OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

Joint Care Transformation and Alternative Payment Methodology Advisory Committees
Meeting Agenda
October 1, 2015, 8:00 A.M. to 10:00 A.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

1. Introductions

2. Review of goals of Affordability Standards to improve the performance of the RI health care system as a whole

3. Discussion of how Affordability Standards work relates to other state transformation initiatives

4. Review charge of Advisory Committees' responsibilities
    a. CT Advisory Committee is to develop a plan to achieve 80% PCMH target
    b. APM Advisory Committee is to develop a plan for increasing the use of alternative payment methodologies for hospital services, medical and surgical services and primary care

5. Summary of 2016 CT and APM Plans

6. Discuss request to combine two advisory committees
    a. Review upcoming agenda items for each committee
    b. Discuss approach for cross-meeting participation

7. Discussion topic: How to ensure ongoing transformation of primary care in light of the growth of ACOs
    a. Roles and responsibilities of ACOs, payers, OHIC, primary care practices

8. Conclusion

9. Public Comment

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Meeting Minutes
October 1, 2015, 8:00 A.M. to 10:00 A.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Committee Members: Gus Manocchia, David Brumley, Tracey Cohen, Mary Hickey, Brenda Briden, Russell Corcoran, Beth Lange, Ed McGookin, Andrea Galgay, Christine Grey, Tina Spears, Darlene Morris, Deb Hurwitz, Pano Yeracaris, Kathleen Calandra, Mary Craig, Todd Whitecross, Dan Moynihan, Al Kurose, Noah Benedict, Sam Salganik, Pat McGuigan, Alok Gupta, Chuck Jones, Tom Breen, Erik Helms, Patrick Tigue

Not in Attendance:
Kevin Callahan, Gina Rocha, Pat Flanagan, Peter Hollmann, Maria Montanaro, Mike Souza, Domenic Delmonico, Chris Dooley, Bill Almon, Jr., Al Charbonneau, James Fanale

1. **Introductions**

2. **Review goals of Affordability Standards to improve the performance of the RI health care system as a whole**

   Kathleen Hittner, Health Insurance Commissioner, stated that decreasing rates is the ultimate goal to make health insurance more affordable. She also stated that she wants practices to be happy in their practices, patients to be satisfied, and would like to further explore the relationship between ACOs and PCMHs.

3. **Discussion of how Affordability Standards work relates other state transformation initiatives, including the Governor's Work Group, SIM, Reinventing Medicaid**

   Kathleen Hittner, OHIC, briefly explained that the state interagency team for SIM has been meeting weekly to prepare for the monthly SIM Steering Committee meetings. She also announced that Marti Rosenberg has been hired to manage the SIM grant – she will be work out of the OHIC office which will continue the coordination between SIM and the Affordability Standards.

Rich Glucksman, BCBSRI, noted that it would be helpful to understand what discussions are being conducted and where so that stakeholders can be present for the decision-making process. He also asked about coordination with the Department of Health, especially regarding ACOs.

Cory King, OHIC, noted that page 14 of the Reinventing Medicaid report speaks to moving away from fee-for-service (FFS) payments to alternative payment methodologies (APMs) with a 2018 target for 50% of payments for APM. OHIC will be working with Medicaid on similar definitions and reporting methods.

Pano Yeracaris, CTC-RI, stated that payment reform is about the "payment under the payment".

Andrea Galgay, RIPCPC, asked about the relationship between the Affordability Standards Committees and OHIC's Health Insurance Advisory Council (HIAC). Sarah Nguyen, OHIC, responded that HIAC is regularly updated on the status of this work and that they give feedback on the topics discussed at the Affordability Standards convenings.

4. **Review charge of Advisory Committees' responsibilities**
   a. Care Transformation Advisory Committee is to develop a plan to achieve 80% PCMH target

      Sarah Nguyen, OHIC, reiterated that the goal of the Care Transformation Advisory Committee is to identify specific responsibilities and initiatives to achieve the 80% PCMH target.

   b. APM Advisory Committee is to develop a plan for increasing the use of alternative payment methodologies for hospital services, medical and surgical services and primary care

      Cory King, OHIC, stated that the APM Advisory Committee goal is to reduce FFS as a payment methodology and to set targets and specify activities to achieve the targets.

5. **Summary of 2016 CT and APM Plans**

   The 2016 Care Transformation and APM Plans were reviewed by Sarah and Cory.

   Pano Yeracaris, CTC-RI, noted a future agenda topic for the Care Transformation Advisory Committee (a name change from "Care Transformation" to "Primary Care Transformation" Advisory Committee). He noted that there was a greater need to involve specialists in these conversations. Sarah Nguyen, OHIC, responded that this would be discussed at Monday's Care Transformation Meeting.

6. **Discuss request to combine two advisory committees**
   a. Review upcoming agenda items for each committee

b. Discuss OHIC's approach for cross-meeting participation

Sarah Nguyen, OHIC, discussed OHIC's approach to a request to combine the two Advisory Committees. She explained that OHIC decided on an initial joint committee to review scheduled topics for each for the fall, but to keep the committees separate. However, each group can attend the other's meetings, and will receive materials for both committees.

Andrea Galgay, RIPCPC, recommended a combined, wrap-up meeting at the end of the fall convenings. Sarah Nguyen, OHIC, responded that OHIC would schedule that joint wrap-up meeting.

Pat McGuigan, Prov Plan, indicated that he would like the two committees to develop a shared agenda, not just share information.

