**State of Rhode Island Office of the Health Insurance Commissioner**
**Alternative Payment Methodology Advisory Committee**
**Meeting Agenda**
**November 5, 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**

3) **Next Steps**

4) **Public Comment**

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## 1) 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, Susane Dressler (for Dan Moynihan), Tom Breen, Liz McClaine (for Patrick Tigue), William Cioffi, David Paller, Weber Shill, Pano Yeracaris, Noah Benedict.

## 2) Recap of 10-16-2015 Meeting

Cory King, Principal Policy Associate for OHIC, opened the meeting with a review of the key takeaways from the 10-16 meeting. Among these were: 1. The Committee endorsed setting targets over a multi-year period (but not specific numerical targets), 2. All parties need to feel the same "burning platform," 3. There is a need for multi-payer specialist performance information on quality and efficiency. The APCD may be leveraged for this, 4. Important contextual variables (such as ACO structure) influence how we think about downside risk.

## 3) Analysis of APM Adoption by Provider Type

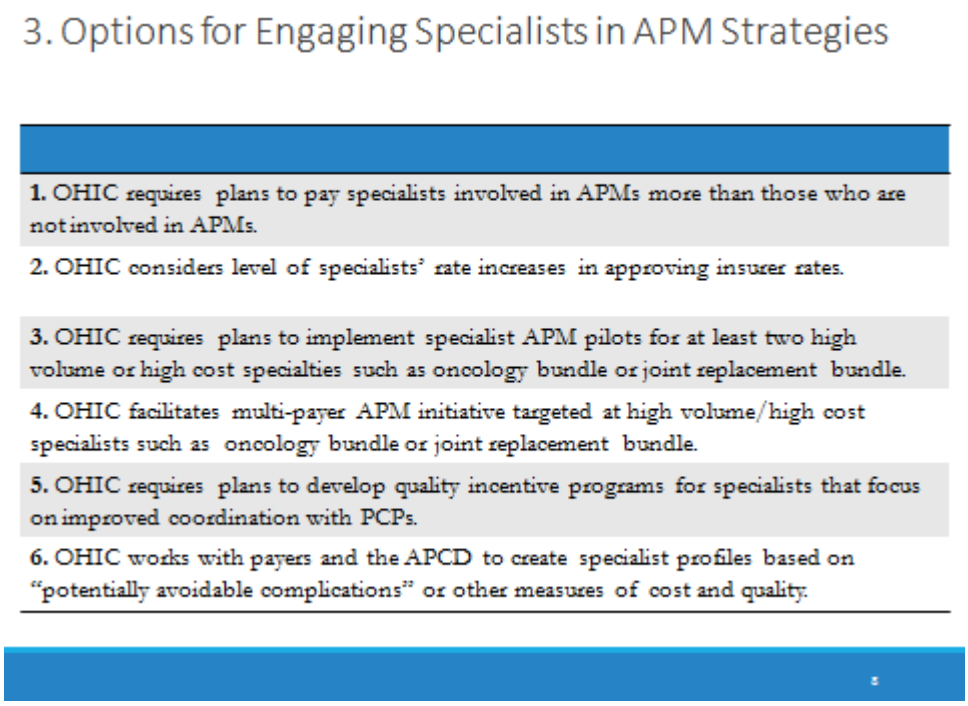
Next Mr. King briefly reviewed data on how APM payments are distributed across provider/service categories (primary care, specialty, hospital, other). The key takeaway was that during the time period reflected in the data, APM payments were largely primary care or hospital focused. There were no specific questions about the data.

Mr. Delmonico asked if the self-insured were participating in APMs and if the insurers had a method of distributing money from the self-insured group to providers if shared savings are achieved. Mary Craig of United Healthcare answered that United requires opt-out for self-insured accounts. Michael Bailit noted that he has observed national trends to be moving toward opt-out, rather than opt-in. Erik Helms of BCBSRI said that Blue Cross is migrating toward having all of their self-funded groups support value-based payment and that they were about half way there now.

