POLICY MANUAL

Rhode Island Affordability Standards

Abstract

This Policy Manual for the implementation of the Rhode Island Office of the Health Insurance Commissioner Affordability Standards provides guidance and data reporting specifications for commercial health insurers. This Policy Manual will be updated periodically.

Rhode Island Office of the Health Insurance Commissioner

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1. Introduction

The Office of the Health Insurance Commissioner (OHIC) has prepared this **Policy Manual** to collect and disseminate all guidance relevant to insurer implementation of the Affordability Standards provisions in 230-RICR-20-30-4 *Powers and Duties of the Office of the Health Insurance Commissioner*. The provisions of § 4.10—Affordability Standards—set forth regulatory requirements for insurers to follow in their efforts to improve the affordability of their products. OHIC developed these requirements to meet its statutory mandate under R.I.G.L § 42-14.5-2, which states:

> *"With respect to health insurance as defined in § 42-14-5, the health insurance commissioner shall discharge the powers and duties of office to:*
>
> *(1) Guard the solvency of health insurers;*
>
> *(2) Protect the interests of consumers;*
>
> *(3) Encourage fair treatment of health care providers;*
>
> *(4) Encourage policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and*
>
> *(5) View the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access."*

The Affordability Standards address insurer implementation of value-based contracts with providers, investment in Rhode Island's primary care infrastructure, and cost containment and quality improvement. In addition to guidance this Policy Manual supplies technical specifications for insurer reporting on primary care expenditures and use of alternative payments models.

2. Affordability Standards Compliance Checklist

The following table summarizes the relevant sections and regulatory targets from 230-RICR-20-30-4 Affordable Health Insurance – Affordability Standards. Health insurers are encouraged to use this checklist to track compliance with the Affordability Standards.

Table 1. Affordability Standards Compliance Checklist

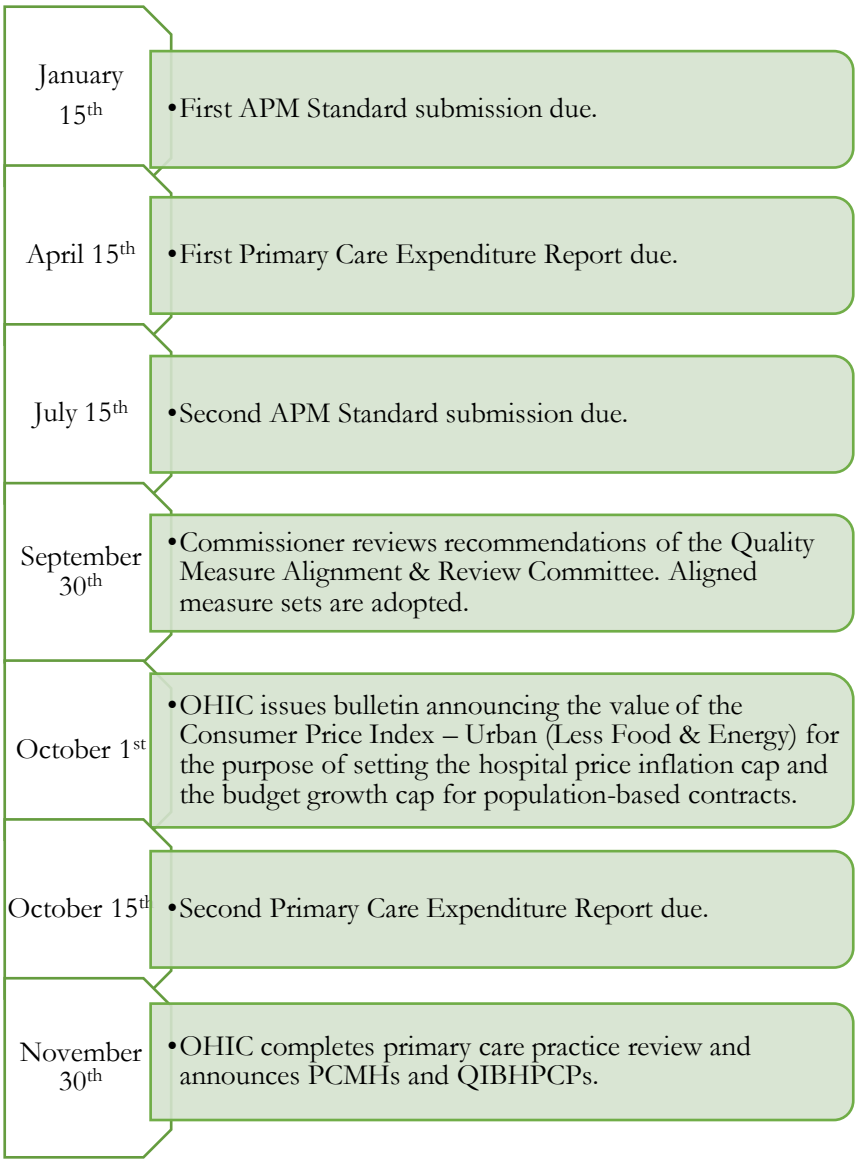
RICR Reference	Requirement Description	Notes
4.10(B)(1)	Primary care spending target	Insurers are required to dedicate at least 10.7% of total medical spending on primary care, with at least 9.7% dedicated to direct primary care support.
4.10(C)(1)(b)	Primary care PCMH financial support	Insurers are required to fund primary care practices that have met the OHIC requirements for PCMH recognition. OHIC conducts reviews of PCMH accreditation and performance in the fall of each year and produces a list of recognized PCMH practices for health insurer contracting. OHIC also determines which primary care PCMHs receive recognition as Qualifying Integrated Behavioral Health Primary Care Practices (QIBHPCP).
4.10(C)(2)(a)	Integrated Behavioral Health Requirements	4.10(C)(2)(a) comprises three discrete requirements of insurers to reduce administrative barriers to patient access to integrated services in primary care practices. • Elimination of copayments for patients who have a behavioral health visit with an in-network behavioral health provider on the same day and in the same location as a primary care visit at a QIBHPCP. • Health insurers shall adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than Current Procedural Terminology (CPT)Coding Guidelines for HABI codes. • Health insurers shall adopt policies for the most common preventive behavioral health screenings in primary care that are no more restrictive than current applicable federal law and regulations for preventive services.
4.10(D)(1)(b)	APM target	Insurers are required to expend at least 50% of insured medical payments through an APM. Payments that shall be credited toward an insurer's APM target are described herein.
4.10(D)(2)(c)	Risk-based contracting target	Insurers are required to have 30% of RI resident commercial insured covered lives attributed to risk-based contracts.
4.10(D)(3)(d)	Primary care APM targets	Insurers are required meet annual targets for implementation of primary care APMs based on percentage of Rhode Island resident covered lives attributed according to the following schedule: 1/1/2021: 10% 1/1/2022: 25% 1/1/2023: 40% 1/1/2024: 60%

