State of Rhode Island Office of the Health Insurance Commissioner
Alternative Payment Methodology Advisory Committee
Meeting Agenda
October 16, 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 Committee Charge**

3) **Review 2016 APM Plan and State Initiatives to Promote Payment Reform Since Last Meeting**

4) **Considerations for the 2017 APM Plan**

5) **Public Comment**

State of Rhode Island Office of the Health Insurance Commissioner
Alternative Payment Methodology Advisory Committee
Meeting Minutes
October 16, 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
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1) Introductions & Review of Agenda

Members in Attendance: Erik Helms, Billy Almon, Mary Craig, Dr. Al Kurose, Al Charbonneau, Sam Salganik, Todd Whitecross, Chris Dooley, Alok Gupta, Dr. Ted Long (DOH), Domenic Delmonico, Dan Moynihan, Chuck Jones, Tom Breen, Patrick Tigue

2) Review Committee Charge

Cory King, Principal Policy Associate for OHIC, opened the meeting with a summary of the Joint Advisory Committee meeting on October 1st and a review of the APM Advisory Committee's charge. The constituent parts of this charge include specifying annual targets for increasing the use of APMs and activities necessary to support achievement of the targets. He noted that the Committee convened in the fall of 2015 was required to develop a plan that specifically addresses medical and surgical specialty providers.

3) Review 2016 APM Plan and State Initiatives to Promote Payment Reform Since Last Meeting

Next Mr. King briefly reviewed the final 2016 APM plan as developed with the input of the Advisory Committee in the spring. Key elements of the 2016 plan include: definition of alternative payment methodologies, a two-part APM target for commercial insurers, specific numerical targets for APM use defined as fixed percentage point increases above 2014 baselines, and activities by the health plans and OHIC to support achievement of the targets.

Mr. King noted that OHIC was unsuccessful in its efforts to recruit specialists and a representative of the state employee health plan to join the committee. OHIC may use the RI Medical Society as a means of disseminating recommendations that impact specialist providers.

Dr. Kurose stated that he knows specialists who are doing innovative work and will reach out to them to invite their participation.

Mr. King also threw light on other state initiatives to promote payment reform, including the Reinventing Medicaid initiative and the Governor's Work Group for Health Care Innovation. These initiatives wrapped up or got underway after the spring convening of the APM Committee. Mr. King noted that, given the size of Medicaid as a major payer, and the goals of the Administration to improve RI's health care system, these initiatives signal a serious move to value-based payment and APM adoption.

As this work continues committee members stressed that we need to evaluate the impact of APMs on the total cost of care. How much savings are being realized under APMs?