During the discussion of committee topics, Pano Yeracaris, CTC-RI, asked if the plan design conversation would be happening as a part of the "consumer engagement" topic. Dr. Hittner responded that that is the case and that the plan design conversation was also happening at OHIC's Administrative Simplification Taskforce. Patrick Tigue, NHPRI, remarked that plan design is a cross-cutting topic that should be addressed by both the Affordability Standards committees and by the Administrative Simplification Taskforce.

There was also a discussion on behavioral health – one member suggested that behavioral health be specifically called out in the Affordability Standards work and that there is still a strong need for better integration. Cory King, OHIC, discussed the SIM RFP approach to the Population/Behavioral Health Plan.

During the discussion of each committee's topics, the following points were noted by Committee members:

i. The PCMH sustainable funding model is important to the APM conversation as well.
ii. Involving specialists in APMs should include behavioral health specialists.
iii. It should be made explicit that plan design is a part of the consumer engagement strategy.

7. Discussion topic: How to ensure ongoing transformation of primary care in light of the growth of ACOs

Michael Bailit, Bailit Health Purchasing, framed the issue and encouraged development of a consensus longer term vision of primary care transformation and payment. Kathleen Hittner, OHIC, reiterated her commitment to primary care and that she was hopeful but uncertain about ACOs.

Committee members discussed the fact that there are different ACO models (some are primary care based and others are institutionally-baesd) and that their differences should be accounted for when discussing this topic. Members also discussed the governance model for ACOs and many committee members advocated for a strong primary care presence and involvement in the governance of ACO entities. Some practices are worried that ACO care management dollars are not flowing to the practice.

Sam Salganik, RIPIN, noted that he sees three ways better that integration and lower costs can be achieved through ACOs: better coordination of care, restriction of access, or seeking out healthy patients. Sam emphasized the need to have consumer protections in place to prevent the latter two approaches.

Committee members also discussed the need for engagement of small practices and specialists, specifically noting that primary care practices should not be the only ones held accountable – hospitals and specialists should also be held accountable.

Darlene Morris, RIQI, gave a brief overview of the Practice Transformation Network grant they received from CMS: This is a quality improvement project that will provide:

- Practice transformation assistance towards NCQA or other recognition, with an emphasis on specialists and small practices;
- A physician leadership academy;
- Care coordination and transition assistance through CurrentCare;
- Assistance to practices looking to enter into value-based contracts (RIQI can only give technical assistance when the practices are not in value-based contracts); and
- Performance measurement.

Gus Manocchia, BCBSRI, indicated that Blue Cross is now starting to see a return on investment from PCMHs that have been involved in the program for four years. He also stated that he believes the system should move faster towards accountable care models – where care is cost effective, high-quality, and there is patient satisfaction.

Chuck Jones, Thundermist, remarked on the need for better information flow to practices if primary care is to succeed. Other committee members echoed his statement.

David Brumley, Tufts, discussed the need to leverage specialist and address pharmacy spend – committee members generally agreed and noted the need to align incentives between providers and focus on specialists. Erik Helms, BCBSRI, suggested that specialists be called out as a specific bullet in this work – he also suggested tying reimbursement to quality targets for specialists.

Michael Bailit, Bailit Health Purchasing, noted that Vermont will be tying hospital payments to a fixed revenue budget with a fixed trend over five years and pursuing primary care capitation as part of a state-wide, all-payer initiative.

Committee members discussed the need for cost and quality goals for PCPs but also mentioned the burden of measuring these goals and lack of provider satisfaction – one committee member asked about primary care physician incomes over the past few years.

Dan Moynihan, Lifespan, suggested that regulation around standards such as attribution, risk adjustment methodologies, and quality metrics would help level the playing field while still allowing systems of care the flexibility to create value within these standards.

Committee members discussed the value of multi-payer approaches and both incentives and disincentives in order to move the health care system towards accountable care, including specifically mentioning the PCP educational campaign outlined in the 2016 Care Transformation Plan.

Pat McGuigan, Providence Plan, asked what the Commissioner can do to accelerate progress away from fee-for-service payments.

8. Conclusion

9. Public Comment

There was no public comment.

OFFICE OF THE
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STATE OF RHODE ISLAND

Joint Meeting of the Care Transformation & Alternative Payment Methodology Advisory Committees

October 1, 2015

Agenda

- Introductions
- Review goals of the Affordability Standards
- Discuss how the Affordability Standards process relates to other state transformation initiatives
- Review charge of Advisory Committees' responsibilities
- Summary of 2016 CT and APM Plans
- Discuss request to combine the two advisory committees
- *Discussion*: How to ensure ongoing transformation of primary care in light of the growth of ACOs.
- Conclusion
- Public Comment

Goals of the Affordability Standards

- Reduced rates of premium increase for fully insured, commercial health insurance.
- Reduced incidence of hospitalizations for ambulatory care sensitive conditions, and of potentially preventable readmissions.
- Reduced incidence of emergency room visits for ambulatory care sensitive conditions.
- Strong payer-provider networks capable of managing population health and total cost of care.

Committee Charges

- Primary Care Transformation Committee:
  - To develop a plan to achieve target of 80% of primary care providers in a PCMH by 2019.
  - To specify activities necessary to achieve the transformation target.

- Alternative Payment Methodology Committee:
  - To significantly reduce fee for service as a payment method and to set annual targets for payment reform.
  - To specify activities necessary to achieve the payment reform targets.

Summary of 2016 Care Transformation Plan

- Three-part definition of PCMH for purposes of PCMH financial support:
  - NCQA Level 3 recognition;
  - Implementation of cost containment strategies;
  - Performance improvement;

- 2016 PCMH Target: + 5 percentage points above baseline.