4.10(D)(4)(e)	Specialist APM targets	Insurers with at least 30,000 covered lives are required to implement APMs with specialists. Insurers may draw from a menu of specialties and are required to meet an annual schedule of targets based on the number of specialties with APM contracts: 12/31/2021: (2) specialties 12/31/2022: (3) specialties 12/31/2023: (4) specialties 12/31/2024: (5) specialties

In addition to the requirements enumerated above, health insurers are required to comply with the Aligned Measure Sets described under § 4.10(D)(5) and the guidelines pertaining to hospital contracts (§ 4.10(D)(6)) and population-based contracts (§ 4.10(D)(2)).

OHIC monitors compliance with the Affordability Standards through a schedule of semi-annual reports, ad hoc requests for information, and formal examinations. Below is a timeline for compliance reporting and other important dates for insurers to know.

Figure 1: Affordability Standards Report Timeline & Important Dates



3. Primary Care Spending Guidance[1]

Investment to support a robust primary care infrastructure is foundational to a high-performing health care system. Since 2010 OHIC has required commercial insurers to meet annual targets for spending on primary care as a percentage of their total medical spending. The types of payments that are credited toward primary care spending reflect policy choices that meet the needs of Rhode Island's local health care system stakeholders.

Report Frequency

Health insurers are required to report primary care expenditure data on a semi-annual basis. Reports are due by April 15th and July 15th each year. In specific circumstances the Commissioner may request more frequent reporting at his/her discretion.

Primary Care Spend Standard Submission Working Definitions (Revised as of 9/2/09)

For each calendar year, for all fully insured commercial business, all medical payments made to primary care providers in Rhode Island, regardless of where the member resides, will count toward the calculation of total primary care expenditures. Payments should be reported as both total dollars spent during the time period and as a percentage of total medical payments during the time period.

Numerator specifications:

1. Payments defined as paid claims. Primary care payments exclude Rx, lab, and imaging services and are broken out by:
   - Payment for services: CPT codes, capitation, etc.
   - Incentive/bonus payments, including both performance and infrastructure payments
   - All other payments (please explain)

Primary care provider specifications:

2. As of January 2021:
   - Practice type: Family practice, internal medicine, geriatric, and pediatrics
   - Professional credentials: Doctor of medicine, doctor of osteopathy, nurse practitioners, and physicians' assistants

Denominator specifications:

3. Total medical payments include all payments made to Rhode Island facilities and providers, regardless of where the member resides.
   - This should include Rx, behavioral health, lab and imaging services.

[1] OHIC is currently reviewing the primary care spending guidance for potential revisions in calendar year 2021.

- Medical payments should be inclusive of any secondary payer payments.
- Rx payments[2] should include Rhode Island payments only.
- BCBSRI will include only those payments made to pharmacies in Rhode Island, plus mail order payments (again, regardless of where the member resides). Rx carve outs will be adjusted by the percentage of members with pharmacy benefits, and that percentage will be included in ongoing reporting
- UnitedHealthcare will include only those payments for scripts written by RI providers, regardless of where it is filled.

4. Lump sum payments (e.g., EMR, performance bonuses) paid out as a one-time, fixed dollar amount to primary care providers may be credited in full toward fully insured commercial spend. Per member per month (PMPM) payments to primary care providers on the basis of fully insured and Medicare risk membership may be credited toward fully insured commercial spend. All other primary care expenditures (e.g., fee-for-service payments and PMPM payments for self-insured) must be appropriately allocated to the products/segments they support.