## 4) Presentation & Discussion: Goals and Activities for the 2017 APM Plan

Next Mr. King noted that the Committee will focus its attention on two key topics during the meeting: options for engaging specialists in APM strategies and the draft definition of meaningful downside risk.

The slide inserted below shows the proposed strategies to engage specialists in payment reform. Each strategy was discussed by the Committee.




Mr. Delmonico asked whether the state needed to be prescriptive. ACO's are going to tackle specialist-related issues and the concern is that the state will take away flexibility from the Accountable Entities. Commissioner Hittner responded that the system hasn't done very well without some regulation. If someone has an innovative idea that may conflict with existing standards, they should approach the Office and we will consider a waiver.

Dr. Lou Rice asked for clarification of strategy 1 on the list. Cory King stated that the option allows for payments to specialists involved in APMs to be increased at a higher rate than specialists not involve in APMS. Dr. Rice commented that he worries about bundled payments, since so much, like pharmacy and imagining, is uncontrollable.

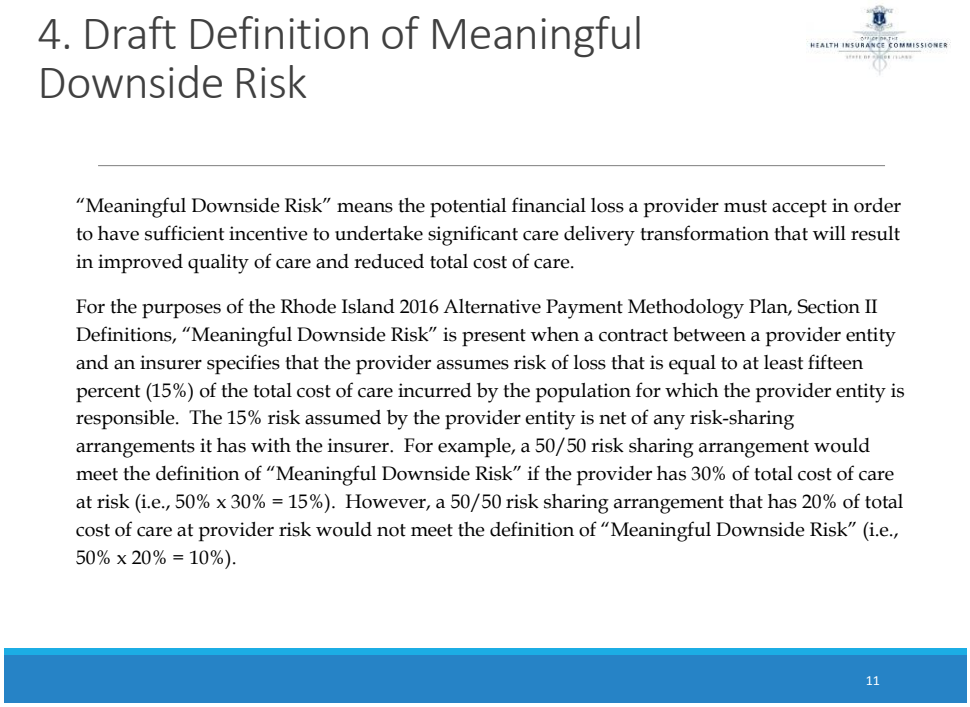
Dr. Cioffi asked what an oncology bundle looks like. There is so much variation between cancers. Dr. Ted Long stated that we should look at scope, exclusion criteria, and outcomes. OHIC promised to bring some examples to the next meeting.

Pano Yeracaris stated that he supports options 5 and 6 on the list. Option 5 would require insurers develop and implement quality incentive programs with specialists that focus on improved coordination with PCPs. Option 6 would require stakeholders to develop specialist profiles using cost and quality data to help inform and guide referrals.