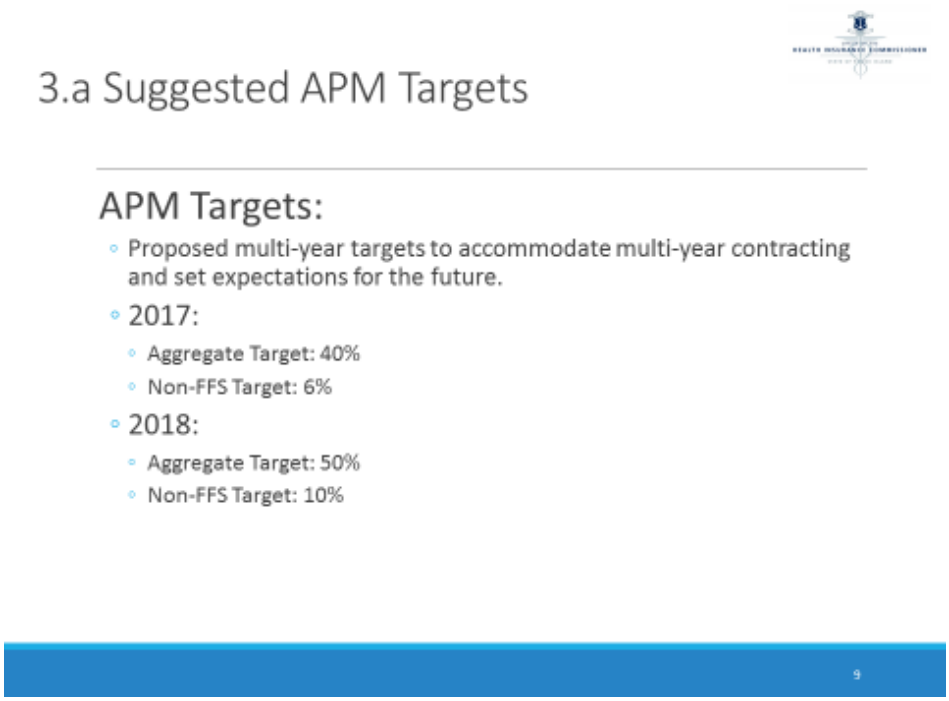
4) Considerations for the 2017 APM Plan

Next Mr. King introduced an overview of the topics the committee will be asked to consider in drafting the 2017 APM plan. The four topics include: 2017 APM targets, activities involving specialists, proposals to safeguard consumer access under risk based contracts, and defining "meaningful downside risk."

Mr. King asked the committee to endorse setting targets over a multiyear period. The rationale for this request is grounded in the common practice of multi-year contracting between health plans and providers. Targets over multiple years will help the contracting parties understand the long-term expectations up front and enable them to better plan to meet the expectations.

The Committee endorsed setting targets over multiple years.

OHIC proposed the following schedule for APM targets through 2018. The 2018 aggregate targets align with the goals articulated for the RI Medicaid program on page 14 of the Reinventing Medicaid report and the goals articulated for the Medicare Fee for Service program articulated by Secretary of Health and Human Services Sylvia Mathews Burwell.



The Committee was not asked to endorse these specific targets during the meeting, but some members shared their reactions.

Erik Helms stated that there needs to be shared accountability for meeting these targets, payers should not be solely responsible. Other committee members expressed the importance of provider readiness to operate effectively under APMs. Dr. Kurose stated that we don't know to what degree providers are ready to

embrace real payment reform. He suggested provider readiness be studied. Dr. Ted Long, from the Department of Health, informed the committee that DOH possesses data that was collected for the statewide capacity and utilization study that throws light on provider readiness. This data could be presented after November 1st.

Around the non-FFS targets committee members asked if OHIC could provider finer breakdowns of non-FFS payments by provider type/setting, i.e., primary care, specialty, hospital. OHIC will follow up.

Sam Salganik mentioned that large patient populations are required to implement non-FFS payment models. Alok Gupta reminded the committee that the RIQI PTN grant is meant to transform care delivery and enhance provider readiness to embrace payment reform. Al Charbonneau stated that if our goal is to control premiums, then we should figure out which providers have the biggest impact. Primary care has least impact on premiums. Dominic Delmonico suggested that OHIC look into penalty provisions in the legislation that replaced the Medicare Sustainable Growth Rate (SGR) for physician payment. [The legislation referred to is the Medicare Access and CHIP Reauthorization Act]. Mr. Delmonico also expressed doubts about focusing on APMs for specialists, in his view, looking at referral management may make more sense.

Next, Marge Houy of Bailit Health, presented options for addressing specialist payment models in the 2017 APM plan. Mrs. Houy also presented ideas, drawn from other states, on designing enrollee-facing and provider-facing referral reports for specialist services which include cost and quality data.

The payer representatives stated that they are using a mix of payment arrangements with specialists. Blue Cross Blue Shield of RI has episode-based payments for maternity and orthopedics. They will also introduce a new P4P program in 2016. Erik Helms stated that there is no single approach to take with specialists.