In 2021 OHIC will be reassessing the methodology used to define primary care spending and will update this Policy Manual.

[2] There was discussion of the possibility that there would be a growing share of business with Rx carve-outs. OHIC agreed that issuers could and should report on this issue on their primary care spend standard submissions and may report an adjusted spend percentage, reflecting the impact of Rx carve-outs.

4. Value-Based Payment Contracting Guidance

4.1 Alternative Payment Models

OHIC views the alignment of provider financial incentives to efficiency and quality improvement goals through payment reform as an essential input to improved health care system performance. **§ 4.10(D)(1)** requires that health insurers take such actions as necessary to have at least 50% of insured medical payments made through an "alternative payment model."

Definition / "Alternative Payment Model" (APM) as used in **§ 4.10(D)(1)** of 230-RICR-20-30-4 means a payment methodology structured such that provider economic incentives, rather than focus on volume of services provided, focus upon:

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

To qualify as an APM, the payment models must define and evaluate provider 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. While not meeting the foregoing definition of APM, certain pay-for-performance payments, care management payments, and infrastructure payments, as described below, will be credited toward achievement of the health insurer's APM target.

Approved Alternative Payment Models include:

- Total cost of care (TCOC) budget models;
- Limited scope of service budget models, such as primary care capitation;
- Episode-based (bundled) payments;

The 50% spending requirement is an Alternative Payment Model Target that refers to 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;

- Pay-for-performance payment distributions, supplemental infrastructure payments for patient-centered medical home functions, including care management, paid to primary care providers (PCPs) or to accountable care organizations (ACOs)[3], and supplemental infrastructure payments to specialists to provide incentives to improve communications and coordination among PCPs and specialists,
- Shared savings distributions, and
- Any payment model, payment distribution, or infrastructure cost that satisfies the definition of an APM or advances the payment reform objectives set forth under the Affordability Standards may be granted prior approval by the Commissioner upon petition by the insurer and credited toward the insurer's APM spend.

Health insurers shall report expenditures through APMs on a semi-annual basis using a template approved by the Commissioner. Technical specifications for the APM reporting template are provided below.

4.2 Population-based Contracts with Total Cost of Care Accountability

Population-based contracts, under which providers assume accountability for the total cost and quality of care of their attributed patient populations, form an important basis of payment reform. **§ 4.10(D)(2)** of 230-RICR-20-30-4 sets forth a number of requirements governing population-based contracts.

§ 4.10(D)(2) incorporates minimum downside risk standards into the regulation and provides for a progression of the standards toward greater downside risk by 2021. The standards vary based on the type of ACO and the size of the population attributed to the ACO contract. OHIC differentiates two types of ACOs: ACOs that include hospital systems and Physician-group based ACOs. This binary typology was developed in consultation with the Alternative Payment Methodology Advisory Committee in 2017 and is based on the different financial capacities of provider organizations to cover losses in relation to their total operating revenue. The downside risk standards also account for the size of the population attributed to the ACO under contract. Population size is important due to the potential volatility in health care costs observed in small populations.

Table 2 and **Table 3** present the downside risk requirements for ACOs which include hospital systems and physician group-based ACOs, respectively.

[3] 230-RICR-20-30-4 employs the term "Integrated System of Care" which for the purposes of the regulation and this Policy Manual is used interchangeably with the term "Accountable Care Organization."

Table 2. Minimum Downside Risk Standards for ACOs Including Hospital Systems[4]

10,000-20,000 lives	2020 requirement	2021+ requirement
Risk exposure cap[5]	At least 5%	At least 6%
Minimum loss rate[6]	No more than 3%	No more than 3%
Risk sharing rate[7]	At least 40%	At least 50%
20,000+ lives	**2020 requirement**	**2021+ requirement**
Risk exposure cap	At least 5%	At least 6%
Minimum loss rate	No more than 2%	No more than 2%
Risk sharing rate	At least 40%	At least 50%

Table 3: Minimum Downside Risk Standards for Physician-based ACOs

10,000-20,000 lives	2020 requirement	2021+ requirement
Risk exposure cap	At least 7% revenue, or 2% TCOC	At least 8% revenue, or 3% TCOC
Minimum loss rate	No more than 3%	No more than 3%
Risk sharing rate	At least 40%	At least 50%
20,000+ lives	**2020 requirement**	**2021+ requirement**
Risk exposure cap	At least 8% revenue, or 3% TCOC	At least 8% revenue, or 3% TCOC
Minimum loss rate	No more than 2%	No more than 2%
Risk sharing rate	At least 40%	At least 50%

§ 4.10(D)(2) also governs population-based contract budget increases. Annual budget increases for population-based contracts are capped at percentage changes in the national Consumer Price Index-Urban (Less Food & Energy) plus 1.5%, after risk adjustment. The budget cap is announced in October each year by means of a bulletin issued by OHIC. **§ 4.10(D)(2)(g)** provides for a discretionary increase to budgets for ACOs with low spending relative to the health insurer's network. When assessing the eligibility of an ACO for the discretionary budget adjustment and calculating the eligible budget adjustment, health insurers should follow the following steps:

[4] A hospital-based ACO has ownership held in whole or in part by one or more hospitals.