- Sustainable Financial Model:
  - Two-stage payment model

Summary of 2016 APM Plan

- Defines Alternative Payment Methodologies for the purposes of the Affordability Standards.

- Establishes an Aggregate APM Target and a strictly Non-Fee for Service Target, based on commercial insured medical spending.
  - Specifies which types of payments count for each target.

- Sets 2016 Targets as percentage point increases over baseline year 2014.
  - Aggregate Target: + 7 Percentage Points.
  - Non-FFS Target: + 1.5 Percentage Points.

Fall Committee Topics

Care Transformation

- # of practices meeting PCMH definition
- 2017 PCMH target
- Initiatives to promote PCMH transformation and remove barriers
- **High-risk patient list**
- Sustainable funding model
- **Common contractual standards**

APM

- **Meaningful downside risk**
- Protecting member access
- **Involving specialists in APMs**
- **Consumer engagement**
- 2017 and 2018 APM Targets

How to ensure ongoing transformation of primary care in light of the growth of ACOs.

- Discussion
  - What are the roles and responsibilities of:
    - ACOs;
    - Payers;
    - OHIC;
    - Primary care practices.
  - Regarding:
    - Technical assistance to practices to guide transformation;
    - Building infrastructure to manage risk (e.g., care management, informatics, community health workers);
    - Funding care transformation.
  - Special considerations when PCPs are employed by hospitals or large medical groups?

Fall Schedule of Meetings

- Please see handout and note dates/times of future meetings.
- Members of the Committees are free to participate in any or all meetings.

Updated as of August 14, 2015

Fall 2015 Affordability Standards Committees

Care Transformation Committee	Alternative Payment Methodology Committee
Thursday October 1st: 8am-10am	Thursday October 1st: 8am-10am
Monday October 5th: 8am-11am	Friday October 16th: 8am-11am
Thursday October 22nd: 8am-11am	Thursday November 5th: 8am-11am
Friday November 13th: 8am-11am	Friday November 20th: 8am-11am
Monday November 23rd: 8am-11am	Monday November 30th: 8am-11am

Meeting Location:
Department of Labor and Training (DLT)
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920

Care Transformation Advisory Committee
Upcoming Meeting Agendas for Fall 2015

Meeting One (October 5, 2015)

- Name change to Primary Care Transformation Advisory Committee
- Finalize definition of PCMH
    - Requirements regarding cost containment strategies
    - Requirements regarding performance improvement
- Discuss provider focus group results and barriers to transformation
- Identify initiatives to reduce/eliminate barriers to transformation
- Discuss opportunity to refine high-risk patient list provided by payers to practices
- Update on SIM Measure Alignment Workgroup

Meeting Two (week of October 22, 2015)

- Develop consensus on initiative to reduce barriers to transformation
- Continue discussion on enhancing high-risk patient list
- Discuss implementation of sustainable PCMH financial model
- Discuss possible common contractual requirements

Meeting Three (November 13, 2015)

- Review baseline data on percent of practices meeting PCMH definition
- Establish 2017 PCMH targets
- Finalize recommendations to refine and aggregate high-risk patient lists from payers
- Finalize actions by payers to address barriers to transformation
- Finalize agreement on common contractual standards and procedures to include in Care Transformation Plan
- Discuss steps to develop, review and submit Care Transformation Plan to the Commissioner by January 1, 2016

Meeting Four (November 23, 2015)

- Finalize 2017 PMCH target
- Finalize 2017 Care Transformation Plan

Alternative Payment Methodology Advisory Committee
Upcoming Meeting Agendas for Fall 2015

Meeting One (October 16, 2015)

- Discuss proposed 2017 and 2018 Aggregate and Non-Fee-for-Service targets
- Review current stakeholder activities to achieve 2016 targets
- Discuss plan design options to promote APM adoption, including strategies for including specialists
- Discuss potential unintended adverse consequences of Total Cost of Care contracting
- Discuss proposed definition of Meaningful Downside Risk
- Discuss plan initiatives to achieve APM targets

Meeting Two (November 5, 2015)

- Finalize recommendations regarding 2017 and 2018 APM targets
- Discuss developing value-based specialists profiles to inform PCP referrals
- Discuss priorities regarding plan design options to promote APM adoption, including strategies for including specialists
- Discuss steps to mitigate unintended adverse consequences of Total Cost of Care contracting
- Finalize strategy for achieving Meaningful Downside Risk targets

Meeting Three (November 20, 2015)

- Finalize recommendations regarding developing value-based specialists profiles
- Finalize recommendations regarding plan design options to promote APM adoption
- Finalize recommendations to mitigate unintended adverse consequences of Total Cost of Care contracting
- Discuss steps to develop, review and submit 2017 APM Plan to the Commissioner by January 1, 2016

Meeting Four (November 30, 2015)

- Finalize 2017 APM Plan

Rhode Island 2016 Care Transformation Plan
As Adopted by the Health Insurance Commissioner Kathleen C Hittner
July 9th, 2015

I. Background

This 2016 Care Transformation Plan is adopted pursuant to Section 10(c)(2)(A) of Regulation 2: Powers and Duties of the Office of the Health Insurance Commissioner, by Kathleen C Hittner, Health Insurance Commissioner.

Pursuant to Section 10(c)(2)(A) of Regulation 2, the Care Transformation Advisory Committee submitted to the Health Insurance Commissioner a 2016 Care Transformation Plan which is designed to move primary care practice transformation activities towards achieving OHIC's 2019 target of 80% of Rhode Island primary care clinicians practicing in a Patient-Centered Medical Home (PCMH).[1] A plan was developed over the course of three Committee meetings by the Committee members, who are listed in Appendix A. The Committee's plan was then adopted with the following modifications (in red and underlined) by the Commissioner.