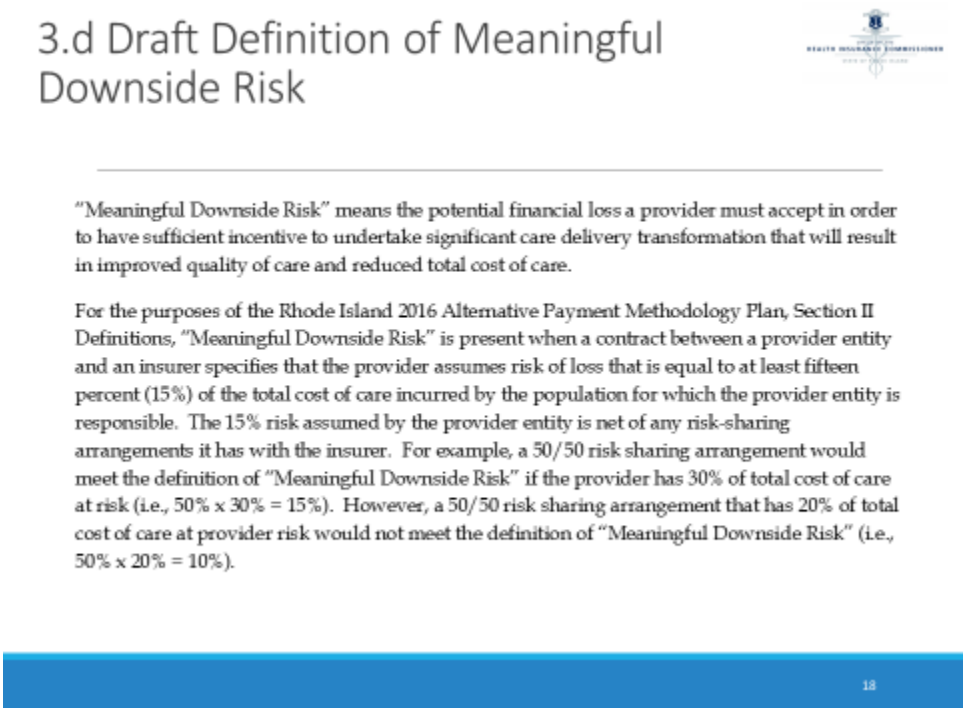
Mrs. Houy was asked to do some follow up research on the enrollee-facing and provider-facing referral reports for specialist services. Some committee members noted that patient populations may be too small to produce meaningful reports by payer and suggested using the state's all payer claims database to pool experience across payers for these reports. OHIC will take this suggestion as an action item for further development.

Mr. King introduced the next topic on safeguarding consumer access to care under risk-based contracts. During the spring convening some committee members expressed concern that APMs which incorporate downside risk may incent providers to cherry-pick patients and skimp on care, which would have deleterious effects on access and outcomes. Two proposed options to guard against these practices were to modify the APM definition, such that payment methodologies that impair consumer access to care would not count toward achievement of an insurer's APM target. The key challenge to this option is the difficulty of measuring deterioration in access and linking this to specific payment models. A second option was for OHIC to require insurers to submit written summaries of APMs to OHIC which address efforts to monitor access and describe contractual incentives and safeguards to obviate provider risk selection, skimping, etc. OHIC asked committee members for input and ideas.

Dominic Delmonico suggested that we look a measuring patient satisfaction in line with the Medicare Shared Savings Program (MSSP). Dr. Kurose mentioned that the MSSP also monitors for cherry-picking which is something we should look at. Sam Salganik expressed that we need to view this issue from two

perspectives: the patient perspective and the system perspective. He spoke to the need for transparency around ACO performance on quality and cost at a systems level. Mr. Salganik also spoke to the need for a regulatory structure for ACOs, including oversight of financial risk assumption, reserve requirements, etc. Commissioner Hittner noted that a means of monitoring at the patient level is through consumer complaints submitted to OHIC. Mr. Charbonneau declared that RI should become a Choosing Wisely state to promote consumer engagement. A conversation about the merits and demerits of Choosing Wisely ensued.

Finally, Michael Bailit of Bailit Health, presented the draft definition of "Meaningful Downside Risk."



The committee asked clarifying questions about the 15% threshold. Some members noted that downside risk defined as 15% of the total cost of care was a substantial amount of risk for certain provider types, namely primary care driven ACOs, to assume.

Dr. Kurose expressed concern that the downside risk target could expose a physician group practice-based ACO to significant losses.

Committee members stated that it may make sense to vary the downside risk definition by provider type or take an incremental approach. Other suggestions were to tie the target to the percent of non-FFS payments.

There was discussion about whether the wording in the draft definition was clear and OHIC will revise to reflect discussions. Committee members noted that most risk sharing models involve shared risk on the difference between the actual cost of care PMPM and the target cost of care PMPM for the attributed population, with a 50/50 split between payer and provider.

Some committee members noted that providers may face challenges in acquiring reinsurance. One committee member asked whether the state could provide a pool of funds for this purpose.