[5] **Risk exposure cap** is defined as a cap on the losses which may be incurred by the provider under the contract, expressed as a percentage of a) the total cost of care or b) the annual provider revenue from the insurer under the population-based contract.

[6] **Minimum loss rate** is defined as a percentage of the total cost of care, or annual provider revenue from the insurer under a population-based contract, which must be met or exceeded before actual losses are incurred by the provider. Losses may accrue on a first dollar basis once the minimum loss rate is breached.

[7] **Risk sharing rate** is defined as the percentage of total losses shared by the provider with the insurer under the contract after the application of any minimum loss rate.

1. Determine if the ACO would qualify for a possible upward adjustment based on historical performance. This is the three-year look back referenced in the regulation.
2. Determine the ACO's trended budget for the next contract year, applying a trend factor that is at or below the OHIC budget growth cap.
3. Compare the ACO's risk-adjusted trended budget to health insurer's risk-adjusted trended commercial insured average (excluding the group).
    a. This may require an estimate if all of the other commercial contracts have yet to be negotiated.
4. If the ACO's trended risk-adjusted budget is below the health insurer's risk-adjusted commercial insured average (excluding the ACO), determine whether health insurer wishes to increase the ACO's non-risk-adjusted budget by up to 2% so long as the ACO's risk-adjusted trended budget remains equal to or below health insurer's risk-adjusted commercial insured average (excluding the ACO).

4.3 Hospital Contracts

Hospital inpatient and outpatient expenses account for a significant proportion of total medical expense and are a key driver of the aggregate value and rate of growth of premiums. Hospital contracts are required to comply with the standards set forth in **§ 4.10(D)(6)**. These standards include a cap on the aggregate growth of hospital inpatient and outpatient prices, the adoption of unit-of-service payment methodologies for both inpatient and outpatient services that realign payment to provide incentives for efficient use of health services, and requirements around hospital quality measurement and performance.

As previously stated, annual hospital price growth for inpatient and outpatient services is capped at percentage changes in the national Consumer Price Index-Urban (Less Food & Energy) plus 1%. The cap is announced in October each year by means of a bulletin issued by OHIC.

One-Time Inpatient Services Rates Adjustment

§ 4.10(D)(6)(f) of 230-RICR-20-30 provides that Rhode Island acute care hospitals within an insurer's network that are paid at less than the network median case-mix adjusted inpatient services rate shall qualify for a one-time inpatient services rate increase sufficient to bring the hospital's case-mix adjusted rate to the median. Specifically, the regulation states:

> "Hospitals which have been paid by a health insurer at less than the median commercial payments made to all Rhode Island acute care hospitals for inpatient services, including inpatient behavioral health services, in the health insurer's provider network, as determined by the health insurer summing all of its inpatient payments (numerator) and dividing that by a sum of all DRG case weights (denominator) to provide a case-mix-adjusted discharge payment rate for each hospital for inpatient services, shall receive an equal percentage increase in payment for each inpatient service until the hospital's average payment per case-mix-adjusted DRG for inpatient services is equal to the median.

At the time of the calculation, the health insurer shall utilize the most recent 12-months of claims data for which the health insurer's Rhode Island hospital claim runout is at least 95% complete."

Calculation of the One-Time Inpatient Services Rate Adjustment

Calculation of the eligible rate adjustment shall be made at a point in time and be in addition and anterior to any negotiated rate increase up to the hospital rate cap. Once the insurer calculates the rate adjustment, it shall be dispersed to the hospital in one fee schedule adjustment. OHIC expects insurers to base the calculation of the one-time inpatient services rate adjustment on the full universe of claims to which the hospital rate cap applies and should be applied to that same universe of future claims payments. All hospitals should be compared on the same DRG basis, such APR-DRGs or MS-DRGs. In relation to the Cost Growth Target and annual assessment of insurer performance relative to the Cost Growth Target, the one-time inpatient services rate adjustment will be considered contextually. This means that should the implementation of the rate adjustment cause an insurer to exceed the Cost Growth Target during the year of implementation, public reporting will state that the observed total medical expense trends were due in part to a regulatory requirement.

Reasonable Access to Data and Independent Verification by the Hospital

OHIC expects insurers to accommodate any reasonable request by a hospital to understand the methodology and data used to calculate the one-time inpatient services rate adjustment. OHIC endorses the practice of sharing claims data with an independent third-party entity, mutually agreed upon by the insurer and the hospital, to perform validation checks on the insurer's calculations. OHIC believes it is possible to share this data with an independent third-party in a manner that comports with existing obligations of the insurer around confidentiality.

5. Alternative Payment Model Standard Submission - Data Specifications

Pursuant to 230-RICR-20-30-4 commercial health insurers are required to report expenditures through alternative payment models (APMs) and value-based contracts. This data is collected to monitor and assess health insurer compliance and to support public reporting around health insurer efforts to improve the efficiency and quality of health care service delivery in Rhode Island.

