OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Proposal for a Rhode Island Primary Care Transformation Plan

Care Transformation Advisory Committee Meeting
March 23, 2015

Presentation Outline

1. Update on APM Committee
2. Key take-aways from March 4th meeting
3. Discuss recommendations for Care Transformation Plan
   a. Definition of PCMH
   b. Supporting PCMH Transformation
   c. Supporting ACO Transformation
   d. PCMH 2016 Target
4. Next Steps

1. Update on APM Committee

- Committee charge: develop annual targets for alternative payment methodologies and a plan to achieve these targets
- First meeting:

1. Establish a baseline understanding by reviewing summary of current APM use by health insurers
2. Discuss criteria for determining which payment methodologies qualify as APMs
3. Discuss steps, programs, initiatives to facilitate use of APMs by RI insurers and providers
4. Discuss the target for 2016

2. Key Take-Aways from 3/4/15 Meeting

- PCMH Definition
  - Support for NCQA accreditation as a component of the PCMH definition
  - Support for EMR with patient registry as a requirement
  - Disagreement on performance improvement requirement
  - Support for requiring PCMH processes that focus on reducing costs
    - Disagreement on including ED visits as a cost measure
  - Disagreement on whether care managers need to be nurses – need clarification on role definition
  - Agreement that ACO participation is not sufficient to be considered a PCMH

2. Key Take-Aways from 3/4/15 Meeting

- Supported Strategies for PCMH Transformation
  - Use "sticks" in addition to providing education and assistance
  - Focus groups to understand concerns of small practices
- Supported Strategies for ACO Formation
  - Education of practices on benefits/expectations of joining an ACO
  - Focus groups of practices
  - "Sticks" and "Carrots" approach
- Practice Accountability
  - Need timely information
  - Consistent set of expectations for Care Managers

2. Key Take-Aways from 3/4/15 Meeting

- Sustainable Payment Model
  - Need to coordinate Care Manager activities between practices and insurers
  - Could track ED utilization as a proxy for access
- Measure Set Alignment
  - Providers are concerned about the number of measures they have to submit

Consumer Considerations

- Any consolidation of providers should not inadvertently restrict access for consumers
- Payment incentives should be considered for consumers
- Promote positive consumer centered strategies and patient engagement
- Generate and promote multidisciplinary team approach to providing care coordination
- All quality measures should also be tied to patient engagement as well as satisfaction of patients and families/caregivers.
- Uniform measures and allow pediatric specific measures

Recommendation Introduction

- The draft recommendations that follow reflect the input provided by the Advisory Committee members during the March 4th meeting.
- The recommendations extend to practices serving adults, those serving families and those serving children.

2a. Recommendations: Defining PCMH

1. The practice is participating in CTC-RI or in a payer-sponsored program or practice achieves NCQA Level 3 recognition by end of 2019
2. The practice implements the following cost-containment strategies:
   - Develops and maintains a high risk patient list
   - Implements care management, focusing on high risk patients and interventions that will impact ED and inpatient utilization
   - Develops referral protocols informed by cost and quality data provided by payers
   - Develops and maintains an avoidable ED use reduction strategy

Definition of PCMH (cont'd)

3. The practice demonstrates meaningful improvement over an annual two-year look back period for:
   - A to-be-defined number or percentage of measures, including ED visit rate and selected HEDIS quality measures
   - Measures identified through a collaborative process to develop either a common multi-payer measurement set or a pool of measures from which payers and providers would make selections for the purpose of assessing improvement.

- Payers and practices will collaboratively…
  - Set minimum denominators for use of the performance measures when assessing improvement
  - Define "meaningful improvement" in statistical terms

2b. Supporting Transformation: Assuring Accountability

- Identify CTC-RI as the chief primary care transformation agent for the state
- CTC-RI would be responsible for:
  - Tracking/reporting PCP PCMH transformation
  - Creating/holding learning collaborative for small practices
  - Creating/holding annual learning academy for all CMs
  - Providing practice coaches for the first two years of practice transformation
  - Collecting/reporting provider and payer data to assess required performance improvement
  - Evaluating practices on cost-containment strategies

Assuring Accountability (cont'd)

- Responsibilities of CTC (continued)
  - Manage behavioral health integration initiatives
  - Promote standardized payer data reporting to practices, particularly
    - Practice profiles
    - High risk patient lists
  - Work with payers to evaluate embedded care managers for effectiveness
    - Annual evaluation of large practices or ACOs
    - Annual evaluation of a random sample of smaller practice sites (number to be determined)
  - Oversee activities of Community Health Teams
  - Host multi-stakeholder/payer convenings, including Medicaid, to address care transformation and payment reform issues
- Payers would be invited to annually evaluate CTC-RI and Community Health Teams for effectiveness

Potential Funding Sources 2015/2016

- CTC Operations: Insurers
- Learning Collaborative for Small Practices: Insurers and SIM grant (PCMH Expansion Funding Request: $500,000, subject to SIM Steering Committee discussion)
- Annual Learning Academy for Care Managers: Insurers
- Practice Coaches: SIM grant (Practice Assistance Funding Request: $650,000 and subject to SIM Steering Committee discussions. To begin in Year 2 of grant.)