There was emerging consensus among the members of the Committee that the Committee should endorse options 5 & 6. Erik Helms stated that the group should contemplate a series of strategies to engage specialists. Blue Cross is pursuing all six of the approaches listed. Mr. Helms also stated that OHIC should support products that advance integration between primary care and specialists.
Some members expressed interest in leveraging SIM dollars and the RIQI grant to advance the specialist strategies. Rhode Island could also learn from other states, like Michigan, which are setting up, or have set up, clinical registries.

Committee members asked for OHIC to draft a problem statement and goals around specialist engagement to be shared at the next meeting. OHIC will do so.

Next the Committee turned its attention to a continued discussion of the draft definition of meaningful downside risk.




Michael Bailit, of Bailit Health, began by saying that during the last meeting, his initial explanation of the draft definition was valid. The draft definition says that an ACO should be at risk of at least 15% of the total cost of care for their attributed population.

Sam Salganik expressed grave concerns with this definition because it would expose a physician group-based ACO, without significant capital reserves, to losses that could exceed their annual revenue. This was a concern express during the last meeting. Mr. Bailit asked members of the Committee for their suggestions in order to account for differences in ACO structure and capability to bear risk.

Dr. Kurose noted that the slide showing feedback that OHIC received misrepresented his feedback. Dr. Kurose suggested a 5% withhold on FFS revenue, not a risk exposure of 5% of total cost of care. Dr. Kurose

admonished the group that we do not want to impose barriers to providers moving into alternative payment arrangements by being too aggressive with risk sharing in the short run.

Some Committee members advocated for a model that places providers at risk for a percentage of their revenue, instead of the total cost of care for their attributed population. This model could still incent changes in provider behavior, while weakening fee for service.
The Committee did not reach a consensus on the definition. OHIC will draft a revised definition that accounts for provider types and may tie risk to revenue.

Pat McGuigan summed up the conversation: "we all agree we want to change behavior, recognize provider differences, and not screw anybody."

Dr. Rice cautioned that there is a downside to pushing services to the lowest cost setting. We have some expensive, but needed, services in the state that don't pay for themselves. Some services subsidize other services. Commissioner Hittner agreed, but reiterated that we need to address costs, and do it in a responsible way.

The meeting was concluded with no public comment.

The next meeting will be Friday November 20th 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

RHODE ISLAND ALTERNATIVE PAYMENT METHODOLOGY ADVISORY COMMITTEE MEETING

NOVEMBER 5, 2015

# Agenda

1. Key Takeaways from the 10-16 Meeting
2. Data on APM Adoption by Provider Type
3. Options for Engaging Specialists in APM Strategies
4. Draft Definition of “Meaningful” Downside Risk
5. Next Steps

# 1. 10/16 Key Takeaways

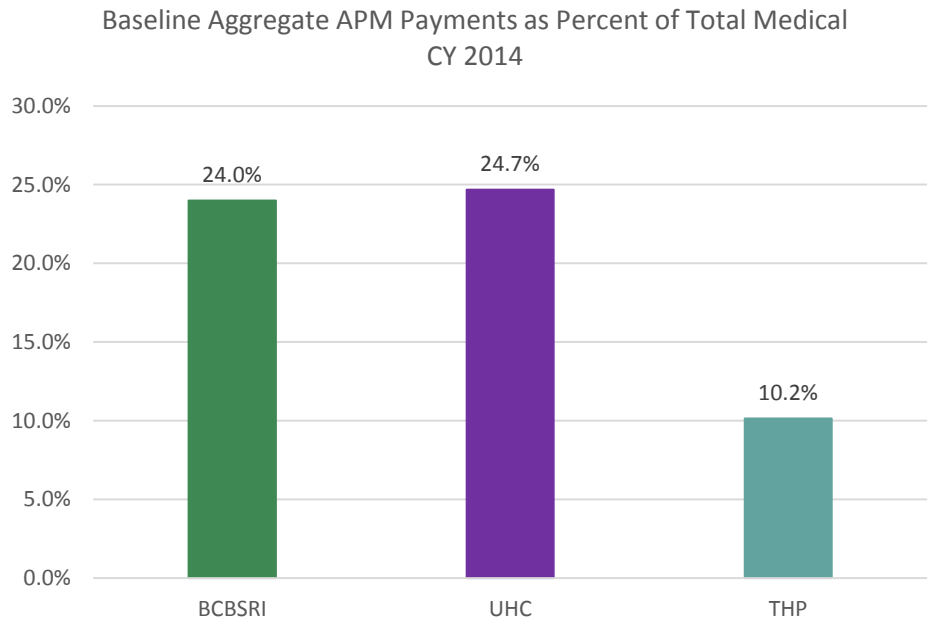
- The Committee endorsed setting APM targets over a multi-year period. Specific numerical targets were not endorsed.
- Everyone needs to feel the same “burning platform.”
- Committee members asked for more detailed breakdowns on how APM dollars are allocated by provider type.
- There is need for multi-payer specialist performance information on quality and efficiency. The APCD could be leveraged for this.
- Downside risk in payment arrangements is an important goal. However, there are contextual variables at play. For example, ACO structure, infrastructure support, and access to reinsurance to name a few.