Report Frequency

Health insurers are required to report APM data on a semi-annual basis. Reports are due by July 15th and January 15th each year. In specific circumstances the Commissioner may request more frequent reporting at his/her discretion.

Report Date	Report Period
By July 15th	Year to date through May 31st plus true-up from previous years.
By January 15th	Year to date through November 30th plus true-up from previous years.

OHIC is requesting reporting by date of service. This means that health insurers should true-up reporting from previous periods as additional claims and provider incentive payments accrue. For example, the report due July 15th, 2021 should include all payments for 2021 through May 31st and all payments, including provider incentive payments, for calendar year 2020. The report due July 15th, 2022 should include all payments for 2022 through Mary 31st, 2022 and all payments, including provider incentive payments, through calendar year 2021. This allows six months for claims run out and reconciliation of incentive payment settlements.

Membership and Payment Universe

Health insurers shall report on medical, pharmacy, and performance-based payments made to providers for services rendered to covered members in their insured Rhode Island book of business, regardless of where the care was delivered. An insurer's Rhode Island book of business refers to members associated with policies written in Rhode Island and may include non-residents of Rhode Island who obtain their insurance through a Rhode Island-based employer group.

Report Contents

The Alternative Payment Model Standard Submission comprises four tabs.

I. Cover Sheet
II. APM (Alternative Payment Model) Report
III. VBP (Value-based Payment Model) Report
IV. Definitions

APM Report Tab

Covered Lives Reporting

Group A.1 in the report template requests data on membership attributed to population-based contracts and total membership as of the reporting period. Population-based contracts are defined pursuant 230-RICR-20-30-4.3(17) as "a provider reimbursement contract with an Integrated System of Care that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered lives population."

Group	Line(s)	Field Name	Definition
A.1	1.1	Attributed Member Months	Member months for covered lives attributed to population-based contracts.
	1.2	Total Member Months	Member months for covered lives in the issuer's insured RI book of business.
	1.3	Number of Covered Lives Represented in Line 1.1	Number of covered lives attributed to population-based contracts.
	1.4	Number of Covered Lives Represented in Line 1.2	Number of covered lives in the issuer's insured RI book of business.
	1.5	Total Rhode Island Resident Insured Member Months	The total number of Rhode Island resident insured member months.
	1.6	Total Rhode Island Resident Insured Member Months Attributed to Risk-Cased Contracts	The total number of Rhode Island resident insured member months attributed to risk-based contracts where the provider is accountable for the total cost of care and there is downside risk.
	1.7	Total Rhode Island Resident Insured Member Months Attributed to Primary Care APMs	The total number of Rhode Island resident insured member months attributed to primary care APMs.

Reporting by Payment Model

Reporting by payment model in the APM report tab is classified into groups. Groups B.1 – B.5 in the report template capture payments made under alternative payment models. Group B.6 captures fee for service claims payments that are not associated with an alternative payment model. Group C.1 captures an issuer's total medical expense for its insured Rhode Island book of

business, inclusive of medical claims payments, pharmacy, lab and imaging, settlement payments, and supplemental payments that qualify as medical expense. Issuers should report based on allowed claims.

Group B.1: Alternative Payment Models – Population-based Contracts

Population-based contracts are defined as "a provider reimbursement contract with an Integrated System of Care that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered lives population." Population-based contracts may include shared savings or shared risk contracts built on a fee for service architecture or a global capitation contract. Some population-based contracts may exclude pharmacy, behavioral health, outlier or other infrequent high cost claims.

Within Group B.1 issuers must report all allowed claims payments for covered lives attributed to population-based contracts. The following table provides definitions of each field by line number in the reporting template.

Group	Line(s)	Field Name	Definition
B.1	1.1	Total Dollars Allowed for All Services	Allowed claims payments for attributed lives for which the contracted provider is assuming accountability. ****Services not included in the claims experience used to derive and evaluate cost targets for providers should not be reported here (example see line 1.5).****
	1.2	Shared Savings Model (upside gain only)	Total dollars allowed for all services under a population-based contract with shared savings.
	1.3	Shared Risk Model (upside & downside risk)	Total dollars allowed for all services under a population-based contract with risk sharing (upside and downside risk).
	1.4	Full Risk Model	Total dollars allowed for all services under a population-based contract with full risk.
	1.5	Total Dollars Allowed for Services Excluded	Allowed claims payments for attributed lives which are excluded from total cost of care targets in population-based contracts. Examples may include pharmacy, behavioral health, or outlier claims.
	1.6 - 1.8	Examples of Excluded Services	Allowed claims payments for attributed lives which are excluded from total cost of care targets by service category.
	1.9	Total Dollars for Settlement Payments	Settlement payments including shared savings and other financial or clinical performance-based distributions. Targeted infrastructure

		payments, PCMH payments, and P4P earned under the contract should be reported here.
1.10 – 1.12	Total Dollars for Settlement Payments By Risk Arrangement	Settlement payments by risk arrangement (shared savings model, shared risk model, full risk model).
1.13	Total Dollars Paid Under a Population-based Contract	The sum of Total Dollars Allowed for All Services (Line 1.1) and Total Dollars for Settlement Payments (Line 1.9).