II. Definition of Patient-Centered Medical Home

Cognizant that being recognized as a PCMH by an external organization does not mean that a practice has effectively implemented PCMH processes to improve cost and quality of care, the Committee developed the following three-part definition of PCMH against which RI primary care practices will be evaluated:

a. Practice is participating in or has completed a formal transformation initiative[2] (e.g., CTC-RI, PCMH-Kids or a payer or ACO-sponsored program) and/or practice has obtained NCQA Level 3 recognition.
b. Within 12 months of seeking PCMH status under the Affordability Standards, Practice has implemented the following specific cost-containment strategies (strategy development and implementation at the practice level rather than the practice site level is permissible):
    i. develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;
    ii. practice uses data to implement care management[3], focusing on high-risk patients and interventions that will impact ED and inpatient utilization;

[1] Affordability Standards Section 10(c)(1)

[2] A formal PCMH transformation initiative is a structured training program for primary care providers and support staff with a pre-defined curriculum and technical assistance based on an evidence-based PCMH transformation model and designed to systematically build the skills within the practice to function as a PCMH.

iii. implements strategies to improve access to and coordination with behavioral health services;
iv. expands access to services both during and after office hours;
v. develops service referral protocols informed by cost and quality data provided by payers; and
vi. develops/maintains an avoidable ED use reduction strategy.

c. Practice has demonstrated meaningful performance improvement. Using a two-year lookback period with a 6-months' claims lag, initial performance improvement must be demonstrated based on the claims data covering the first 24-months after seeking PCMH status under the Affordability Standards. Practice must continue to demonstrate improvement annually thereafter, using a rolling two-year look-back period with a 6-months' claims lag. OHIC shall define "meaningful performance improvement" in consultation with the Advisory Committee.

Under this definition, the Practice will be considered a PCMH so long as the Practice is participating in a formal transformation initiative and/or has attained NCQA Level 3 recognition. In addition, by the end of the first year, the Practice must also meet the cost containment strategy implementation requirements, and by the end of the second year, following a 6-month claims run-out, the practice must meet all three requirements in the definition of PCMH. These requirements are displayed in the following chart:

Practice Responsibility	Initial PCMH designation	End of Year One	End of Year Two
Participating in formal initiative and/or attained NCQA Level 3 recognition	x	x	x
Implemented cost containment strategies		x	x
Demonstrated required performance improvement			x

The recommended process for operationalizing this definition is outlined in Appendix B.

[3] Practices shall implement "care coordination" for children, which is a broader set of services not exclusively focused on high-risk patients. See R Antonelli, J McAllister, J. Popp. "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework." The Commonwealth Fund, publication number 1277, May 2009.

III. PCMH Target for 2016

OHIC requires that by December 31, 2016 each insurer subject to the Affordability Standards shall increase the percentage of its primary care network functioning as a PCMH by 5 percentage points, compared to the baseline rate calculated by OHIC pursuant to the process outlined in Appendix B. OHIC intends to calculate a baseline percentage by September 1, 2015 or soon thereafter. This baseline will not include the practices associated with PCMH-Kids that are slated to begin receiving PCMH payments starting January 1, 2016.

For 2016, the baseline and target percentages will be calculated based on the practice achieving NCQA PCMH Level 3 recognition or receiving sustainability payments consistent with the Sustainability Financial Model, detailed in Section VI of the Care Transformation Plan. Beginning January 1, 2017, to be considered a PCMH for the purposes of this calculation, a practice must meet all requirements specified in the definition of PCMH delineated in Section II of the Care Transformation Plan, and be receiving sustainability payments from insurers that are consistent with the Sustainability Financial Model, detailed in Section VI of the Care Transformation Plan.

IV. Stakeholder Activities in 2015 to Promote PCMH Adoption

OHIC will require the following activities during the balance of 2015 to advance PCMH transformation by Rhode Island primary care practices. The activities are designed to both engage new primary care practices in practice transformation and to improve the performance of practices currently undergoing PCMH transformation.

1. PCP Educational Campaign

Insurers have reported that there are a large number of small primary care practices that are not currently engaged in practice transformation activities. To increase practice understanding of the benefits and expectations associated with practice transformation, The Commissioner shall request CTC-RI to conduct an educational campaign directed towards unaligned primary care practices. The leadership of CTC-RI should lead the outreach efforts to practices sites and include an open forum to all practices who are interested. The campaign's messaging and communications vehicles should be informed by OHIC-convened provider focus groups and likely include:

- Educational sessions: in-person and webinars
- Written materials, explaining how PCMHs differ from usual practice
- Articles in payer and professional association newsletters

The campaign should run in the Fall of 2015.

Estimated cost: $6,190, to be funded by insurers:

- Hold 10 breakfast meetings for 20 participants @ $25.00 each = $5,000

- WebEx webinars: $100 per month for 6 months = $600
- One-page, two-sided, color handout summarizing PCMH benefits/expectations: 500 copies at $1.18 each = $590

The estimated cost for this insurer-funded PCP education campaign shall count as indirect primary care spending.

2. Care Manager Academy

Clinical care managers have a major role in controlling costs and improving patient health. To build their skill set, the Commissioner shall request CTC-RI to hold a one day-long learning academy for all current and new practice-based care managers, including care managers functioning within the context of an Accountable Care Organization. The learning academy should be staffed by experienced, skilled payer care managers and experienced, skilled practice-based care managers. The focus should be on 1) enhancing identification and management of high risk patients for whom care management interventions will have a significant impact on future costs and patient well-being 2) functioning within an integrated behavioral health environment, and 3) coordinating care management services among provider and payer organizations. To implement the learning academy, CTC-RI should solicit input from practice-based care managers regarding their areas of concern. Additionally, this effort could have multiple tracks – one for beginning care managers and one for more advanced care managers.

