OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Developing a Care Transformation Plan: Challenges and Possible Responses

Care Transformation Advisory Committee
March 4, 2015

Presentation Outline

1. Background
2. Defining a PCMH
3. Care Transformation Challenges
4. Possible Responses to Insurer-identified Care Transformation Challenges
5. Possible Responses to Provider-identified Care Transformation Challenges
6. Next Steps

1. Background

- A robust primary care infrastructure is a necessary component of a health care delivery system that supports affordable health care coverage.
  - PCMHs are a critical way to build a strong primary care base, including for ACOs.
- A strong primary care system that uses PCMH principles is an essential foundation for entities looking to provide more integrated care.
- PCMH expansion is also a key component of the SIM process.

Background

- OHIC held numerous discussions with provider and insurer stakeholders
  - During development of updated Affordability Standards
  - While preparing for Care Transformation Advisory Committee meetings
- Identified several key issues that inhibit primary care transformation in Rhode Island
  - From insurer perspective
  - From practice perspective
- Will share themes and options for responding

Background: Affordability Standards

- Section 10(c) of the revised OHIC Affordability Standards recognizes the need to transform how primary care is delivered in RI.
  - However, primary care practice transformation should not be considered an ultimate goal in and of itself.
- Reg 2 requires each health insurer to take actions so that 80% of contracted primary care practices are functioning as PCMHs by Dec. 31, 2019. Such actions shall include:
  - Contractual incentives and disincentives for PCMH participation

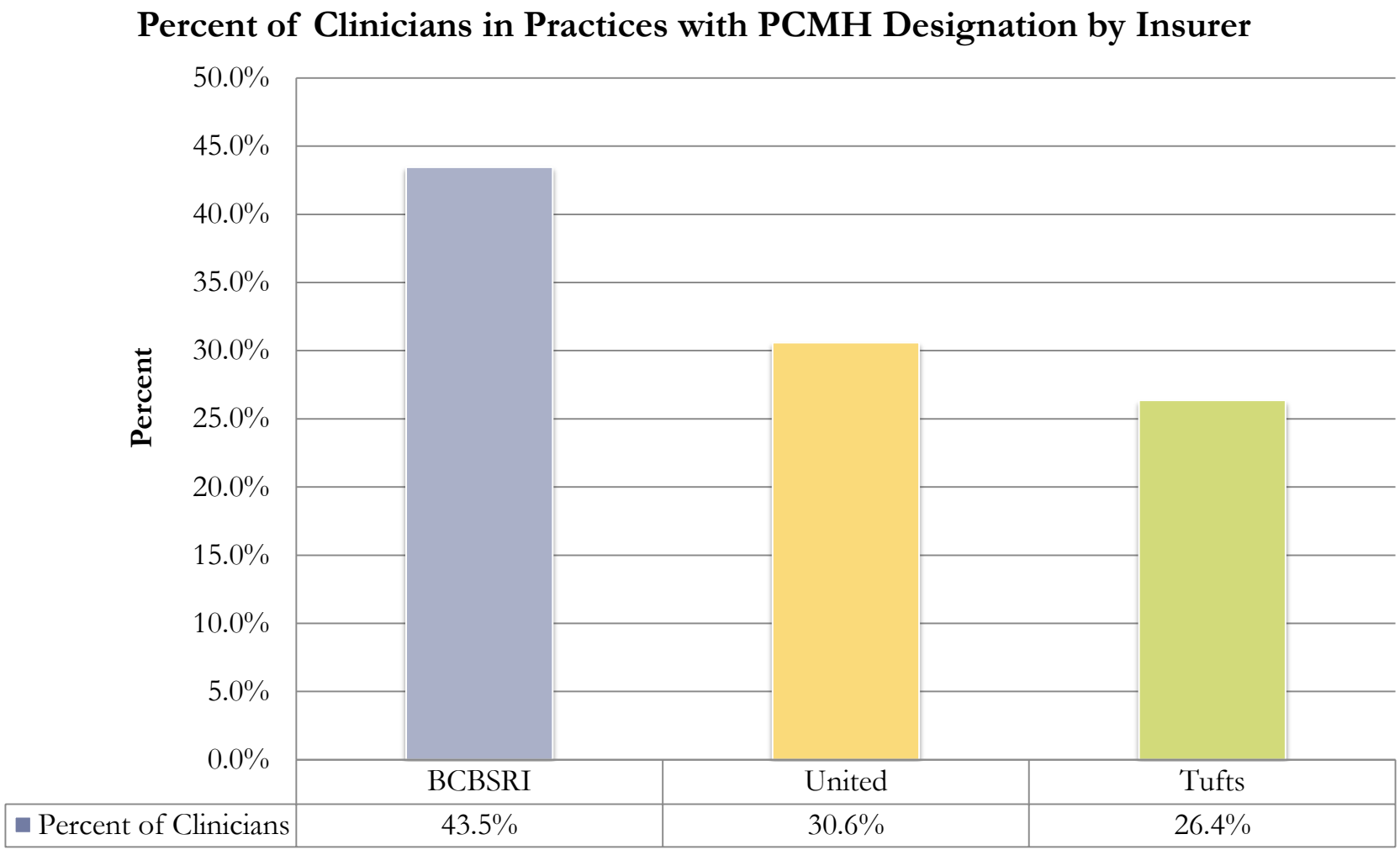
Background: Care Transformation Committee

