

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 contract³ with shared savings⁴ 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 Manager⁶ 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

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.



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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.	Clafin Co.
Al Charbonneau	RIBGH
Alok Gupta	RIQI
Pano Yeracaris	CTC-RI