The learning academy should be held no later than September or October 2015.

Estimated cost: $8000, to be funded by insurers:

- Conference for 150 participants
- Light breakfast
- Lunch: sandwiches and salads
- AV equipment
- Room rental

3. Care Management Coordination Work Group

As an increasing number of care managers are practice-based or functioning within the ACO structure, there is a greater need to coordinate care management activities between practices and payers. The Commissioner shall request CTC-RI to expand its current work in this area by expanding participation on its work group to non-CTC-RI practices in order to develop a standard protocol(s) for coordinating activities. It is anticipated that the work group would meet monthly for a year, beginning in June 2015, to develop coordinating protocols. The work group should present its work at future care manager learning academies.

Estimated Cost: participants' time

4. Annual Care Transformation Advisory Committee Meetings

Pursuant to the Affordability Standards, Section 10(c)(2)(A), the Care Transformation Advisory Committee will reconvene on or around October 1, 2015 to develop the next annual Care Transformation Plan. The stakeholders anticipate holding between three and four meetings to develop the Care Transformation Plan for 2017.

5. Standard Core Measure Set

The Committee recognizes the need to coordinate measures payers use to reward performance so that providers are receiving a consistent, coherent message regarding priorities for change. The Commissioner will formally request that the SIM HIT and Measurement Work Group be convened and develop a core measure set for use by all Rhode Island public and private payers that takes into account existing multi-payer measure sets.

V. Stakeholder Activities in 2016 to Promote PCMH Adoption

The following activities in 2016 will help advance PCMH transformation by Rhode Island primary care practices. The activities are designed to both engage new primary care practices in practice transformation and to improve the performance of practices previously engaged in PCMH transformation.

1. PCP Transformation Support Activities

Supports will need to be expended in order to help practices transform to and operate effectively as PCMHs. The Commissioner shall request CTC-RI to continue to support previously identified and engaged practices, including those pediatric practices identified through the PCMH-Kids initiative. The Commissioner shall also request the Executive Office of Health and Human Services, OHIC, CTC-RI and major Rhode Island payers coordinate transformation approaches in order to maximize the impact of payer, CTC-RI and SIM-funded activities to provide transformational support. In the event that RIQI receives a PTN grant, The Commissioner shall request RIQI to also coordinate its transformation activities for primary care practices with CTC-RI, PCMH-Kids and major Rhode Island payers. Transformation supports should be aimed at building and sustaining high performance in access, quality of care, patient experience, and cost management and position PCMHs to participate in ACO arrangements to the extent that they may not be doing so already.

Estimated Costs:

- CTC-RI administrative funding support from insurers (currently being funded).
- CMS grant to RIQI, if awarded.

2. Care Manager Academy

To continue building care managers' skill sets, the Commissioner shall request CTC-RI to hold two day-long learning academies for all CTC-RI and non-CTC-RI, practice-based care

managers, including care managers functioning within the context of an Accountable Care Organization. The learning academy should be staffed by experienced, skilled payer care managers and experienced, skilled practice-based care managers. The focus should be on enhancing identification and management of high risk patients for whom care management interventions will have a significant impact on future costs and patient well-being, as well as on coordinating care management services among provider and payer organizations and on working within an integrated behavioral health environment. To implement the learning academy, CTC-RI should solicit input from practice-based care managers regarding their areas of concern.

The learning academies should be held in April and October 2016.

Estimated cost: $8000 per session; $16,000 for two sessions, to be funded by insurers:

- Conference for 150 participants
- Light breakfast
- Lunch: sandwiches and salads
- AV equipment
- Room rental
- Printed materials

3. Community Health Team (CHT) Pilot

The Commissioner shall request that the SIM Steering Committee use the proposed SIM funds allocated to CHTs be used to expand CTC-RI's current CHT program.

The CHT pilot should run from September 1, 2015 through August 31, 2017.

Estimated cost: $290,000 per year; $580,000 for two years, to be funded by SIM grant funds, if approved by the SIM Steering Committee:

- Community Health Team including behavioral health care manager, social worker, and community health workers: $290,000
- Office space: in-kind contribution by payer or other host organization
- Telephone: in-kind contribution by payer or other host organization

4. Annual Care Transformation Advisory Committee Meetings

Pursuant to the Affordability Standards, Section 10(c)(2)(A), the Care Transformation Advisory Committee will reconvene on or around October 1, 2016 to review the success of the prior year's plan while learning from the past year's experience, develop the next annual Care Transformation Plan. The stakeholders anticipate OHIC holding between three and four meetings to develop the Care Transformation Plan for 2018.

VI. Sustainable PCP Financial Model

OHIC shall require insurers to adopt the following two-stage payment model to sustain primary care transformation in practices beginning January 1, 2016. Insurers shall minimally apply this model to practices that have met the OHIC definition of a PCMH delineated in Section II, above. This includes those practices participating in a formal transformation initiative (e.g., CTC-RI, PCMH-Kids or a payer or ACO-sponsored program).