- OHIC Commissioner to convene multi-stakeholder Care Transformation Committee annually to develop care transformation targets and care transformation plan.
- First set of meetings in March and April 2015 to develop plan and targets for 2016.
- October 2015 meetings tasked with developing care transformation plan for 2017.
- Committee to meet October 1 and complete work before January 1, annually thereafter.

Background: Care Transformation Plan

- The Care Transformation plan is to include:
  - Annual care transformation targets prior to 2019;
  - Specific health insurer activities, resources, and financial supports needed by providers to achieve the targets (Including community health teams and practice coaches); and
  - Common standards and procedures governing health insurer-primary care provider contractual agreements, such as, alignment of performance measures and insurer provision of this information to the practice.
- The 2015 APM plan must be submitted to the Commissioner by May 1st.
- If the plan is not developed, or is viewed as inadequate by the Commissioner, the Commissioner may require a plan to be implemented by insurers.

Background: PCMH Data



2. Defining a PCMH: Context

- The Affordability Standards require that 80% of insurer network primary care practices be PCMHs by 2019 and charge the Care Transformation Committee with developing a plan to meet the target

- We need a viable PCMH definition to measure progress and target attainment
  - Definition should consider PCMH transformation as a process occurring over time
  - Transformation likely to occur at different rates, depending on size, capabilities and commitment level of primary care practice
  - Challenge is determining appropriate indications that transformation is occurring or has occurred

2. Defining a PCMH: Context (cont'd)

- Consensus among insurers is that NCQA accreditation alone is insufficient

- General agreement that practices need:
  - a) some minimal infrastructure, and
  - b) to show improvement in patient care to be considered a PCMH

AHRQ PCMH Definition

- The federal Agency for Healthcare Research and Quality (AHRQ) defines a medical home as a model of the organization of primary care that delivers five core functions of primary health care:
  - Comprehensive care
  - Patient-centered
  - Coordinated care
  - Accessible services
  - Quality and safety
- The Patient-Centered Primary Care Collaborative (PCPCC) has adopted this definition.

Joint Principles of a PCMH

- In 2007 the AAP, AAFP, ACP, and the AOA identified seven principles of a PCMH:
  - Personal physician
  - Physician-directed practice
  - Whole person orientation
  - Care is coordinated and/or integrated
  - Quality and safety are hallmarks of the medical home
  - Enhanced access to care
  - Payment

Option 1: Definition of a PCMH - for Adult and Pediatric Practices

- Baseline requirement: Practice has an EMR *or* has access to and uses a patient registry
- Step 1: Practice commits to achieving NCQA Level 3 recognition and begins process, including implementing nurse care manager function
- Step 2: Practice achieves NCQA Level 3 recognition
- Step 3: Practice annually generates improvement in a specified percentage of measures or achieves best practice targets
  - Prevention
  - Chronic conditions

Options 2 & 3: Definition of a PCMH - for Adult and Pediatric Practices

Option 2:

- Practice is participating in a payer PCMH program or is participating in an ACO contract.
- Practice annually generates improvement in a specified percentage of measures or achieves best practice targets.

Option 3:

- Practice is participating in a payer PCMH program or is participating in an ACO contract.

Two Key Policy Questions

1. Is external recognition by NCQA validation of PCMH status, or do the practices need to demonstrate clinical excellence or improvement?

2. Does signing a contract to participate in an ACO shared savings agreement validate PCMH status?

Possible Means for Operationalizing These Definitions

1. Develop an aligned measure set
   - SIM HIT and Measurement Workgroup
2. Practices without an EMR access a web-based tool or are supported by a CHT that provides the practice's patient registry
3. Use claims data to measure PCMH improvement
   - A third party aggregates insurer numerators and denominators for reporting PCMH multi-payer performance
   - Could use the APCD in the future
4. Use clinical data to measure PCMH improvement
   - Practices enter numerators and denominators through a web portal
   - Collect data from EMRs through SIM Health Care Quality Measurement, Reporting and Feedback System

Discussion

- What are your thoughts on these three definitions of PCMH for purposes of recommending the care transformation targets for the OHIC Affordability Standards?
- Are there any additional elements that you would like to add? Some you wish to drop or modify?
- Are there any operational considerations that you think warrant additional consideration?

