State of Rhode Island Office of the Health Insurance Commissioner
Alternative Payment Methodology Committee
Meeting Minutes
April 2, 2015, 1:00 P.M. to 4:00 P.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Attendance

Members

Erik Helms, Kevin Callahan, Todd Whitecross, Emily Colton (for Patrick Tigue), Mike Souza, Dan Moynihan, Domenic Delmonico, Chris Dooley, Al Kurose, Noah Benedict, Sam Salganik, Pat McGuigan, Al Charbonneau, Alok Gupta, Pano Yeracaris.

Not in Attendance

Tom Breen, Chuck Jones, Bill Almon Jr., Patrick Tigue

1. Welcome & Introductions

Cory King welcomed the committee members to the second meeting of the Alternative Payment Methodology Advisory Committee.

2. Review of Minutes from March 5, 2015 Meeting

The minutes from the March 5, 2015 meeting were adopted.

3. Update on Care Transformation Committee Activity

Sarah Nguyen, OHIC Principal Policy Associate, provided an update on the activities and discussions of the Care Transformation Advisory Committee.

Committee members commented that the Care Transformation work, including the proposed sustainable funding model for patient centered medical homes, interface with the work the APM Committee is doing. Committee members expressed an interest in learning more about the work of the Care Transformation Committee and OHIC promised to share all Care Transformation Committee materials, including minutes and presentations with the APM Committee members in advance of the next meeting.

Domenic Delmonico asked how the care transformation work interacts with the work of CTC-RI and reinventing Medicaid. The Committee can't develop commercial targets without talking to Medicaid because practices don't differentiate this way. OHIC agreed that it is important to coordinate this work.

4. Key Take-Aways from First APM Committee Meeting

Cory King presented the key take-aways from the first APM meeting which included:

- Agreement on APM definition, except that some modifications to language were necessary to support inclusion of population-based payment models where FFS remains the underlying payment methodology.
- Support for inclusion of "increased access" and "patient engagement" as goals of APMs.
- Recognition that assumption of "meaningful downside risk" is conditioned by provider competency and financial strength to manage risk.
- General consensus on the types of payment models that should count as APMs.
- Support for including P4P as an APM, at least in the short-term.
- Benefit design plays an important role.
- Need for prospective attribution and PCP selection to give providers the tools and information to manage risk. It is difficult to measure performance with retrospective information around patients and budget targets.
- Concerns expressed about freezing fee schedules included:
  - 1) driving lower cost independent providers to higher cost systems, and
  - 2) driving more doctors to border states with higher fee schedules.
- Support for inclusion of FFS payments made under population-based contracts with shared savings or shared risk as part of the APM target calculation.
- Strong support that the composition of the "payment under the payment" must move away from FFS.

There was some discussion among Committee members about how payment reform should be sequenced. Dominic Delmonico suggested beginning with primary care. Primary care capitation was discussed. Al Kurose said that focusing on primary care is reasonable, but primary care only accounts for about 10% of medical spend, so we need to impact the other 90% of spend as well, including specialist and hospital services.

Cory King, OHIC, remarked that the Committee will focus on ways to engage specialists in payment reform during the fall convening.

Al Charbonneau requested that any write-up about benefit design as a tool to advance payment reform should be specific. Dominic Delmonico suggested PCP selection, network definition, and referral requirements (make the benefit design more lined up with what we want to do here).

Sam Salganik remarked that transparency and communication with consumers is needed. A lot of consumers were upset about capitation in the early 1990s – need consumer protections around this.

5. Presentation/Discussion

Please refer to APM Committee Presentation for greater detail.

5.1 Revised APM Definition and Criteria

Cory King presented the revised APM definition and criteria based on feedback given during the March 5th, 2015 meeting.

Sam Salganik asked if the list of APM criteria and goals were to be read as "and" or as "and/or." Cory King, OHIC, responded that the list was to be read "and/or."

Al Charbonneau stated that the goal to "**reduce cost of care growth"** should be the top priority. We need to send a strong message to achieve goals.

There was some disagreement among the table as to ordering of priorities, so the group decided to leave the ordering of the list as is.

Al Charbonneau commented that we really need to look at costs, particularly on the hospital side. A lot of the money in hospital is overhead, such as administrative cost and employee benefits, and not clinical. We should look at expenses as part of this work to drive down costs.