Todd Whitecross remarked that we need to bear in mind the upside potential in these contracts, in addition to the downside; downside risk looks different in the greater context of upside.

Al Kurose noted that whether incremental infrastructure costs are shared with the payer, or whether they are financed out of provider profits, influences how a provider views the deal with the payer.

Tom Breen asked whether we were moving in the right direction; is this another layer of complexity that we don't need?

Mr. King responded by articulating the reason for the discussion around risk. OHIC regulations require health insurers to have at least 10% of covered lives attributed to provider contracts with downside risk. However, OHIC did not define the level of risk that should be assumed. The discussion around meaningful downside risk helps clarify what level of risk will meaningfully impact provider behavior and advance the affordability standard.

The meet was concluded with no public comment.

The next meeting will be Thursday November 5th at 8 a.m. at the same location.

Alternative Payment Methodology Advisory Committee
Upcoming Meeting Agendas for Fall 2015

Meeting One (October 16, 2015)

- Discuss proposed 2017 and 2018 Aggregate and Non-Fee-for-Service targets
- Review current stakeholder activities to achieve 2016 targets
- Discuss plan design options to promote APM adoption, including strategies for including specialists
- Discuss potential unintended adverse consequences of Total Cost of Care contracting
- Discuss proposed definition of Meaningful Downside Risk
- Discuss plan initiatives to achieve APM targets

Meeting Two (November 5, 2015)

- Finalize recommendations regarding 2017 and 2018 APM targets
- Discuss developing value-based specialists profiles to inform PCP referrals
- Discuss priorities regarding plan design options to promote APM adoption, including strategies for including specialists
- Discuss steps to mitigate unintended adverse consequences of Total Cost of Care contracting
- Finalize strategy for achieving Meaningful Downside Risk targets

Meeting Three (November 20, 2015)

- Finalize recommendations regarding developing value-based specialists profiles
- Finalize recommendations regarding plan design options to promote APM adoption
- Finalize recommendations to mitigate unintended adverse consequences of Total Cost of Care contracting
- Discuss steps to develop, review and submit 2017 APM Plan to the Commissioner by January 1, 2016

Meeting Four (November 30, 2015)

- Finalize 2017 APM Plan

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Considerations for the 2017 Alternative Payment Methodology Plan

RHODE ISLAND ALTERNATIVE PAYMENT METHODOLOGY ADVISORY COMMITTEE MEETING

OCTOBER 16, 2015

Agenda

1. Review Committee Charge
2. The 2016 APM Plan & Other State Initiatives to Promote Payment Reform
3. Considerations for the 2017 APM Plan
   a. Suggested APM Targets
   b. Activities Involving Specialists
   c. Proposals to Safeguard Consumer Access Under Risk Based Contracts
   d. Draft Definition of Meaningful Downside Risk
4. Next Steps

10/1 Joint Committee Summary

Discussion of overlapping topics between the two committees and alignment with other state initiatives

Primary care transformation and ACOs

- Consumer protections
- ACO governance and different ACO models

Focus on Specialists

Standardization and alignment of attribution, risk adjustment and quality measures.

Strategies to accelerate movement towards “accountable care” and APMs

Incentives and disincentives for physicians (PCPs and specialists) and patients

1. Review of Committee Charge

Requirement of Regulation 2:

- **Purpose**: To significantly reduce the use fee-for-service 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 care services.
- **Health insurers** shall annually increase their use of nationally recognized alternative payment methodology payments.