Group B.2: Alternative Payment Models – Bundled Payments

Bundled Payment is a payment methodology under which a single, set rate of payment covers services delivered by two or more providers during a single episode of care or over a specific period of time. A case rate for a specific service (e.g., case rate for heart valve replacement) is not a bundled payment unless it covers services delivered by two or more providers. Bundled payments may be administered retrospectively (reconciling to a budget) or prospectively.

Issuers are required to report all claims and settlement payments made through bundled payment models for all covered lives (Lines 1.1 – 1.5) and for the subset of lives not attributed to a population-based contract (Lines 1.6 – 1.10).

Group	Line(s)	Field Name	Definition
B.2	1.1	Total Dollars Allowed for All Services Under Bundled Payment	Allowed claims payments for services rendered under a bundled payment model.
	1.2 – 1.4	Total Dollars Allowed for All Services Under Bundled Payment By Risk Arrangement	Allowed claims payments for all services rendered under a bundled payment model by risk arrangement (shared savings model, shared risk model, full risk model).
	1.5	Settlement Payments Under Bundled Payments	Settlement payments including shared savings and other financial or clinical performance-based distributions.
Lines 1.6 – 1.10 represent a subset of lines 1.1 – 1.5 and should reflect bundled payments for lives not attributed to a population-based contract. This request is made to ensure that payments are not double counted when payments are summed across APMs.			
	1.6	Total Dollars Allowed for All Services Under Bundled Payment	Allowed claims payments for services rendered under a bundled payment model.
	1.7 – 1.9	Total Dollars Allowed for All Services Under Bundled Payment By Risk Arrangement	Allowed claims payments for all services rendered under a bundled payment model by risk arrangement (shared savings model, shared risk model, full risk model).

1.10	Settlement Payments Under Bundled Payments	Settlement payments including shared savings and other financial or clinical performance-based distributions.

Group B.3: Alternative Payment Models – Limited Capitation

Limited Capitation is a payment methodology that usually covers a specific grouping of services, such as primary care services, provided to an identified group of patients, but which do not constitute total or near total medical expense. A case rate for a specific service (e.g., case rate for heart valve replacement) is not a limited capitation because capitation is paid based on number of covered lives, not on each occurrence of services provided.

Group B.4: Pay for Performance

Pay-for-Performance is a payment methodology that offers financial rewards, in addition to payment for services provided, to providers who achieve or exceed specified performance targets. Payments may be made at the individual, group, or institutional level. Performance may be measured using benchmarks, relative comparisons or improvement goals and may measure structure, process or outcomes.

Please note that group B.4 is not asking for the total dollar value of contracts which include pay for performance. Rather, group B.4 requests the specific earned performance payments distributed to providers. These payments will be credited toward the health insurer's annual APM target.

Insurers should report all pay for performance payments at Line 1.1. At Line 1.2 insurers should report all pay for performance payments not associated with lives or episodes of care that are reflected under Groups B.1 – B.3.

Group B.5: Alternative Payment Models – Other

Other Alternative Payments are payments that reward quality and efficiency, other than limited capitation, bundled payment and Pay-for-Performance models.

Please note that supplemental payments to support patient-centered medical homes (PCMH) that do not fall under an APM-Population-based Contract (Group B.1) should be reported here. PCMH supplemental payments should be reported at Line 1.1.

Group B.6: Fee for Service Payments

Fee for Service (FFS) is a payment mechanism in which all reimbursable health care activity is described and categorized into discrete and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment

includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs)), claims-based payments adjusted by performance measures, and discounted charges-based payments. All allowed FFS payments not reported in Groups B.1 – B.5 should be reported at Group B.6 Line 1.1.

Group C.1: Total Medical Expense

Report total medical expense for all insured covered lives associated with policies written in Rhode Island in the insurer's book of business regardless of where the care was delivered. This includes medical claims payments, pharmacy, lab and imaging, settlement payments, and supplemental payments that qualify as medical expenses. These payments should be reported at Group C.1 Line 1.1.

VBP Report Tab

The value-based payment (VBP) report tab asks for high level data on value-based payment arrangements that are broader than the APMs reported in the APM report tabs. For the purposes of this submission, and for tracking progress toward the state's goal of having 80% of payments linked to value, a value-based payment arrangement is defined as a contract in which contracted providers are evaluated on a set of cost or quality measures and rewarded or penalized for reporting (pay for reporting) or actual performance (pay for performance). Some examples follow:

- Insurer A has a contract with hospital B in which hospital B is evaluated on a core set of clinical quality measures. Incentive payments may be made as a lump sum, may be tied to fee for service rate increases, or delivered through some other mechanism. As a concrete example, OHIC requires that insurers have a quality incentive program with hospitals and tie rates of price growth for inpatient and outpatient services to quality performance. Therefore, contracts in compliance with the OHIC regulations qualify as "value-based" under the definition given above.
- Insurer B has a contract with primary care group C in which primary care group C is evaluated on a core set of clinical quality measures. Incentive payments may be made as a lump sum, may be tied to fee for service rate increases, or delivered through some other mechanism.