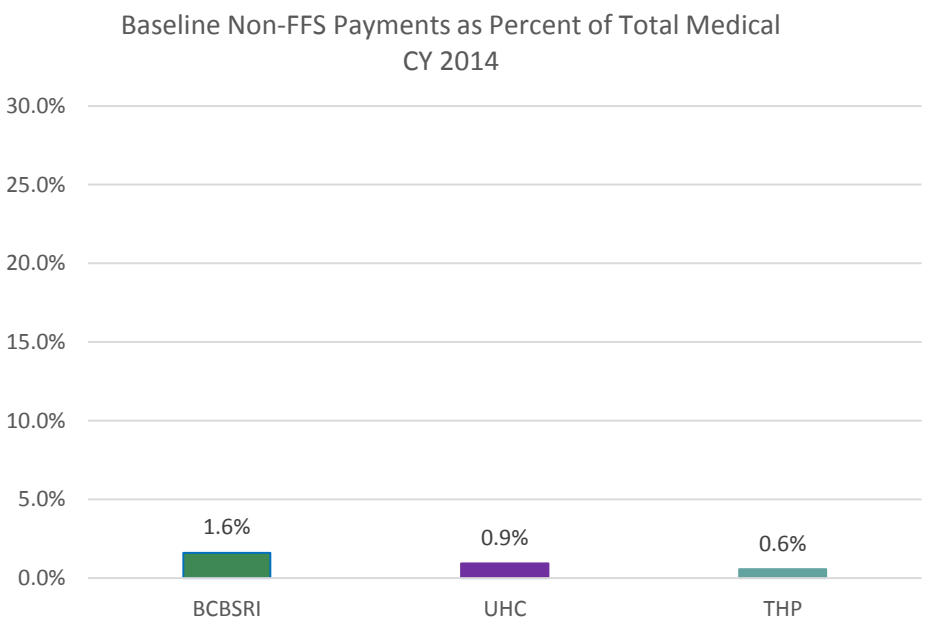
# 2. Data on APM Adoption by Provider Type

Questions raised during the 10/16 meeting:

