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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2018

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A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- HEALTH AND SAFETY--
ALTERNATIVE PAYMENT INCENTIVE FOR CERTAIN ELIGIBLE HOSPITALS

Introduced By: Representatives Messier, Johnston, Tobon, and Coughlin

Date Introduced: May 25, 2018

Referred To: House Finance

It is enacted by the General Assembly as follows:

1 SECTION 1. Title 42 of the General Laws entitled "STATE AFFAIRS AND
2 GOVERNMENT" is hereby amended by adding thereto the following chapter:

3 CHAPTER 14.7

4 TRANSITIONAL ALTERNATIVE PAYMENT INCENTIVE ACT

5 **42-14.7-1. Short title.**

6 This chapter shall be known and may be cited as the "Rhode Island Transitional
7 Alternative Payment Incentive Act".

8 **42-14.7-2. Findings.**

9 The general assembly makes the following findings:

10 (1) The governor and many of the state agencies have been promoting care
11 transformation and health care payment reform among providers and health insurers. The office
12 of the health insurance commissioner (OHIC), for example, has been in the forefront of this
13 effort.

14 (2) As part of its regulatory charter, OHIC has undertaken the mission of shifting health
15 insurance contracting from the traditional fee-for-service payment model to, ultimately, risk-
16 based contracts holding providers accountable for the health care quality and costs for a defined
17 population under their care. One of OHIC's most important regulatory missions is to
18 "significantly reduce the use of fee-for-service payment as a payment methodology, in order to

1 mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the
2 overall cost of care, and to replace fee-for-service payment with alternative payment
3 methodologies that provide incentives for better quality and more efficient delivery of health
4 services."

5 (3) While each health insurer has committed to some degree, to implement advanced
6 alternative payment methods (APM), such as capitation financing, the shift has been sluggish and
7 incremental. The pace of moving to capitation has been much slower than would be beneficial to
8 the citizens of Rhode Island and is inconsistent with the public interest.

9 (4) The state and its agencies must continue to provide support, and pressure when
10 necessary, to health insurers and providers to move more quickly to full provider accountability
11 for quality and cost through comprehensive population based payment, for example through
12 global capitation and full delegation.

13 (5) Since 2010, OHIC has effectively set hospital rate increases, pursuant to its regulatory
14 authority - more specifically the provisions at regulation 2, § 10(d)(4)(E). At the time this process
15 was instituted, there was no rationalization of rates among hospitals and there remains significant
16 variability in the payment amounts paid by health insurers to hospitals in the state. This
17 variability has never been rectified and has left a number of the state's hospitals with rates that are
18 far below the average payment to all hospitals in the state.

19 (6) In 2012, OHIC and the Rhode Island executive office of health and human services
20 (EOHHS) commissioned a study on hospital payment variation. A study report was issued in
21 December of 2012 entitled "Variation in Payment for Hospital Care in Rhode Island" (the 2012
22 report") that identified and quantified the variation in public and private payer payments to Rhode
23 Island hospitals. This report utilized 2010 data, however, because of the limit on rate increases
24 that has been in place since 2010, the percentage variation in private payer payments remains
25 today. The 2012 analysis should be updated with more current data; until such time an update is
26 available, the 2012 report shall be used to calculate the transitional APM incentive.

27 (7) The rates for these hospitals under the average payment level are unsustainable and
28 therefore must be rectified. This must be done in a manner that does not unduly increase the costs
29 of health care in Rhode Island and in a way that supports the public interest.

30 (8) This chapter establishes a unique hospital services pricing arrangement as an
31 alternative to the traditional fee-for-service model, with its inherent cost increasing outcome - the
32 transitional APM incentive. The purpose of the transitional APM incentive is twofold:

33 (i) To provide a strong incentive to make an expeditious shift to institutional services
34 capitation-a goal that has been vigorously endorsed by the state and its agencies-and;

1 (ii) To mitigate any particular hospital's historic and significant rate disparity, resulting
2 from the implementation of OHIC regulation 2, § 10 (d)(4) and only for the limited period of time
3 it will take to transition to capitation.

4 **42-14.7-3. Hospital eligibility for the transitional APM incentive.**

5 (a) In order to be eligible for the transitional alternative payment method (APM)
6 incentive, a hospital must meet the following conditions:

7 (1) The hospital is located in Rhode Island and has entered into commercial contracts
8 with health insurance carriers, which require it to be at more than nominal contractual and
9 financial risk for institutional and other health care services; and

10 (2) The hospital has formally requested their contracted health insurance carriers to
11 capitate them for institutional services for their commercial populations under management; and

12 (b) All hospitals within the CharterCARE system including Roger Williams Medical
13 Center and Our Lady of Fatima Hospital, are presumed to meet both of the two (2) conditions
14 listed in subsections (a)(1) and (a)(2) of this section.

