Rhode Island 2018 Alternative Payment Methodology Plan Adopted by Health Insurance Commissioner Marie Ganim

January 24th, 2018

I. Background and Purpose

This 2018 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 Marie Ganim, 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."

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. This plan was developed over the course of three Alternative Payment Methodology Advisory Committee meetings in the fall of 2017.

II. Definitions

1. "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;
- 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 methodologies must define and evaluate 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 insurer's APM targets 3(a) and 3(b), below.

2. "Approved Alternative Payment Methodologies" include:

- Total cost of care budget models;
- Limited scope of service budget models;
- Episode-based (bundled) payments;
- Pay-for-performance payments;
- Supplemental infrastructure payments for patient-centered medical home functions, including care management, paid to PCPs or to ACOs;
- Supplemental infrastructure payments to specialists to provide incentives to improve communications and coordination among PCPs and specialists, and
- Other non-fee-for-service payments that meet the definition (a) above as approved by OHIC.

3. The Alternative Payment Methodology Plan specifies three targets for insurers to achieve.

(a) "Alternative Payment Methodology 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 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 payments, supplemental infrastructure payments for patient-centered medical home functions, including care management, paid to PCPs or to ACOs, and supplemental infrastructure payments to specialists to provide incentives to improve communications and coordination among PCPs and specialists , and
- Shared savings distributions.

(b) "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 insured medical spend. The Non-FFS target defined in this subsection 3(b) is a subset of the APM Target defined in subsection 3(a), above. The Non-FFS Target shall include:

- Episode-based (bundled) payments, either prospectively paid or retrospectively reconciled, where providers share in any losses (or gains);
- Limited scope-of-service capitation payments and global capitation payments (excluding the value of fee-for-service payments for services not covered by the capitation contracts);
- Pay-for-performance payments, supplemental infrastructure payments for patient-centered medical home functions, including care management, paid to PCPs or to ACOs and supplemental infrastructure payments to specialists to provide incentives to improve communications and coordination among PCPs and specialists, and
- Shared savings distributions.

(c) "Risk-Based Contract Target" means the percentage of Rhode Island resident commercial insured covered lives attributed to a population-based contract that holds

the provider financially responsible for a negotiated portion of costs that exceed a predetermined population-based budget, in exchange for provider eligibility for a portion of any savings generated below the predetermined budget, and (ii) incorporates incentives and/or penalties for performance relative to quality targets. Provider financial responsibility may be shared (Risk Sharing Contract) or wholly assumed by the provider (Global Capitation Contract).

Effective 2018, Risk-Based Contracts with 10,000 or more attributed lives must meet the following Minimum Downside Risk requirements to be counted towards the Risk-Based Contract Target defined in Section 3, with "Net Risk" defined to mean the percentage of risk a provider assumes, after the application of any Minimum Loss Rate (MLR), risk corridor, or risk-sharing formula, relative to the total cost of care (or ACO contract revenue for a physician-based ACO). Attachment A provides sample calculations.

ACOs including Hospital Systems[1]	Physician-based ACOs
Between 10,000 and 20,000 commercial lives, as % of projected total cost of care: 2018: Net Risk >/= 1%	Between 10,000 and 20,000 commercial lives, as % of physician organization's ACO contract revenue: 2018: Net Risk >/= 3%
Over 20,000 commercial lives, as % of projected total cost of care: 2018: Net Risk >/= 2%	Over 20,000 commercial lives, as % of physician organization's ACO contract revenue: 2018: Net Risk >/= 5%

The Minimum Downside Risk requirements above, while not applicable to population-based contracts with fewer than 10,000 attributed lives, should not be construed to preclude or discourage health insurers and providers from entering into contracts with downside risk for fewer than 10,000 covered lives. OHIC recommends insurer and provider caution when doing so, however, in order to account for the decreased statistical certainty with attributed populations less than 10,000.

III. Alternative Payment Methodology Targets

1. For purposes of meeting the "**Alternative Payment Methodology Target**" for calendar year 2018, health insurers subject to the Affordability Standards shall take such actions as necessary to have 50% of insured medical payments made through an alternative payment methodology throughout the entirety of the calendar year. For calendar year 2019 the **Alternative Payment Methodology Target** shall remain fixed at 50%.

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

2. For purposes of meeting the "**Non-Fee-for-Service Target**" for calendar years 2018 and 2019, health insurers subject to the Affordability Standards shall take such actions as necessary to have 6% of insured medical payments made through non-fee-for-service models for the entirety of calendar year 2018 and 10% of insured medical payments made through non-fee-for-service models for the entirety of calendar year 2019.