3. Challenges to Care Transformation

- Insurer perspective
  1. How can we move small practice PCPs into ACOs for long-term health system viability?
  2. How can small practices efficiently and effectively undertake transformation?
  3. How can we increase accountability of practices to manage costs and improve quality?

- Provider Perspective
  1. What is a sustainable payment model?
  2. How can we reduce the current reporting burden complicated by non-aligned measurement sets?

4. Possible Responses to Insurer Issues: a. Moving Small Practice PCPs into ACOs

- Educate PCPs about existing opportunities, and associated requirements and expectations
  - OHIC could sponsor webinar with ACO representatives
- Create "exoskeleton" for a virtual ACO (reporting, funds management, etc.)
  - Step taken by Independence Blue Cross in Philadelphia ("Tandigm Health")
  - Possibly a jointly-sponsored payer-based initiative

4a. Moving Small Practice PCPs into ACOs (cont'd)

- Provide technical assistance to practices on forming and managing an ACO
  - Fund as a SIM Provider Technical Assistance activity
  - Insurer(s) fund (BCBSMN with Southern Prairie)
- Create momentum for change by lowering or freezing fee schedules for PCPs not in an ACO
  - Strategy used by BCBSMA to move providers into its Alternative Quality Contract

Discussion

- Are any of these options responsive to the challenge?
- Are some more likely than others to be effective?
- Are there other options that you would like to suggest for group consideration?

4. Possible Responses to Insurer Issues: b. Transforming Small Practices into PCMHs

- Demonstrate that there is a viable course for transforming into a PCMH, joining an ACO and remaining an independent practice
  - Implement Community Health Teams statewide
    - SIM initiative
  - Hold learning collaboratives for small practices
  - Provide practice coaches
- Create tiered benefit plans that reward PCMHs through higher reimbursement and lower consumer contribution

4. Possible Responses to Insurer Issues:
b. Transforming Small Practices into PCMHs (cont'd)

- Create state-wide system of Community Health Teams to provide care management and data support to small practices.

- Create home care teams led by nurse practitioners and overseen by a physician medical director to engage challenging patients.

Discussion

- Would one or more of these approaches encourage small practices to transform?
- What other options should we consider?

4. Possible Responses to Insurer Issues: c. Increasing Practice Accountability

- Create an accountability model with clear expectations
  - Year 1: delineate expectations in provider contract
  - After year 1: must meet threshold performance levels on specified number of measures to receive bonus payments.
    - Bonus level increases with higher levels of improvement
    - Bonus also available to practices at "best practice level"
  - When practice moves into an ACO, practice transitions to primary care capitation
    - Includes investment in nurse care manager
    - Has P4P add-on tied to selected quality measures
    - Practice participates in shared savings through ACO
  - Perform nurse care manager educational audits periodically (Northeast PA/Geisinger example)

4c. Increasing Practice Accountability (cont'd)

- Insurers provide enhanced reporting to PCPs (and ACOs)
  - High-risk patient lists
  - Notification of inpatient ADTs
  - Specialty profiling
  - Comprehensive, actionable cost/quality information to inform referral patterns
- Promote (or require) CurrentCare participation and expand capabilities to notify providers of inpatient ADTs and real-time ED admissions
- Conduct statewide pilot to integrate behavioral health providers into PCMHs

5. Possible Responses to Provider Issues:
a. Sustainable Payment Model

- Tie qualification for, and level of, PMPM to improvement in quality measures when under FFS payment model. Align with PCMH requirements.
  - Increase PMPM with number/% of measures seeing improvement
  - Allow payments to practices that achieve "best practice" levels so long as levels are sustained

- Assure adequate PCP support when in an ACO by:
  - Moving to PCP capitation payment model that includes nurse care management support
  - Add on pay-for-performance payment to continue incentivizing quality improvement and goal achievement

Discussion

- Are these options viable?
- What other considerations should be on the table?

5. Possible Responses to Provider Issues: b. Aligned Measurement Sets

- Develop common measurement set for PCMHs (and ACOs) through SIM process
  - Plans for the HIT and Measurement Workgroup to address the issue
  - Measurement sets may have some variation based on line of business (e.g., Medicaid, Medicare and commercial)
  - Collect and report data through SIM Health Care Quality Measurement, Reporting and Feedback System (to be defined)

Discussion

- Is this option viable?
- What other possible approaches should be considered?

6. Next Steps

- OHIC will draw upon discussion to perform any indicated research and to develop a first draft of recommendations
- Draft recommendations will be circulated in advance of next meeting
- OHIC may reach out to discuss particular issues with some advisory committee members