15 **42-14.7-4. The transitional APM incentive.**

16 (a) On or before July 1 of each calendar year, all health insurers (as defined in § 42-14.6-
17 3) shall calculate and submit to OHIC, the insurer's fee-for-service base rates for each eligible
18 hospital, by a percentage calculated under this chapter, in an amount sufficient to account for the
19 difference between the eligible hospital's average private payer payments and the average
20 payments made to all Rhode Island acute care hospitals, for the twelve (12) month period
21 immediately preceding March 31 of each calendar year (referred to herein as "the transitional
22 APM incentive"). The health insurer shall provide each eligible hospital the transitional APM
23 incentive amount, at the same time it is submitted to OHIC. Upon the enactment of this chapter,
24 each health insurer shall amend all of its contracts, with all hospitals, and include in its hospital
25 contracts the terms required by this chapter. The hospital rates developed under this chapter shall
26 not be subject to the provisions of OHIC regulation 2, § 10(d)(4)(E).

27 (b) OHIC shall review and verify the transitional APM incentive calculation within thirty
28 (30) days of receipt from the health insurer. OHIC's verification of the calculation shall be based
29 solely on a determination of the accuracy of the calculations submitted by each health insurer. If
30 applicable, OHIC shall take into account the findings of any independent third party engaged by
31 the eligible hospital, as provided for below. The rates shall be implemented within thirty (30)
32 days after the date of OHIC's verification. The transitional APM incentive, as implemented
33 pursuant to this chapter shall become the base rate for the eligible hospital and may not be
34 reduced without the eligible hospital's written consent. Notwithstanding the foregoing, the

1 eligible hospital may request that the data and calculation provided by the health insurer to OHIC,
2 pursuant to this subsection, be submitted to an independent third party chosen by the eligible
3 hospital, for the purpose of verifying health insurer's calculation of the transitional APM
4 incentive. The independent third party shall not disclose any health insurer's confidential
5 information of the other than its conclusion as to whether it agrees with the health insurer's
6 calculation or, if it does not agree, its reasons, and identifying what it believes to be the
7 appropriate transitional APM incentive, for the eligible hospital.

8 (c) The transitional APM incentive amount for any contract year shall not be
9 implemented if the health plan's commercial line of business population under management by
10 the low rate hospital reaches fifty percent (50%) under an institutional service capitation
11 arrangement, for the immediately preceding contract year, then the transitional APM incentive
12 will end for after subsequent contract year. If, in that subsequent contract year or any contract
13 year thereafter, the population under institutional services capitation to the low rate hospital, falls
14 below fifty percent (50%) for the health plan's commercial line of business, the health plan shall
15 apply the transitional APM incentive or, after negotiation and agreement with the hospital,
16 implement an alternative set of mutually-agreed-upon rates. Nothing in these provisions shall
17 result in a lower reimbursement rate to any hospital in any contract year.

18 **42-14.7-5. Calculation of the transitional APM incentive.**

19 (a) The transitional APM incentive shall be calculated based on the percentage difference
20 between the following:

- 21 (1) The hospital's average payment per encounter from private payers; and
22 (2) The average payment per encounter from private payers for all Rhode Island acute
23 care hospitals, utilizing the data set forth in the most recent version of the 2012 report as
24 described in § 42-14.7-2(f).

25 (b) The 2012 report identifies an inpatient and an outpatient mix-adjusted average private
26 payer payment per encounter for each of the eleven (11) acute care hospitals in Rhode Island. In
27 general, the formulas are as follows:

28 (1) Inpatient payments divided by inpatient discharges and divided by "all patient refined
29 diagnostic related groups" (APR DRG) case mix index equals inpatient average mix-adjusted
30 payment.

31 (2) Outpatient payments divided by outpatient visits and divided by enhanced ambulatory
32 patient grouping" (EAPG) service mix index equals outpatient average mix-adjusted payment.

33 (c) Using the values set forth in the 2012 report, the transitional APM incentive
34 percentage should be calculated using the following four (4) steps:

1 (1) The average inpatient and outpatient payments, derived using the formulas noted
2 above, as updated to the current year by applying the percentage rate increases utilized by OHIC
3 in its annual rate review process.

4 (2) The average as determined for the updated inpatient and outpatient average payments.

5 (3) Each hospital's inpatient and outpatient payments are recomputed using the average
6 values from subsection (c)(2) of this section, and combined.

7 (4) The percentage difference between the amount derived in subsection (c)(3) of this
8 section and the hospital's actual private payer payments is then calculated.

9 (d) If the percentage described in subsection (c)(4) of this section is a positive value
10 (payments at the average exceed actual payments), the percentage shall be utilized, for the
11 transitional APM incentive. Hospitals with negative percentages (actual payments exceed the
12 average) shall not eligible for the incentive.

13 **42-14.7-6. Severability.**

14 If any provision of this chapter or its application to any person or circumstance is held
15 invalid, the invalidity shall not affect other provisions or applications of this chapter which can be
16 given effect without the invalid provision or application, and for this purpose the provisions of
17 this chapter are severable.

18 SECTION 2. This act shall take effect upon passage.

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EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO STATE AFFAIRS AND GOVERNMENT -- HEALTH AND SAFETY--
ALTERNATIVE PAYMENT INCENTIVE FOR CERTAIN ELIGIBLE HOSPITALS

1 This act would establish a formula to create a transitional alternative payment method
2 incentive to be used in calculating reimbursement rates that must be paid by health insurance
3 carriers to eligible Rhode Island hospitals.

4 This act would take effect upon passage.

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