Committee Charge

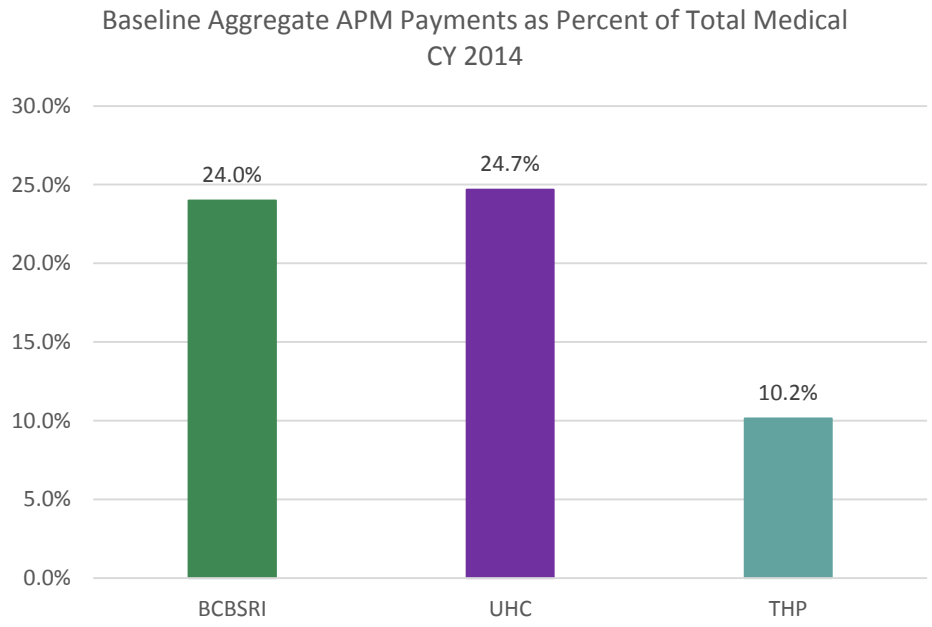
- **The APM Committee** shall develop a plan by January 1st that specifies annual targets for increasing use of APMs and activities necessary to support achievement of the target.
- The Committee that convenes on October 1st, 2015 shall develop a plan that specifically addresses medical and surgical specialty providers.

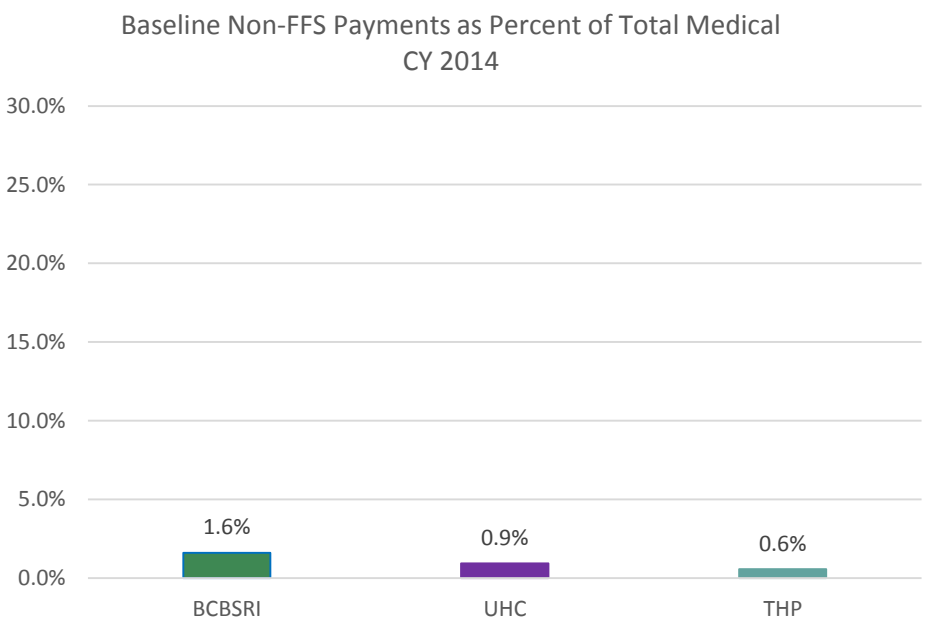
2. The 2016 APM Plan

Key Components:

- Definition of Alternative Payment Methodologies
- Two-part APM Target:
  - Aggregate Target (includes FFS claims payments made under TCOC contracts).
  - Non-FFS Target (strictly non-FFS payments).
- Specific 2016 APM Targets
  - 2016 Aggregate Target: **+7** percentage points above 2014 baseline
  - 2016 Non-FFS Target: **+1.5** percentage points above 2014 baseline
- Activities
  - Core measure set (Being done through SIM).
  - Employer engagement activities (Begin conversations with HIAC).
  - Expand participation to specialists & state employee health plan.
  - Plan Design, Safeguarding Access, Meaningful Downside Risk (Deferred to Fall 2015).