- First Stage: Practices actively engaged in first-time PCMH transformation activity and without NCQA recognition Level 3 or practices with NCQA recognition Level 3, but which have not yet met the cost containment strategy or performance improvement requirements within the timeframe outlined in Part II, receive both infrastructure and care management (CM) (care coordination for pediatrics) PMPM payments. Practices are eligible to receive infrastructure payment for a maximum of 24 months or until NCQA PCMH Level 3 recognition is achieved, whichever occurs first. If the practice is part of an ACO, the payer may make the CM PMPM payment to the ACO, but the ACO must use that payment to finance CM services at the practice site earning the payment.
- Second Stage: Practices with NCQA Level 3 recognition and which have implemented the cost containment strategies and demonstrated performance improvement receive a CM PMPM payment and have an opportunity to earn a performance bonus. If the practice is part of an ACO, the payer may make the CM PMPM payment to the ACO, but the ACO must use that payment to finance the CM services at the site earning the payment.

Example Scenarios for Practices Engaged in Practice Transformation:

Example	NCQA Level 3	All Required Cost Containment Activities Implemented	Performance Improvement Achieved	Care Management PMPM	Infrastructure Payment PMPM	Performance Bonus Opportunity
1	✓	✓	✓	✓	X	✓
2	✓	X (but still within 12-month timeframe for implementation)	X (but still within 24-month timeframe for implementation)	✓	✓	X
3	✓	X (but still within 12-month timeframe for implementation)	✓ (but still within 24-month timeframe for implementation)	✓	✓	X
4	✓	✓ (but still within 12-month timeframe for	X (but still within 24-month timeframe for	✓	✓	X

		implementation)	implementation)			
5	✓	X (and 12-month timeframe for implementation has passed)	X (and 24-month timeframe for implementation has passed)	X	X	X
6	X (newly participating in a formal transformation initiative)	X but still within 12-month timeframe for implementation)	X (but still within 24-month timeframe for implementation)	✓	✓	X
7	X	X (and 12-month timeframe for implementation has passed)	X (and 24-month timeframe for implementation has passed)	X	X	X

The purpose of the CM PMPM payment is to support development and maintenance of a care management function within that practice and is not limited to supporting a care manager, per se. The purpose of the infrastructure payment is to compensate practices for the time and effort involved in achieving NCQA PCMH Level 3 recognition and establishing basic policies and procedures necessary for PCMH function, including developing clinical data capture, reporting and analysis capacity.

The monetary levels of support for CTC-RI and for PCMH-Kids are determined by the program participants, subject to the approval of OHIC. The monetary levels of support for practices with NCQA Level 3 recognition not currently participating in a formal transformation initiative (e.g., CTC-RI, PCMH-Kids, and payer or ACO-sponsored program) should be independently determined by the payers.

To assure that the care management function is being implemented as effectively as possible, payers should conduct regular CM evaluations. OHIC shall work with the payers to follow the Committee recommendation that large volume practices and ACOs have an evaluation annually and that other practices receive evaluations on a rotating basis, possibly every two-to-three years. The evaluations should be designed to provide helpful, real-time feedback to the care managers.

The sustainability model shall become effective in 2016.

Estimated minimum cost, to be funded by insurers:

- CTC-RI
- PCMH-Kids: ~18,000 covered children at $TBD pmpm, effective January 1, 2016

- Care manager evaluations: evaluators' time (this estimate will be revised as conversations continue with payers to develop the scope and model for this evaluation)

VII. Conclusion

The Commissioner has adopted the Care Transformation Advisory Committee's plan with modifications as meeting the requirement of Regulation 2 to develop a Care Transformation Plan. This plan sets an achievable PCMH goal for 2016 and draws upon the resources and commitment of a range of stakeholders while creating a solid foundation for more aggressive steps in future years.

Dated at Cranston, Rhode Island this 9th day of July, 2015.

Kathleen C Hittner, MD

Kathleen C Hittner, MD.
Health Insurance Commissioner
Office of the Health Insurance Commissioner

Appendix A

List of Care Transformation Advisory Committee Members and Organizational Affiliations

Committee Member	Affiliation
Gus Manocchia	BCBSRI
Kevin Callahan	UnitedHealthcare
David Brumley	Tufts Health Plan
Alison Croke	NHPRI
Gina Rocha	HARI
Mary Hickey	Lifespan
James Fanale	Care New England
Brenda Briden	CharterCare
Russell Corcoran	South County Hospital
Beth Lange Pat Flanagan	PCMH-Kids
Ed McGookin	Coastal Medical
Andrea Galgay	RIPCPC
Peter Hollmann	University Medicine
Christine Grey	Blackstone Valley CHC
Tina Spears	RIPIN
Maria Montanaro	BHDDH
Darlene Morris	RIQI
Deb Hurwitz Pano Yeracaris	CTC-RI
Kathleen Calandra	HealthCentric Advisors
Deidre Gifford	Medicaid

Appendix B
Operational Definition of PCMH

The following definition applies only to Rhode Island-based primary care practices.

1. Identify practice sites participating in a formal transformation initiative
    a. OHIC requests the following information:
        i. Obtain from CTC-RI: list of CTC-RI providers, providers' National Provider Identifier (NPI) numbers, names of practice sites, and practice site contact information;
        ii. Obtain from PCMH-Kids: list of PCMH-Kids providers, providers' NPI numbers, names of practice sites and practice site contact information;
        iii. Obtain from RIQI: in the event that RIQI receives a PTN grant, list of participating PCPs, providers' NPI numbers, names of practice sites, and practice site contact information;
        iv. Obtain from BCBSRI: list of non-CTC-RI providers in PCMHs, providers' NPI numbers, names of practice sites and practice site contract information; list of all contracted PCPs in the BCBSRI network, providers' NPI numbers, names of practice sites and practice site contact information.
        v. Obtain from UnitedHealthcare: list of all contracted PCPs in the United network, providers' NPI numbers, names of practice sites and practice site contact information.
    b. OHIC obtains from NCQA the names of providers, names of practice sites and practice addresses that have NCQA PCMH recognition, including Level 3 recognition
        i. As necessary, OHIC obtains from either United or BCBSRI the providers' names, practice addresses, and national ID numbers.
    c. OHIC creates a master database based on BCBSRI's and United's contracted network.
    d. OHIC indicates in its database which of the practice sites is participating in which formal care transformation initiative and which have NCQA PCMH Level 3 recognition.

