagement efforts, including implementation of messaging strategies around purchaser engagement in payment reform and consumer education and assistance with innovative plan designs that employ demand-side incentives to support the use of alternative payment models.

3. Plan Design

Cognizant that health insurers file plans for OHIC approval more than six months before the plans are marketed, during the rest of calendar year 2015 and calendar year 2016, Rhode Island's health insurers should continue to design product offerings to be marketed in 2017 and thereafter that include tiered networks that align provider and enrollee incentives to promote highly efficient, high quality networks. Furthermore, the Committee shall deal more fully during the fall 2015 convening with aspects of plan design as a facilitator of payment reform, including the potential modification of PPO products to require PCP selection.

4. Fall Committee Meetings

The Alternative Payment Methodology Advisory Committee shall reconvene on or around October 1st, 2015. The Committee's fall agenda will include specification of 2017 APM targets, activities to support achievement of the 2017 APM targets, and engagement of specialists in payment reform. Furthermore, the following topics shall be addressed during the course of the fall meetings:

4.1. Safeguard Access to Care: Some Committee members expressed concerns that the movement to shared risk and full risk payment models may adversely affect consumer access to appropriate medical care. Cognizant that advanced risk-based payment models should be designed to improve patient care and facilitate access through greater care coordination and affordability, OHIC shall review and present options in the fall for safeguarding consumers and protecting against adverse provider behavior resulting from excessive provider assumption of downside risk. In developing options, OHIC shall consider revising the definitions of APMs, as needed, and developing a process for monitoring for pernicious behavior that impedes access.

4.2 Create a Measurable Definition of "Meaningful Downside Risk": There is an emerging consensus that downside risk is necessary, but not sufficient, to fundamentally align provider incentives to meet the goals of the Triple Aim. A majority of Committee members endorsed 2017 as the target date for alternative payment models to introduce meaningful downside risk. The 2017 APM Plan shall include an operational definition of "meaningful downside risk" in the context of the payment reform targets and activities developed pursuant to the OHIC Affordability Standards.

5. Expansion of Committee Participation

The Health Insurance Commissioner shall designate representatives from the specialist physician community and an advocate for small independent practices to further enhance the

Committee. Furthermore, the Commissioner shall expand employer representation and invite representation from the State of Rhode Island Office of Employee Benefits.

V. Measurement and Tracking

By July 15th, 2015 OHIC shall develop a compliance tracking tool for Rhode Island's health insurers to report progress on achieving the payment reform targets specified herein. OHIC will work collaboratively with the insurers to develop the tool. OHIC shall issue guidance on alternative payment methodology reporting by September 1st, 2015. OHIC shall collect an initial round of alternative payment methodology data for calendar year 2014 by October 15th, 2015. Data collection will occur on a quarterly basis thereafter.

VI. Conclusion

This 2016 Alternative Payment Methodology Plan is derived from the draft recommendations of the Alternative Payment Methodology Committee.

Dated at Cranston, Rhode Island this 9th day of July, 2015.

Kathleen C Hittner, MD.
Health Insurance Commissioner
Office of the Health Insurance Commissioner

Appendix A

Committee Membership

Committee Member	Affiliation
Erik Helms	BCBSRI
Kevin Callahan	United
Todd Whitecross	Tufts
Patrick Tigue	NHPRI
Mike Souza	HARI
Dan Moynihan	Lifespan
Domenic Delmonico	CNE
Chris Dooley	CharterCare
Tom Breen	South County
Al Kurose	Coastal Medical
Noah Benedict	RIPCPC
Chuck Jones	Thundermist
Sam Salganik	RIPIN
Pat McGuigan	Providence Plan
Bill Almon Jr.	Claflin Co.
Al Charbonneau	RIBGH
Alok Gupta	RIQI
Pano Yeracaris	CTC-RI