Sustainable PCMH Payment Model

- Framing
  - Model recognizes level of commitment and effort required by practices to manage transformation into a PCMH
  - Model recognizes the growth of ACOs and suggests how PCMHs can continue to be supported within that framework
  - Model requires expansion of Community Health Teams (CHTs) to serve small practices throughout the state
  - Model recognizes that Community Health Teams may be performing some services for small PCMHs that will be otherwise performed directly by larger PCMHs

Payment to PCPs without NCQA Recognition and in Early Transformation

- Practice receives PMPM in recognition of NCQA application efforts and Care Manager (CM) PMPM once the CM has been hired
  - Exception: If a practice is using a CHT for CM support, the practice does not receive CM PMPM
  - If a practice is a part of a larger group practice or health system, the PMPM shall be used to finance CM providing services to the site earning the payment.
  - Consider different level CM PMPM payments for children across family practices and pediatric practices vs. adults

Payment to Practices with NCQA Recognition

- Practice receives CM PMPM
  - Exception: If PCMH is using a CHT for CM, practice does not receive CM PMPM
  - Note: If PCMH is part of a group or system which has an ACO contract with the payer and the group or system is centrally coordinating CM, payment can go to the group or system and not the site – but payment must directly support CM at each practice site.
- Practice eligible for performance bonus
  - Improvement regarding specified performance measures
  - Performance improvement deemed if site achieves best practice
- Practices must have a sufficient number of attributed lives

Potential Funding Source 2015/2016

- CHT expansion: SIM grant (Community Health Team Funding Request: $1,000,000, subject to SIM Steering Committee discussions)
- PMPM payments and performance bonuses: insurers

Payer Incentives/Contractual Requirements

- At payer option, cease paying supplemental payments to practices that do not meet and maintain definitional requirements of a PCMH
- Offer PCP capitation option for PCPs with sufficiently large patient base. Design capitation with prospective payments to cover primary care services, care management, and offer bonus opportunity based on meeting performance improvement targets
- Freeze fee schedules for PCPs not participating in PCMH practice transformation
- Utilize other contractual incentives or disincentives for PCMH participation as defined by the insurer

Aligning Measures

- Care Transformation Advisory Committee documents need for alignment
- Care Transformation Advisory Committee requests that the SIM HIT and Measurement Workgroup develop a core measure set as its first order of business.

Other PCMH Transformation Support

- Hold two or three focus groups of PCPs who have indicated an unwillingness to transform into a PCMH and/or join an ACO
  - Hold between close of these initial Advisory Group meetings and beginning of the Fall Advisory Group meetings
- Create a separate work group of care managers from practices, ACOs, plans and state agencies to address the need for service coordination and avoid duplication of services and patient confusion
  - Hold between close of these initial Advisory Group meetings and beginning of the Fall Advisory Group meetings

2c: Supporting ACO Transformation

- Educate PCPs about existing opportunities, and associated requirements and expectations by holding a series of webinars and in-person meeting presentations
- Hold learning academy sessions for practices forming and managing ACOs, concentrating on key skills tied to ACO success:
  - Managing and interpreting data
  - Care management
  - Identifying cost savings opportunities beyond care management and developing effective responses
  - Building a culture of total population management
  - Implementing value-based specialty referral protocol

Potential Funding Source 2015/2016

- PR campaign: joint initiative by CTC-RI, Medicaid, insurers and OHIC
- Focus groups: OHIC
- Learning academy: insurers

2d: PCMH 2016 Target

- Section 10(c)(1) of the Affordability Standards requires that 80% of primary care practices be PCMHs by 12/31/19
- The Commissioner is seeking input from the Care Transformation Advisory Committee on annual goals to assure the 80% target is reached
- Proposed 2016 target is as follows:
  - By 12/31/16, each commercial insurer has increased the percentage of primary care practice sites that meet the PCMH definition by at least 5% compared to an insurer-reported, OHIC-approved baseline
  - By 12/31/16, 50% of all insurer-contracted primary care practice sites meet the definition of PCMH

Discussion

- Do you agree with the definition of PCMH? Are there changes you would like to suggest?
- What should be the CM models to support PCPs joining ACOs?
- Will the transformation support activities make a difference
  - From the perspective of the providers?
  - From the perspective of the payers?
- What changes would you propose to the transformation support activities?
- Do you agree with the PCMH 2016 target?

Next Steps

- Gather feedback
- Generate a second draft transformation plan in a narrative format
- Hold conversations with selected stakeholders in advance of the next meeting
- Distribute a final set of recommendations prior to the third, and, hopefully, final meeting
  - Option for a fourth meeting in late April if necessary