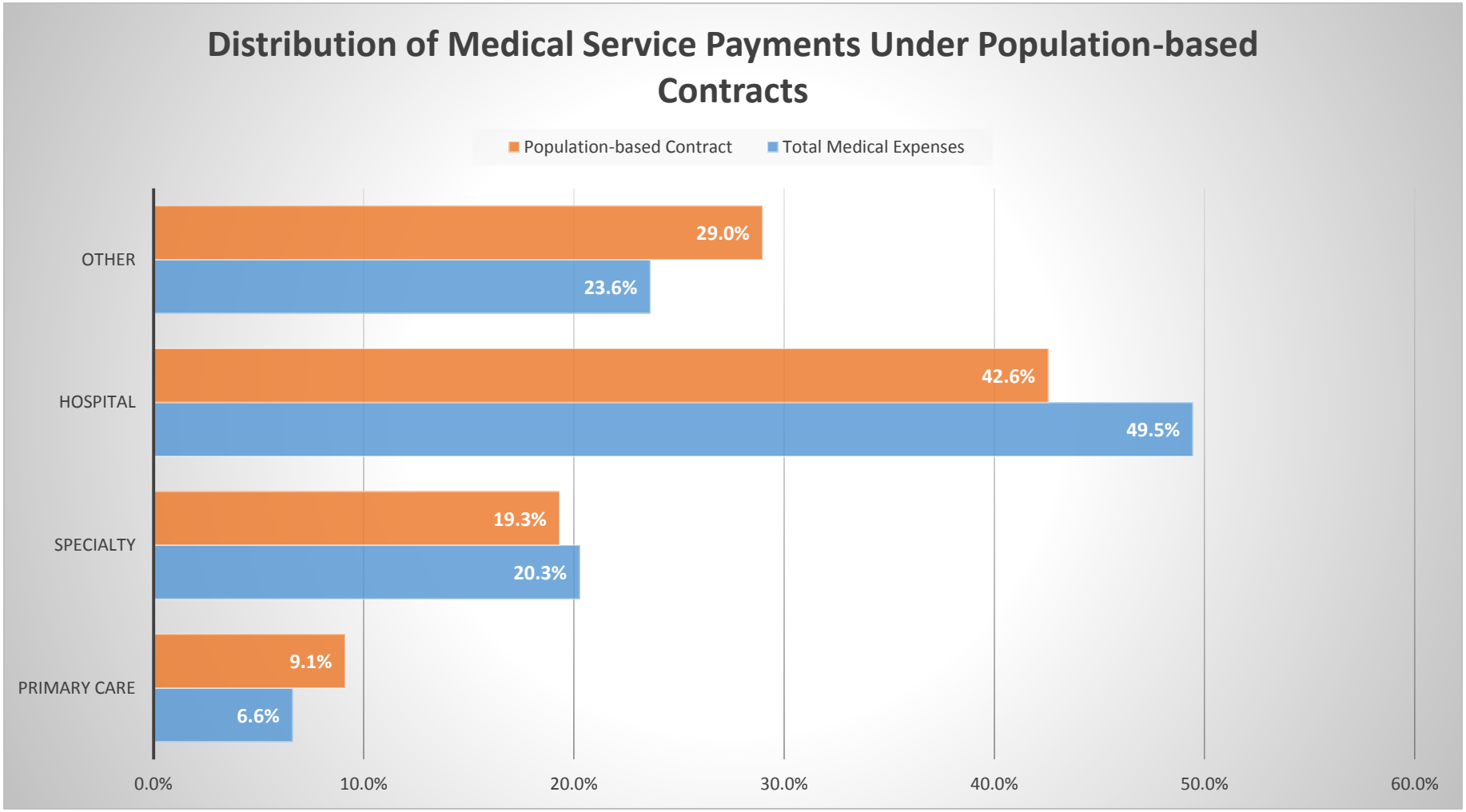
- Which provider types are best positioned to operate under APMs and, specifically, non-FFS based payment models?
- Where can we get the biggest bang for our buck?

# 2014 APM & Non-FFS Baselines



# 2013-14 Distribution of Payments: All Commercial Payer Fully Insured




Note: Data refer to July 2013 – June 2014.