3. For purposes of meeting the "**Risk-Based Contract Target**" health insurers subject to the Affordability Standards shall take such actions as necessary to have:

- 10% of Rhode Island resident insured covered lives under Risk-Based Contracts for the entirety of calendar year 2018, including but not limited to contracts subject to the Minimum Downside Risk requirements (i.e., including any contracts with fewer than 10,000 lives).
- 30% of Rhode Island resident insured covered lives under Risk-Based Contracts for the entirety of calendar year 2019, including but not limited to contracts subject to the Minimum Downside Risk requirements (i.e., including any contracts with fewer than 10,000 lives).

During the fall of 2018, OHIC shall reassess the Risk-Based Contract Target and the Minimum Downside Risk Requirements for 2019 and beyond.

IV. Identified Support for Value-Based Payment Reform

1. Implement a Multi-Payer APM Pilot for Primary Care

Supporting the shift away from fee-for-service-based payment models is an objective of public policy in Rhode Island. OHIC views transformed primary care payment as a means of improving health system performance and promoting access and affordability. Uptake of truly non-FFS based payment models in Rhode Island has been slow.

Building off of the primary care alternative payment model parameters developed by the Primary Care APM Work Group, and issued by OHIC on August 9th, 2017, OHIC will facilitate a collaborative process between interested primary care provider groups and health insurers to implement an APM pilot. OHIC will not mandate strict adherence to the primary care APM model framework, but will encourage as much cross-payer alignment of contracting terms as possible, and OHIC will encourage the selection of a common group of practices among which to deploy the payment model.

A series of ad hoc meetings will be convened by OHIC no later than February 1st, 2018 to facilitate this process. Meeting participants will include parties with a serious interest in pilot participation.

2. Explore Value-Based Payment Model(s) for Pediatrics

Recent payment model innovations in health care prioritize the achievement of short-term cost savings through care management of high risk patients. With few exceptions, the cost-saving imperatives of these payment models focus resources on high cost adult populations, with little meaningful attention or engagement of lower cost pediatric populations. Given the temporal return on investment biases of prevailing population-based payment models against pediatrics,

and the individual and societal benefits that accrue from prevention and promotion of childrens' health, in 2018, OHIC will facilitate a working group process to explore opportunities for improved value-based payment for pediatrics, including but not limited to, how value-based payment for pediatrics could support behavioral health services for children.

3. Assess Opportunities for Selected Commonly Defined Episodes of Care

Specialist engagement in payment reform remains a priority for the OHIC. In November 2017 OHIC was awarded technical assistance support from the Robert Wood Johnson Foundation's State Health and Value Strategies program to analyze and evaluate the magnitude and causes of variation in spending, including but not limited to potentially avoidable complications and price variation, for certain episodes of care in the Rhode Island market. The analysis will supply the empirical basis for the selection of episodes of care by bringing to light information on spending by episode, variations in spending or volume, and the key drivers of total spending by episode. The project is tentatively scheduled to run through the winter and spring of 2018. Upon completion of the project OHIC will reconvene the APM Advisory Committee to discuss the findings and next steps.

4. Assess Operational & Financial Capacity Requirements for ACO Contracts

In 2018 OHIC will explore the development of methods to assess a provider's operational and financial capacity for risk-based contracts. The work will review practices in other states and will also assess the present state of Rhode Island law with respect to risk bearing entities.

V. Conclusion

This 2018 Alternative Payment Methodology Plan is derived from the deliberations and input of the Alternative Payment Methodology Committee. It advances progress towards the goals set forth in the OHIC Affordability Standards.

Dated at Cranston, Rhode Island this 24th day of January, 2018.

Marie Ganim

Marie Ganim, PhD
Health Insurance Commissioner
Office of the Health Insurance Commissioner

Attachment A
Sample Net Risk Calculation

The following examples are based on a contract with a total cost of care (hospital-based ACO) or contract revenue (physician-based ACO) target of $400, where risk is shared: 60% to the provider and 40% to the insurer.

Loss sharing only applies to losses above the Minimum Loss Rate (which is expressed as a percentage of the target). The Maximum Loss Rate is a cap on losses that are shared with the provider (also expressed as a percentage of the target).

Example 1 • Risk sharing: 60/40 • Minimum Loss Rate: 2% • Risk cap: 5%	Maximum Loss: $400 x 0.05 = $20 Minimum Loss Value: $8 Total Provider Risk with Risk Sharing: ($20 - $8) x 0.6 = $7.20	1.8 %
Example 2 • Risk sharing: 60/40 • Minimum Loss Rate: 2% • Risk cap: 7.5%	Maximum Loss: $400 x 0.075 = $30 Minimum Loss Value: $8 Total Provider Risk with Risk Sharing: ($30 - $8) x 0.6 = $13.20	3.3 %
Example 3 • Risk sharing: 60/40 • Minimum Loss Rate: 2% • Risk cap: 10%	Maximum Loss: $400 x 0.1 = $40 Minimum Loss Value: $8 Total Provider Risk with Risk Sharing: ($40 - $8) x 0.6 = $19.20	4.8 %