Committee members again discussed how to deal with specialists in payment reform. There was some discussion as to whether the focus should be on referral guidance for PCPs, as opposed to changing the way specialists are paid.

5.2 Structure of Proposed APM Targets

Cory King presented on the proposed structure of the APM targets. OHIC proposes two related targets, one that accounts for aggregate use of alternative payment methodologies and a second one that includes Committee-endorsed, strictly non-fee for service payments.

Al Kurose stated support for inclusion of a non-FFS target. He suggested we also include shared savings distributions and pay for process payments to support care transformation among the payments that count toward insurer achievement of the target.

Erik Helms suggested that the targets refer to earnable (or potential) incentive payments, as opposed to payments actually paid out. There was some disagreement over this and we agreed to have a follow up conversation.

Sam Salganik asked how the targets are actualized. Cory King, OHIC, stated that the targets would be set prospectively and insurer progress would be tracked throughout the year.

Insurer representatives stated that supplemental payments should be contingent on performance. Members agreed that accountability should be built in to infrastructure supports.

Dominic Delmonico stated that the proposed targets are "insider" targets. He challenges staff to come up with a different measure that is easier to communicate to businesses and consumers.

Al Charbonneau agreed. We need to draw links between reform and costs to business and employer benefits. It is reasonable to ask staff to come up with metrics that translate to business.

Cory King, OHIC, stated that health care payment concepts are complicated and invited the RI Business Group on Health and other members of the Committee to brainstorm metrics with their members or colleagues. Cory King stated that OHIC needs to carefully pick understandable language when communicating with the public on these issues.

Sam Salganik commented that we should think about shared language. Consumer engagement is necessary to make the spread of alternative payment methodologies work.

5.3 Proposed APM Targets

Marge Houy from Bailit Health Purchasing presented on the proposed APM targets.

Dominic Delmonico stated that these were nonsensible measures and felt artificial and arbitrary. He questioned whether a 100% increase (20% baseline to 45% in 2016) in the percentage of medical payments made through APMs was reasonable or possible. He asked what the insurers thought and asked for more data on the relationship between percent of medical spend paid through and APM and percent of covered lives attributed to a population-based total cost of care contract.

Cory King, OHIC, stated that OHIC would follow-up with health plans to get more information for covered lives vs. payments.

Insurers felt that the concept of a statistically credible population was critical in this discussion. It is difficult to expand population-based contracts without large numbers of enrollees.

Todd Whitecross expressed concern that this work would diminish the discretion of a plan to enter into deals. Maintaining a prospectively attributed population is also difficult. Experience is not a positive one with gainsharing – it's an interim step.

Pat McGuigan remarked that we should think about what we are trying to accomplish with targets, what consequences, what signals are we trying to send? If we need to be aggressive then we need to find appropriately aggressive targets.

Dan Moynihan suggested that the Committee focus on the non-fee for services target.

Committee members expressed that an 8% non-FFS target for 2016 may be too aggressive. Al Kurose proposed 3% in 2016, and perhaps 10%, 15%, and 20% for ensuing years as an option.

5.4 Facilitators of APM Adoption

Marge Houy from Bailit Health Purchasing presented on facilitators of APM adoption.

Todd Whitecross stated that PCP selection as part of plan design is an employer choice and not entirely within a health plan's discretion.

Pat McGuigan stated that the Committee should add employer engagement to the activities/facilitators for 2016 and 2017. Sam Salganik recommended adding consumer engagement as well. As payment reform continues there will be a need for consumer protection and consumer assistance.

Erik Helms suggested requiring PCP selection in products offered on HealthSource RI.

6. Next Steps

The next meeting will take place on May 1, 2015 from 8am to 11am in the same location.

7. Public Comment

Rich Glucksman of BCBSRI commented that OHIC should provide more detail on how the standard will be measured, reported, and enforced. He suggested that OHIC add more representation from the provider community to the Committee, including the Rhode Island Medical Society and specialist providers. He also suggested that the state should explore ways to coordinate different sets of regulatory tools, such as Department of Health authority to license providers and medical facilities. Finally, Mr. Glucksman suggested that

OHIC legal counsel be present during meetings to speak to any legal issues or constraints that may arise during the conversation.