2. Practice sites participate in specific cost-containment strategies
    a. OHIC creates a targeted self-reported survey targeting the specific cost-containment strategies that either:
        i. requires yes/no responses, or
        ii. requires scaled responses that indicate relative level of strategy implementation.

b. OHIC works with the Care Transformation Advisory Committee to determine minimum standards for meeting the PCMH definition.
c. OHIC distributes the survey electronically to practice sites participating in a formal practice transformation initiative or have NCQA PCMH Level 3 recognition.
d. OHIC collects and analyzes the results compared to pre-determined minimum requirements to qualify as PCMH.
e. OHIC incorporates the results into its tracking system.

3. Practice sites demonstrate meaningful improvement over an annual two-year look-back period.
    a. Selection of measures and establishing performance/improvement targets:
        i. Until the SIM committee has created a core measure set, OHIC will use a limited number of adult and pediatric HEDIS measures it selects, after consultation with payers and practices. After the SIM committee has created a core measure set, OHIC will select a limited number of measures to use, after consultation with payers and practices.
        ii. OHIC will work with the Care Transformation Advisory Committee to establish performance improvement targets, taking into consideration the population being served by the provider, minimum denominator size, and also decision rules for determining whether sufficient improvement has been demonstrated across the measure set.
    b. Data Collection
        i. OHIC will investigate if the APCD could be used for this project.
        ii. Until the APCD is available, OHIC will ask payers to submit numerators and denominators for each measure by practice site for all its commercially enrolled covered lives.
    c. Data Reporting
        i. OHIC will obtain the data from the payers and aggregate it by practice site.
        ii. OHIC will incorporate the results into its tracking system.

4. Calculating the percentage of RI primary care practice sites that are PCMHs
    a. OHIC will use the information it has collected regarding each of the three parts of the definition of PCMH to calculate the percentage of RI primary care practice sites qualifying as PCMHs.
    b. OHIC will share the calculated percentage, as well as the practice site-specific assessment for each of the three components of the definition, with the plans and practice sites.

Rhode Island 2016 Alternative Payment Methodology Plan
As Adopted by Health Insurance Commissioner Kathleen C Hittner
July 9th, 2015

I. Background and Purpose

This 2016 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 Kathleen C Hittner, 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."[1] To carry out the purposes of this subsection a plan was developed over the course of four Committee meetings by the Committee members, who are listed in Appendix A. The Committee's plan was then adopted by the Commissioner.

The 2016 APM Plan sets forth:

1. A definition of Alternative Payment Methodologies (APMs);
2. Specification of the types of payments that shall be considered APM payments;
3. Specification of 2016 APM targets for Rhode Island's health insurers, and;
4. Identified support for value-based payment reform in 2016.

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.

II. Definitions

(a) "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; and
- Improving population health; and
- Reducing cost of care growth; and
- 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

[1] OHIC Regulation 2 Section 10(d)(2)(A)

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.

A to-be-defined percentage of APMs must include meaningful downside risk by the end of calendar year 2017.[2]

While generally not employing the aforementioned budget methodology, pay-for-performance payments and supplemental payments for patient-centered medical home functions paid to PCPs or to ACOs will be included in the calculation of an insurer's APM target for calendar years 2016 and 2017.

(b) "Approved Alternative Payment Methodologies" include:

- Total cost of care budget models,
- Limited scope of service budget models,
- Episode-based (bundled) payments,
- Infrastructure payments and pay-for-performance payments for 2016-2017, and
- Other non-fee-for-service payments that meet the definition (a) above as approved by OHIC;

(c) The Alternative Payment Methodology Plan specifies two targets for insurers to achieve.

(1) "Alternative Payment Methodology (APM) 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[3] with shared savings[4] or shared risk.[5]
- Episode-based (bundled) payments; primary care, specialty care or other limited scope-of-service capitation payments, and global capitation payments.
- Supplemental payments for infrastructure development and/or Care Manager[6] services to patient-centered medical homes and to accountable care organizations, and all pay-for-performance payments for years 2016 and 2017, and;
- Shared savings distributions.

(2) "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

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[2] The 2017 target date was supported by a majority vote of the Committee. Four members abstained and one member voted "no".

[3] OHIC Regulation 2 Section 3(l)

[4] OHIC Regulation 2 Section 3(n)

[5] OHIC Regulation 2 Section 3(o)

[6] As stated within the 2016 Care Transformation Plan submitted by the Care Transformation Advisory Group, Care Manager can be interpreted to mean Care Coordinator for pediatric services. For a definition of pediatric care coordination, see R. Antonelli, J McAllister, J. Popp. "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework." The Commonwealth Fund, publication number 1277, May 2009.

insured medical spend. The Non-FFS target defined in this subsection (2) is a subset of the APM Target defined in subsection (1), above. The Non-FFS Target shall include:

- Episode-based (bundled) payments.
- Limited scope-of-service capitation payments and global capitation payments.
- Quality payments that are associated with a non-fee-for-service payment (e.g., a quality payment on top of a bundled payment or PCP capitation)
- Shared savings distributions, and
- All supplemental payments for infrastructure development and/ or Care Manager services to patient-centered medical homes or to accountable care organizations for years 2016 and 2017.