2014 APM & Non-FFS Baselines





2. Other State Initiatives to Promote Payment Reform

Reinventing Medicaid

- In July the Working Group to Reinvent Medicaid endorsed a target of **50%** of Medicaid payments in alternative payment models by 2018.
- The recommendations tie to the Medicare goals announced in January 2015.

Governor's Work Group

- Executive Order 15-13 established the Working Group for Health Care Innovation.
- One of the Work Group's charges is to encourage adoption of alternative and value-based payments.

3. Considerations for the 2017 APM Plan

Outline:

a. Suggested 2017 APM Targets
b. Activities Involving Specialists
c. Proposals to Safeguard Consumer Access Under Risk Based Contracts
d. Draft Definition of Meaningful Downside Risk

3.a Suggested APM Targets

APM Targets:

- Proposed multi-year targets to accommodate multi-year contracting and set expectations for the future.
- 2017:
  - Aggregate Target: 40%
  - Non-FFS Target: 6%
- 2018:
  - Aggregate Target: 50%
  - Non-FFS Target: 10%

Discussion

Do you support the approach of setting targets over the course of multiple years?

Are there modifications to the proposed targets that you would like to propose?

3.b Activities Involving Specialists

Specialist Payment:

- Alternative payment models in place with specialist groups?
- Options to consider:
  - Sub-capitated payments
  - Episode-based payments
  - P4P
  - Multi-specialist risk pool

Data sharing to promote efficient, high quality specialists:

- Found limited number of programs in place
- Data sharing can be either enrollee or provider-facing
- Regardless of focus, data sharing designed to engage specialists to consider performance relative to peers

Specialist Physician Payment Models

Specialist Payment:

- Alternative payment models in place with specialists in other markets:
  - Episode-based payment for orthopedics and cardiology.
  - Medicare Acute Care Episode (ACE) Demonstration
  - Bundled Payment for Care Improvement Program (BPCI)
  - UnitedHealthcare Oncology Payment Pilot (2009 – 2012) – breast, lung, and colon cancer.
  - Optimus ACO/Digestive Healthcare Center Colonoscopy Bundle.

Promoting Efficient Specialists: enrollee-facing program

Anthem BCBS

1. Created Blue Distinction Centers for Specialty Care (cardiac care, complex and rare cancer, transplants, bariatric surgery, joint replacement, spine surgery)
   - Based on quality standards developed with provider input
   - If meet efficiency standards, centers earn a “plus” designation
2. Blue Precision doctor recognition program
   - Limited to cardiology, endocrinology, OB/GYN, rheumatology and pulmonary medicine
   - Quality determined by achieving external designation from either NCQA or Bridges to Excellence OR by following evidence-based guidelines based on evaluation of administrative data
   - Costs based on risk adjusted episode costs compared to maximum cost performance threshold. Must meet 90% confidence intervals.

Promoting Efficient Specialists: physician-facing program

CareFirst Spotlight Program

1. Provides comparative cost information on specialists to PCPs via web portal
2. Uses risk-adjusted GXCG's to calculate actual paid costs for medical and procedural episodes
3. Reports to PCP that cost of episode is low, medium or high
4. In effect since 2014, but internal data suggests that information is opening up PCP-specialist conversations, and is starting to change practice patterns. Specialists are also inquiring about their "scores" and gaining an understanding of how they compare with peers.
5. No plans to add quality component to specialist evaluations

Discussion

What options should we consider around promoting APMs for specialist services?

Does a pilot payment model seem reasonable as an initial step?

What other recommendations would you like to propose?

3.c Proposals to Safeguard Consumer Access Under Risk Based Contracts

In the spring some committee members expressed concern that the shift to risk-based contracting may adversely effect access.

- Options:
  - Modify definition of APMs to exclude payment methodologies where consumer access is impaired.
    - Challenge: Measuring deterioration in access and linking to payment model.
  - Require insurers submit written summaries of APMs to OHIC which address efforts to monitor access, describe structured incentives to obviate provider risk selection, skimping, etc.
  - Others?

Discussion

What recommendations around consumer access to care, if any, do you recommend for inclusion in the 2017 APM plan?

3.d 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?

4. 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: Thursday November 5th at 8 AM.

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

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[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