For contracts that are value-based, insurers should report the aggregate total dollar value of contracts (fee for service payments plus any infrastructure and incentive payments) aggregated within the following categories: primary care, other professional (specialist, etc.), hospital inpatient and outpatient, and other payments. Insurers should also report denominators for each category.

A technical note: It should be emphasized that for the VBP report tab, insurers are asked to view the universe of medical payments in a related, but distinct way, as compared to the APM report tab. All APMs are VBPs, however, not all VBPs are APMs. VBPs are broadly defined. For example,

a hospital contract which has $100 million of claims costs associated with it, and which has a pay for performance component, is a VBP arrangement, but it is not an APM. APMs may be subsumed in the $100 million of claims cost associated with the hospital contract, either because the payments represent bundled payments, or they represent claims payments for services rendered to patients who are attributed to a population-based total cost of care contract, or other reasons. In order to complete the VBP tab, insurers are encouraged to employ a hierarchical approach to payment categorization. A first should pass should consider which contracts are "value-based" in that they incorporate financial incentives for reporting and/or performance. A second pass should consider whether there are any APM payments that fall outside of the aggregate payments identified through the first pass. These payments should be summed and reported in the appropriate line as value-based payments in the VBP Report tab.

6. Guidance on Use of Aligned Measure Sets

For ***contracts subject to amendment or renewal beginning on or after January 1st, 2022.***

The following guidance pertains to the implementation of Aligned Measure Sets required under 230-RICR-20-30-4.10(D)(5). This interpretive guidance will be updated periodically as Aligned Measure Sets are reviewed.

Nothing that follows is to supersede existing regulatory requirements codified in §4.10(D)(6) related to quality programs for hospital contracts.

Timelines

The Commissioner will convene a Quality Measure Alignment & Review Committee by August 1 each year. The Committee will determine whether changes need to be made to existing Aligned Measure Sets. Changes to the Aligned Measure Sets shall be effective for insurer contracts with performance periods beginning on or after the 1st of January following the Annual Review Meeting(s).

Should a stakeholder wish to bring forth a measure for consideration during the annual review of the Aligned Measure Sets, they should submit a request by following the guidelines in Appendix A.

Applicable Contracts

OHIC has developed Aligned Measures Sets for Accountable Care Organization (otherwise known as Integrated Systems of Care) contracts, hospital contracts (including both acute care and behavioral health hospitals), primary care provider contracts, maternity care provider contracts, and outpatient behavioral health care provider contracts. The Commissioner may develop Aligned Measure Sets for other types of provider contracts, including for specific episodes of care, in the future.

Only contracts that incorporate quality measures into the terms of payment must comply with the measure alignment provisions of§4.10(D)(5). §4.10(D)(5) does not mandate an insurer to develop and implement a quality performance incentive and /or disincentive provision within any provider contract that otherwise would not include such terms. The exceptions are hospital contracts, which pursuant to §4.10(D)(6)(d) must include a quality incentive program that complies with OHIC rules, and Global Capitation Contracts and Risk Sharing Contracts, as defined in §§4.3(A)(8) and 4.3(A)(21), respectively.

Applicable provider contracts which incorporate quality measures into the terms of payment shall include all Core Measures that are appropriate to the contract. Any further application of

quality measures into the terms of payment beyond the Core Measures shall be limited to Menu Measures designated as such on the Aligned Measure Set corresponding to the appropriate type of provider contract.

Measures contained within the Primary Care Aligned Measure Set shall be contractually applied by an insurer as appropriate given a primary care practice's specialty. Specifically, insurers should apply those measures with a denominator definition that includes persons under age 18 with pediatric practices. Insurers should apply those measures with a denominator definition that includes persons age 18 and older with adult medicine and family medicine practices. Insurers may also use measures with a denominator definition that includes persons under age 18 with family medicine practices at the insurer's discretion. Similarly, insurers may also use measures with a denominator definition that includes persons over age 18 with pediatric practices at the insurer's discretion.

OHIC acknowledges that in certain circumstances, it may not be appropriate for a Core Measure to be applied. Acceptable scenarios for the exclusion of Core Measures include:

- the measure is not applicable for the patient population (e.g., adult population measures in a contract with a pediatric provider), and
- the denominator size is inadequate (as described in further detail in the Performance Measurement section).

It is unacceptable, however, for an insurer to utilize a Core Measure into the terms of payment with a de minimis weight attached to the measure, such that performance on the Core Measure lacks meaningful financial implication for the provider.

It is also unacceptable for an insurer to utilize a Core Measure as a "reporting-only" measure, i.e., the provider is rewarded for reporting rather than performance, *except* when the measure's specifications have changed such that national benchmarks are non-comparable and therefore may not be utilized in a given year to assess performance. Under such circumstances, the insurer must obtain written authorization to use the Core Measure on a reporting-only basis.

Similarly, there may be limited circumstances in which a measure that is not on the menu list may be used in a contract. Acceptable circumstances for inclusion of a non-menu measure include:

- the insurer and provider are contracting for a pilot program with a unique patient population and/or clinical focus (e.g., substance-using pregnant women).