III. Alternative Payment Methodology Targets

For purposes of meeting the 2016 "Alternative Payment Methodology Target," health insurers subject to the Affordability Standards shall increase the percentage of insured medical payments that are made through alternative payment methodologies by 7.0 percentage points compared to the 2014 baseline percentage calculated by OHIC.

For purposes of meeting the 2016 "Non-Fee-for-Service Target," health insurers subject to the Affordability Standards shall increase the percentage of insured medical payments that are made through non-fee-for-service methodologies by 1.5 percentage points compared to the 2014 baseline percentage calculated by OHIC.

IV. Identified Support for Value-Based Payment Reform

(a) 2015/2016 Stakeholder Activities

The following activities shall be executed during the balance of 2015 and 2016 to advance value-based payment reform in Rhode Island.

1. Core Measure Set

The Committee recognizes the need to coordinate measures payers use to reward performance so that providers are receiving a consistent, coherent message regarding priorities for change. The Commissioner shall formally request that the SIM HIT and Measurement Work Group be convened and develop a core measure set for use by all Rhode Island public and private payers. The state shall actively engage payers and providers in the development of the core measure set and the core measure set developed shall offer payers and providers flexibility in choice of measures.

2. Purchaser and Consumer Engagement

The Committee also recognizes that purchaser (employer and consumer) engagement is essential to advancing value-based payment reform. Therefore, the Office of the Health Insurance Commissioner shall redouble its efforts to engage employers and consumers in health reform. OHIC shall put employer/consumer engagement in payment reform on the agenda of

its Health Insurance Advisory Council (HIAC). HIAC will be asked to design approaches to engaging and communicating with a diverse group of employers, including small and large employers and fully-insured and self-insured groups.

Furthermore, OHIC, or its community partners, shall work to identify funding to support consumer/employer engagement efforts, including implementation of messaging strategies around purchaser engagement in payment reform and consumer education and assistance with innovative plan designs that employ demand-side incentives to support the use of alternative payment models.

3. Plan Design

Cognizant that health insurers file plans for OHIC approval more than six months before the plans are marketed, during the rest of calendar year 2015 and calendar year 2016, Rhode Island's health insurers should continue to design product offerings to be marketed in 2017 and thereafter that include tiered networks that align provider and enrollee incentives to promote highly efficient, high quality networks. Furthermore, the Committee shall deal more fully during the fall 2015 convening with aspects of plan design as a facilitator of payment reform, including the potential modification of PPO products to require PCP selection.

4. Fall Committee Meetings

The Alternative Payment Methodology Advisory Committee shall reconvene on or around October 1st, 2015. The Committee's fall agenda will include specification of 2017 APM targets, activities to support achievement of the 2017 APM targets, and engagement of specialists in payment reform. Furthermore, the following topics shall be addressed during the course of the fall meetings:

4.1. Safeguard Access to Care: Some Committee members expressed concerns that the movement to shared risk and full risk payment models may adversely affect consumer access to appropriate medical care. Cognizant that advanced risk-based payment models should be designed to improve patient care and facilitate access through greater care coordination and affordability, OHIC shall review and present options in the fall for safeguarding consumers and protecting against adverse provider behavior resulting from excessive provider assumption of downside risk. In developing options, OHIC shall consider revising the definitions of APMs, as needed, and developing a process for monitoring for pernicious behavior that impedes access.

4.2 Create a Measurable Definition of "Meaningful Downside Risk": There is an emerging consensus that downside risk is necessary, but not sufficient, to fundamentally align provider incentives to meet the goals of the Triple Aim. A majority of Committee members endorsed 2017 as the target date for alternative payment models to introduce meaningful downside risk. The 2017 APM Plan shall include an operational definition of "meaningful downside risk" in the context of the payment reform targets and activities developed pursuant to the OHIC Affordability Standards.

5. Expansion of Committee Participation

The Health Insurance Commissioner shall designate representatives from the specialist physician community and an advocate for small independent practices to further enhance the

Committee. Furthermore, the Commissioner shall expand employer representation and invite representation from the State of Rhode Island Office of Employee Benefits.

V. Measurement and Tracking

By July 15th, 2015 OHIC shall develop a compliance tracking tool for Rhode Island's health insurers to report progress on achieving the payment reform targets specified herein. OHIC will work collaboratively with the insurers to develop the tool. OHIC shall issue guidance on alternative payment methodology reporting by September 1st, 2015. OHIC shall collect an initial round of alternative payment methodology data for calendar year 2014 by October 15th, 2015. Data collection will occur on a quarterly basis thereafter.

VI. Conclusion

This 2016 Alternative Payment Methodology Plan is derived from the draft recommendations of the Alternative Payment Methodology Committee.

Dated at Cranston, Rhode Island this 9th day of July, 2015.

Kathleen C Hittner, MD.
Health Insurance Commissioner
Office of the Health Insurance Commissioner

Appendix A

Committee Membership

Committee Member	Affiliation
Erik Helms	BCBSRI
Kevin Callahan	United
Todd Whitecross	Tufts
Patrick Tigue	NHPRI
Mike Souza	HARI
Dan Moynihan	Lifespan
Domenic Delmonico	CNE
Chris Dooley	CharterCare
Tom Breen	South County
Al Kurose	Coastal Medical
Noah Benedict	RIPCPC
Chuck Jones	Thundermist
Sam Salganik	RIPIN
Pat McGuigan	Providence Plan
Bill Almon Jr.	Claflin Co.
Al Charbonneau	RIBGH
Alok Gupta	RIQI
Pano Yeracaris	CTC-RI