

State of Rhode Island Office of the Health Insurance Commissioner
Alternative Payment Methodology Committee
Meeting Minutes
May 1, 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

Attendance

Members

Erik Helms, Kevin Callahan, Todd Whitecross, Patrick Tigue, Dan Moynihan, Domenic Delmonico, Chris Dooley, Al Kurose, Noah Benedict, Sam Salganik, Pat McGuigan, Al Charbonneau, Alok Gupta, Pano Yeracaris Tom Breen, Chuck Jones.

Not in Attendance

Mike Souza, Bill Almon Jr.

1. Welcome & Introductions

Dr. Katheen Hittner, Health Insurance Commissioner, welcomed the committee members to the third meeting of the Alternative Payment Methodology Advisory Committee. Dr. Hittner spoke of the committee's work in the context of other state efforts, including Reinventing Medicaid and the SIM grant. She asked the committee to deliver good guidance on 2016 goals and reiterated the importance of setting targets and meeting them.

2. Review of Minutes from April 2, 2015 Meeting

The minutes from the April 2, 2015 meeting were adopted.

3. Update on Care Transformation Committee Activity

Marge Houy of Bailit Health Purchasing presented an overview of the Care Transformation Plan that was adopted by the Care Transformation Advisory Committee on April 27th. The plan adopts a definition of patient-centered medical home that is based on attainment of NCQA level 3 and requires implementation of a set of cost containment strategies and measurable performance improvement of over a two-year rolling look-back period. Ms. Houy also presented the 2016 PCMH target, which requires that insurers achieve a 5 percentage point increase in the percent of contracting primary care clinicians who are operating in a patient-centered medical home. Finally, Ms. Houy presented the sustainable PCMH funding model that was endorsed by the Care Transformation Committee.

Sam Salganik asked if OHIC will be certifying PCMHs. Ms. Houy answered in the affirmative.

Al Kurose commented that implementation of the six cost-containment strategies will be a tall order for small independent practices. This definition is more than standard industry definition. He emphasized that if we want small independent practices to do this, we need to support them and be explicit about this. If we want them to join or create larger entities, we need to be explicit about this.

Noah Benedict stated that the definition doesn't push practices to join ACOs. There needs to be a more explicit tie to what we are doing and whether the OHIC policy is to encourage ACO affiliation.

Erik Helms stated that being a PCMH is necessary but not sufficient. BCBSRI wants small independent practices to migrate to larger systems of care. Mr. Helms also commented that patient experience seems to be missing from OHIC's definition.

Domenic Delmonico commented that the six strategies leave things out. They are also opaque and we need to be able to explain this to people.

Pano Yeracaris stated that four of the six cost containment strategies are already embedded in the NCQA accreditation standards. Therefore, implementation of all six is not as heavy a lift as it seems.

Regarding the 2016 PCMH target, Pano Yeracaris expressed doubt that the addition of the PCMH-Kids practices on 1/1/2016 alone will account for achievement of the insurers' targets.

Erik Helms asked for clarification of how OHIC is defining network. Cory King, OHIC, responded that OHIC is referring to each insurer's contracted RI network.

In the context of the discussion around the PCMH sustainable funding model, Al Kurose commented that the distinction between the two [OHIC] advisory committees doesn't work. Cory King, OHIC, responded that OHIC recognizes the problem and will reconceptualize the committees for the fall.

4. Draft 2016 APM Plan Review

Cory King of OHIC walked the committee through the draft 2016 Alternative Payment Methodology Plan. Committee discussions followed each of the sections of the draft plan.

4.1 Definitions

The committee reviewed the draft language around alternative payment methodology definitions and alternative payment methodology targets.

Dominic Delmonico stated that we should consider longer term goals to reduce fee for service as the primary payment methodology under budget-based models.

Dan Moynihan commented that the two targets [the aggregate and the non-fee for service targets] look redundant. Cory King, OHIC, stated that we could be more explicit about the difference between the two in our write up to explain that the second target is a subset of the first.

Chris Dooley commented that for the “meaningful downside risk” part of the definition, rather than say “overtime,” perhaps we should set a date. Chris Dooley also recommended that we should weigh some payment methodologies more than others on the basis that they are more advanced and innovative.

Marge Houy responded that the inclusion of pay-for-performance and supplemental payment only through 2017 serves as an implicit weighting.

Sam Salganik suggested 2017 as a target date for the movement to meaningful downside risk. Cory King, OHIC, suggested that the committee include 2017 as the target date and operationalize “meaningful downside risk” during the fall convening.