Beyond the circumstances listed above, non-inclusion of core measures, or inclusion of non-menu measures in a contract subject to §4.10(D)(5) must be approved by OHIC.

Should an insurer wish to introduce a contractual quality incentive that is tied not to a quality measure, but instead to documentation of implementation of a new or revised care process,

these Aligned Measure Set requirements shall not prohibit the insurer from doing so. Examples of such care processes include:

- improving hospitalist workflows to facilitate more efficient and collaborative discharge planning, and
- developing and implementing pharmacy system alerts to trigger a pharmacist/prescriber consult on various medication topics.

Performance Measurement

With the exception of hospital contracts and core measures, to the extent noted above, at this time OHIC does not mandate or otherwise articulate specific terms around how financial consequences are tied to quality measures (e.g., based on performance or on reporting only) in provider contracts subject to the provisions of §4.10(D)(5) or dictate the financial terms of these arrangements. Moreover, insurers are granted discretion to set minimum denominator sizes for measures to have financial consequences in individual provider contracts, including for Core Measures, to ensure statistically valid measurements. To the extent that any Core Measure does not meet minimum denominator size, the insurer may elect to not include the measure when applying a performance incentive and/or disincentive provision in the contract. OHIC retains the right to request and review an insurer's minimum denominator size policies.

Regarding Use of Specifications

OHIC has developed a document titled 'Crosswalk of RI Aligned Measure Sets.' The document is a crosswalk of the six Rhode Island Aligned Measure Sets (ACO, Acute Care Hospital, Behavioral Health Hospital, Primary Care, Maternity, and Outpatient Behavioral Health). The crosswalk includes a few notable features including information about the measures, links to specifications for each measure, and measure alignment across the six RI Aligned Measure Sets.

The crosswalk has been developed in Excel. It is an adapted version of the Buying Value Measure Selection Tool. The tool has a number of features that have been developed to help assist states, employers, consumer organizations and providers in aligning measure sets. Below is a quick orientation to what information is included in the "Crosswalk of SIM Measure Sets" tab:

- The navy columns to the left (Columns B – K) include basic information about the measure.
- The green column (Column L) includes a designation of whether the measure is facility-based or professional-based.
- The orange column (Columns M) contains special notes about particular measures.
- The purple column (Column N) includes links to the measure specifications.
- The blue columns (Columns O – U) provide status in each of the OHIC Aligned Measure Sets for 2020.

Health insurers should use the measure specifications included in Column N. Insurers should not modify specifications unless OHIC is consulted and able to provide guidance to all insurers implementing the measures.

Insurers may elect to operationalize measures using claims and/or provider reported clinical data. If a practice or ACO is submitting aggregate practice data and an insurer does not provide any information on which patients are to be included in the practice's or ACO's denominator, then insurers should use the clinical data specifications developed by CTC-RI. Insurers have the authority to validate provider-generated measures.

An insurer may petition the Commissioner to modify or waive one or more of the requirements of §4.10(D)(5). Any request to modify or waive one or more of the requirements must articulate a clear rationale supporting the waiver request and must demonstrate how the insurer's request will advance the quality, accessibility, and/or affordability of health care services in Rhode Island.

Instructions: OHIC Aligned Measure Sets, Submission of Measures for Consideration

1. Prepare a cover letter that explains:
    a. for which measure set(s) the measure is being proposed, e.g., ACO, primary care, hospital, behavioral health or maternity;
    b. whether the measure is to be proposed as developmental (i.e., for refinement and/or testing, as is being done currently with SDOH screening) or for the menu or core sets, and
    c. the rationale for adoption of the measure in commercial and Medicaid contracts.
2. Document the measure's specifications and provide other key information using the "OHIC Aligned Measure Sets Measure Submission Template":
    a. the measure steward;
    b. validation testing, and
    c. how the proposed measure matches the Measurement Alignment Work Group's selection criteria.
3. Communicate with OHIC in June to schedule a date to present the measure to the Work Group.

OHIC Aligned Measure Sets Measure Submission Template

Please complete the following document to submit a measure for consideration by the OHIC Measure Alignment Work Group. The work group meets annually during the summer and will consider your submitted measure during its next annual review process.

Please provide your contact information so we can contact you should we have any questions regarding your submission:

Name:

Organization:

Email:

Telephone Number:

Measure Specification

Measure Name:
Steward:
NQF #:
Description

Eligible Population

Product lines	
Stratification	
Ages	
Continuous enrollment	
Allowable gap	
Anchor date	
Lookback period	
Benefit	
Event/diagnosis	
Exclusions	

Specifications

Data Source	
Denominator	
Numerator	

Additional Information

Please describe how the measure meets the following OHIC Measure Alignment Work Group criteria for measure selection:

Criterion	Measure Alignment with the Criterion
1. Evidence-based and scientifically acceptable	
2. Has a relevant benchmark	
3. Not greatly influenced by patient case mix	
4. Consistent with the goals of the program	
5. Useable and relevant	
6. Feasible to collect	
7. Aligned with other measure sets	
8. Promotes increased value	
9. Present an opportunity for quality improvement	
10. Transformative potential	
11. Sufficient denominator size	

If the measure is homegrown, please describe steps taken to validate the measure: