



Rhode Island Health Care Cost Trends Steering Committee

Compact to Accelerate Advanced Value-Based Payment Model Adoption in Rhode Island

Background

We, the undersigned members of the Rhode Island Health Care Cost Trends Steering Committee (Steering Committee), convened in 2018 to develop an annual health care cost growth target for Rhode Island, have developed a set of recommendations for accelerating the adoption of advanced value-based payment (VBP) models. We believe that these recommendations will help reduce the growth rate of health care spending and support attainment of the state's health care cost growth target. It is important to note at the outset that this compact represents a floor and not a ceiling on the acceleration of advanced VBP models in Rhode Island and nothing in this document should be construed as to preclude a faster pace of progress should there be mutual agreement by the relevant parties to do so. Furthermore, it must be noted that this compact explicitly recognizes that the acceleration of advanced VBP models must occur across all markets: commercial, Medicaid, and Medicare in order to achieve success on a systemic level.

We find that the long-standing fee-for-service (FFS) payment model creates a financial reward for increasing the volume of health care services and especially those services that are reimbursed most generously. The FFS payment model also serves as a barrier to provider organizations redeploying their resources in order to deliver care more efficiently and effectively. Transforming payment away from FFS to a prospective budget-based model can support improved affordability, applying budget discipline to health care spending. It can also reorient care delivery to focus on how best to organize health care resources and care delivery to meet population needs, and improve access, equity, patient experience, and quality.

This compact recognizes that:

- Few Rhode Island organizations are ready today to accept a prospective payment for total cost of care (TCOC) and it is unlikely that most will be ready to do so for some time. It, therefore, sets forth a strategy that represents a significant step away from the current FFS construct that can potentially be achieved sooner than a full prospective TCOC payment model.
- The implementation timeline for hospital global budgets needs to take into account the clinical, financial, and labor market impacts of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) and be accompanied by consideration of a process to achieve rationalized distribution of reimbursement rates across the commercial, Medicaid, and Medicare markets to ensure sustainability.

We, the undersigned members of the Steering Committee, agree upon the following principles, action steps, and targets to accelerate adoption of advanced VBP models in Rhode Island. Further, as signatories to this compact, we agree to work to achieve the targets set forth. We agree that the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) should reconvene the signatories of this voluntary compact no later than July 1, 2023 to revisit this compact to ensure effectiveness in advancing payment reform and supporting cost containment efforts in Rhode Island.

Principles

1. Prospective budget-based payment, with quality-linked financial implications, should be the primary advanced VBP model utilized for all provider types wherever feasible.
2. Where prospective budget-based payment is not feasible, alternatives such as (a) adjusted FFS payment to meet a prospective budget and (b) retrospectively reconciled budget-based FFS payment that includes both shared savings and downside risk should be adopted.
3. Advanced VBP models should support a financially stable delivery system able to invest in technical innovation in care delivery to support population health management and quality excellence such that the delivery system:
 - improves patient experience of care,
 - improves quality of care,
 - improves positive patient outcomes,
 - improves health equity, and
 - anticipates and mitigates negative unintended consequences.
4. Payers should make available a common menu of advanced VBP models to allow providers to have a sufficient volume of similar value-based arrangements, recognizing the need for some differences due to varying plan market share. In addition, the design features of the advanced VBP models should be aligned on selected elements where alignment would reduce provider administrative cost.
5. A foundation of robust primary care is essential for advanced VBP model success. Advanced VBP models should not put the financial viability of primary care providers (PCPs) in jeopardy.
6. Employers, payers, and providers should encourage selection of a PCP, whether or not required by benefit design, to support advanced VBP model effectiveness.
7. Specialty care providers should be integrated into advanced VBP models.
8. Cross-organizational provider relationships should be encouraged to promote efficiency and to avoid unnecessary service duplication.
9. Advanced VBP models for child health require special consideration. Specifically, child health requires a different financing construct, child-specific quality metrics, and child-relevant risk stratification processes.
10. There should be rigorous analysis of any advanced VBP model implementation and effects from the beginning.

Action Steps

1. Commercial and Medicaid payers should continue contracting with accountable care organizations (ACOs) and accountable entities (AEs) on a TCOC basis with “meaningful downside risk” as defined by applicable regulatory guidance.
2. Commercial and Medicaid payers should partner with provider organizations to introduce and/or expand upon three types of advanced VBP models, applicable to both ACO/AE attributed lives and to members not attributed to ACOs/AEs:
 - hospital global budgets for facility and employed clinician professional services,

- prospective payment (capitation or episode-based payment) for high-volume and high-cost specialty care providers who are not employed by hospitals, and
- prospective payment for primary care.

The pace of change should be sensitive to the trajectory of the COVID-19 PHE. In particular, the implementation timeline for hospital global budgets needs to take into account the clinical, financial, and labor market impacts of the COVID-19 PHE.

3. The state will make all necessary efforts to pursue sufficient administrative capacity within state government to oversee the successful implementation of advanced VBP models across the commercial and Medicaid markets as appropriate.
4. The aforementioned advanced VBP models include substantive financial incentives for improved patient experience of care, improved quality of care, positive patient outcomes, and improved health equity. Further, the advanced VBP models should provide explicit protection against harmful withholding of needed care (also known as “stinting”).
5. The state should seek Medicare participation from the Center for Medicare and Medicaid Innovation (CMMI) to maximize the percentage of a provider organization’s payments received through advanced VBP models.
6. Commercial and Medicaid payers should make available a common menu of the advanced VBP models to minimize provider administrative cost.
 - OHIC should facilitate cross-payer collaboration to the extent permitted by applicable law so that payers and providers can agree upon: (a) a sequenced and timed transition plan for global hospital payment, (b) a coordinated plan for sequentially introducing aligned prospective payment to specialty providers, and (c) common payment model design features, consistent with what OHIC previously facilitated for prospective primary care payment.
7. The following steps should be taken to address barriers identified:
 - **Small Payer Populations:** Insurers should include commercially-insured business in advanced VBP contracts and, where agreed to by providers, make such contracts available to self-insured customers, even if the terms vary slightly for the respective populations.
 - **Payer Infrastructure:** Financial commitments from payers, and recognized by regulators, will be necessary to achieve infrastructure changes.
 - **Provider Risk Assumption:** The State of Rhode Island Executive Office of Health and Human Services (EOHHS) and OHIC should perform oversight of risk exposure for certain ACOs/AEs and providers assuming significant downside risk.
 - **Provider Infrastructure:** Payers should offer initial infrastructure payments tied to milestones for providers entering new advanced VBP arrangements.
 - **PCP Selection:** Employers, insurers, and providers should coordinate on steps to increase PCP selection by patients.
8. Notwithstanding all of the above, nothing should constrain an interested payer and ACO or AE from entering a global capitation arrangement for most or all covered services should both parties be willing to do so and the ACO possess sufficient financial resources to protect itself in the event of a possible financial loss.

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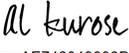
6. A working group of employers, insurers, and provider organizations will develop a detailed plan on how to increase PCP selection by patients by January 1, 2023.

Parties in Compact

This compact, signed on April 13, 2022, shall remain in effect until January 1, 2026.

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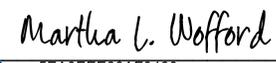
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