There was not a consensus among committee members that 2017 should be included in the plan as the target date for movement to meaningful downside risk. Some committee members requested more specifics before they could support this language. The question of whether to insert 2017 in the plan as the target date was put to a vote. The majority of the committee supported the inclusion of 2017, with 4 members abstaining, and 1 voting “no” due to a lack of upfront consumer protections.

Al Kurose asked whether movement to downside risk was already included in Regulation 2. Cory King, OHIC, responded that there is a provision in Section 10(d)(1)(B) that insurers have at least 10% of covered lives in a population-based contract with downside risk.

Erik Helms said that he would like to see a target date for meaningful downside risk. He also said that we should be more explicit about our cost goals. What is our goal for a sustainable medical trend? For example, trend no greater than CPI by 2019.

Al Kurose agreed that we should have systemic cost trend goals. He commented that OHIC’s caps on hospital rate increases and ACO budgets are not enough.

Al Charbonneau questioned whether the Affordability Standards are working in terms of their impact on cost. He suggested more evaluation of the Affordability Standards. Cory King, OHIC, stated that the regulations call for periodic evaluations of the standards and an extensive evaluation in 2018.

Erik Helms requested that delegated services be included in the payments that count toward achievement of an insurer’s APM target. He would supply a definition for consideration.

On the issue of consumer protections and access to services in a payment environment where providers are assuming downside risk, Sam Salganik suggested the committee add to the APM definition that “APMs must not unduly limit access to care.” He suggested that OHIC could choose not to count APM payments that could potentially harm consumers by limiting access to care. There was not agreement around the table for inclusion of this new language.

Cory King suggested that the committee address the consumer protection and access issue in the fall and that OHIC present the committee with some options to consider. Mr. King also suggested that the committee further consider and develop targets and goals for sustainable medical trend.

4.2 2016 APM Target

Cory King reviewed the proposed APM targets for 2016. The draft 2016 plan provided that 45% of an insurer’s fully insured medical payments be made through an alternative payment methodology with at least 3% of fully insured medical payments representing strictly non fee for service payments.

Chris Dooley asked to be reminded of the baseline. Cory King stated that the baseline was 20% for July 2013 – June 2014.

Noah Benedict asked for clarification about what percentage the proposed targets are referencing: spending or covered lives. Cory King responded that the targets refer to medical spending.

Erik Helms commented that the distinction between “earned” and “earnable” payments matters for the numerical target. Mr. Helms, who represents Blue Cross Blue Shield of Rhode Island, stated that the target should be based on “earnable” payments. Mr. Helms also stated that insurers should not be the only accountable entities, but that providers should be held accountable for meeting the target too.

Todd Whitecross suggested that the targets reflect a percentage change from a baseline.

Some provider representatives suggested using covered lives attributed to a system of care as the target.

Cory King, OHIC, stated that the section of Regulation 2 [section 10(d)2] that calls for setting payment reform targets has as its goal the reduction of fee-for-service as a payment methodology and the expanded use of alternative payment methodologies. In order for OHIC to implement this payment reform provision of the regulation the Office must specify targets for use of alternative payment methodologies that are based on medical spending.

The Committee was unable to reach agreement on a numerical target and Cory King suggested that OHIC ask insurers for an updated round of data for calendar year 2014, set

baseline measures of alternative payment methodology payments as a percent of insured medical spend, and reconvene the Committee to finalize a 2016 target.

4.3 Identified Support for Value-based Payment Reform

Cory King led the Committee through the draft recommendations for activities to support value-based payment reforms in 2016.

On the topic of a core measure set, Noah Benedict requested that providers be involved in measure set development. Cory assured him that providers will be involved and this would be specifically included in the draft plan.

Due to lack of time and the decision to hold one more meeting, the purchaser engagement and plan design components of the draft APM plan were not discussed.

Committee members concluded the meeting by discussing the need for all stakeholders in the delivery system, including the state, to answer important policy questions, such as whether small independent practices should affiliate with larger systems to improve health care delivery and slow medical trend, or whether we should maintain efforts to transform small independent practices.

Al Kurose said that PCMH alone cannot reduce medical trend, but PCMHs operating as part of larger organizations can. Mr. Kurose expressed that there is a need to aggregate practices if our health system goals are to be met.

Several Committee members supported this sentiment.

Chris Dooley stated that our message should be that independent practices can exist, but they should affiliate with a larger organization for purposes of participating in risk contracting and population health management initiatives.

Cory King stated that he will draft some language for inclusion with the plan to reflect the Committee's message to the state regarding system affiliation of independent practices and other issues that the Committee has raised.

5. Next Steps

OHIC will reach out to the insurers for a data refresh.

6. Public Comment

There was no public comment.