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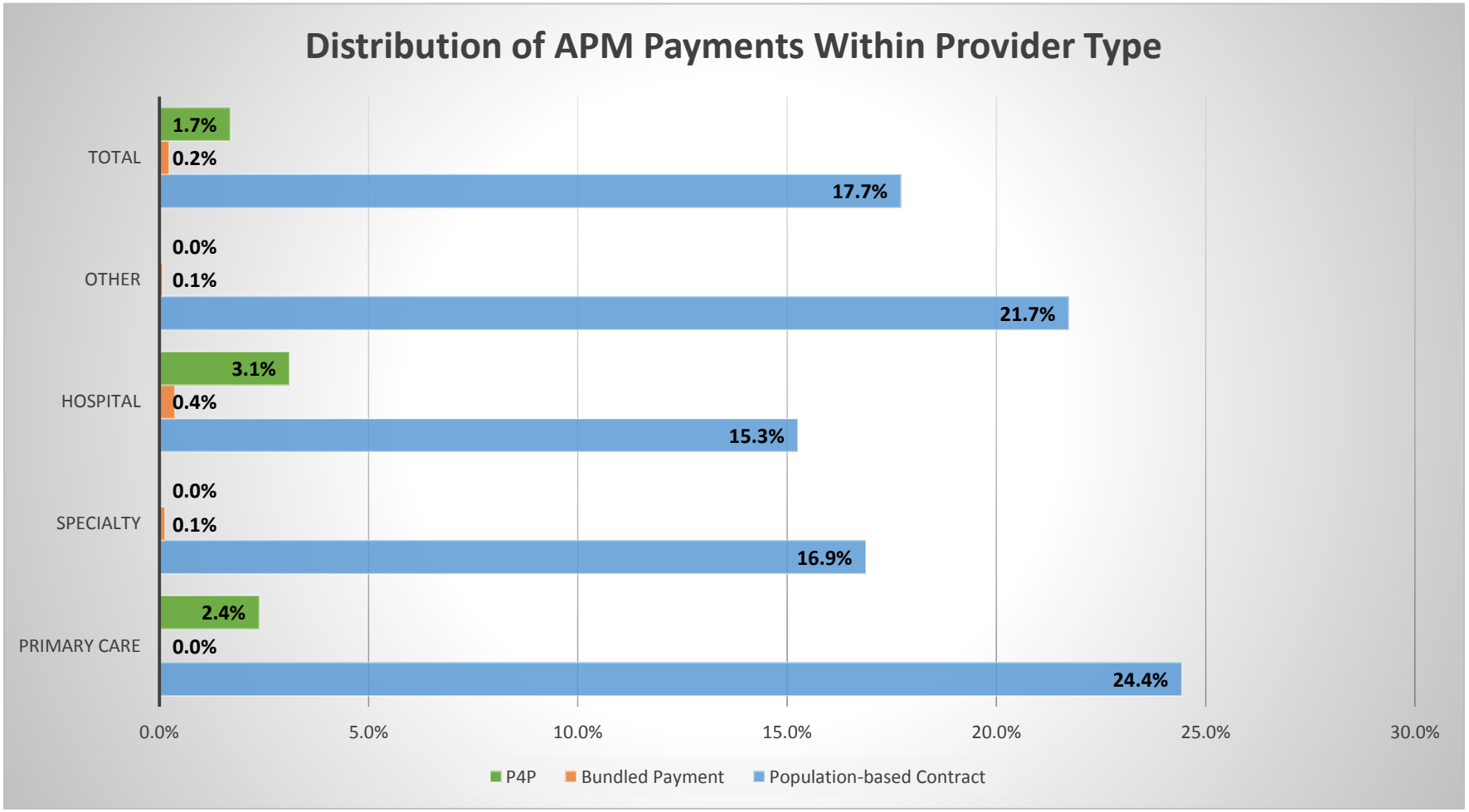


Note: Data refer to July 2013 – June 2014.

# 3. Options for Engaging Specialists in APM Strategies

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| **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

Which of these options should the Commissioner consider to advance the affordability objectives of OHIC?

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

Are there other options that you would like to propose?

# 4. Draft Definition of Meaningful Downside Risk

- Since the last meeting OHIC received feedback on the definition of meaningful downside risk.
- Feedback ranged from 5% to 15%.
- Goals for today:
  - Try to reach consensus around the numerical risk threshold or a reasonable alternative approach.
  - Gather information and feedback for the Commissioner to develop standards should the Committee fail to reach agreement.

# 4. 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%).

# Discussion

Is there anything about the 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?

# 5. Next Steps

OHIC will further refine recommendations in light of feedback received today.

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

Next Meeting: Friday November 20th at 8 AM.