State of Rhode Island Office of the Health Insurance Commissioner
Care Transformation Advisory Committee
Meeting Minutes
March 23, 2015, 1:00 P.M. to 4:00 P.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Attendance

Members

Gus Manocchia, David Brumley, Gina Rocha, Mary Hickey, Russell Corcoran, Beth Lange, Pat Flanagan, Ed McGookin, Andrea Galgay, Peter Hollmann, Christine Grey, Deb Hurwitz, Pano Yeracaris, Kathleen Calandra, Tina Spears, Maria Montanaro, Brenda Briden, Darlene Morris

Not in Attendance

Kevin Callahan, Alison Croke, James Fanale

1. Welcome & Introductions

Sarah Nguyen, OHIC, welcomed committee members to the second Care Transformation committee meeting.

2. Update on the Alternative Payment Methodology (APM) Advisory Committee

Cory King, OHIC, provided an overview of the APM Committee's work to date, including the importance of changing the "payment under the payment". The APM Committee is considering the following types of APMs: total cost of care contracts, bundled payments, pay-for-performance, and PCMH supplemental payments.

3. Review of March 4th Meeting

Sarah Nguyen provided a summary of the key take-aways from the March 4th meeting. Tina Spears, RIPIN, shared consumer considerations that should be kept in mind during care transformation discussions.

4. Draft Recommendations for Committee Review

Please refer to Care Transformation Committee Presentation for greater detail.

The focus of this meeting was to further explore the definition of a PCMH, supports for PCMH adoption, a sustainability plan, and a 2016 PCMH target.

4.1 Defining a Patient-Centered Medical Home (PCMH)

The committee members discussed the presented definition of a patient-centered medical home and discussed the amount of detail that the definition of PCMH should include. Beth Lange, pediatrician, recommended reversing the order of "cost and quality" on slide 9 and Mary Craig, UnitedHealthcare, suggested defining high-risk patients as those who are high risk of using intensive acute services in the near future. Additionally, one committee member asked that payer PCMH programs be OHIC-approved. Members suggested adding a number of cost containment strategies, including: prescription management, DME management, and expanding access to behavioral health. The committee discussed meaningful improvement measures, voicing the following concerns: more clarity is needed on the level at which improvement will be measured (such as practice site, or practice), the severity of the consequences of not meeting improvement targets, including patient-centered measures in the measure set, and adding 30-day readmissions as a measure.

4.2 Supporting Transformation: Assuring Accountability

Members discussed the role of CTC-RI in driving transformation statewide, and expressed the importance of CTC-RI in facilitating discussion and information sharing. However, not all committee members agreed with CTC-RI taking on a more proactive and expanded role as the chief primary care practice transformation agent. The following questions were brought up by members: What changes to CTC-RI's governance structure would be required for it to assume this new role and who should oversee CTC-RI's work, their Board of Directors? What is the relationship between CTC-RI and ACOs in promoting transformation?

Committee members also raised a concern that there was a lack of small practice representation in the room. OHIC does plan to conduct focus groups with small practices during the summer and will consider adding a small practice representative to the fall convening.

4.3 Sustainable Payment Model

Members were presented with a sustainable payment model both for those practices who had already achieved NCQA recognition and for those practices that are in the process of transformation. They discussed how to structure an integrated model for payments to avoid double payment and to support ACO development. Members discussed whether role of regional Community Health Teams should be to provide care management to small practices, to provide links to community services

for all practices as an extension of care management, or to provide both. The need for Care Manager PMPM payments to consider patient acuity was also expressed, with the suggestion to set up rules for complex patients. Members discussed priorities for the relationship among care managers at practices, at ACOs, and at the insurer level, and expressed the need to keep care managers close to the practice to maximize effectiveness. Concern was also raised about how having care managers at the practice level could be cost additive to having insurer-based care managers. The example was made that some care management is shared between practices, where the payment is not covering the costs of care manager, so payments are supplemented by the system. The need was also expressed by some members to support care management at the ACO level, since ACOs can generate savings beyond the practice level and have system-based incentives. Additional concern was raised about the duration of payments; practices are not incentivized to invest if the payments are known to be temporary. Further, payers may be motivated to move away from PMPM payments to value-based contracting.

4.4 Payer Incentives

Members discussed payer incentive and disincentives. Concern was raised about disincentives being implemented without first making available resources for small practices to achieve measurement goals (a sequencing issue). Furthermore, small practices should be provided with leadership outside of the practice, since they may not have resources for transformation practices and patients in non-PCMH practices may be negatively affected by disincentives. Members expressed a need for common payer contractual elements (but not specific contract language). Concern was also raised that tying incentives to measures may unfairly affect pediatric practices.

4.5 Alignment of Measures

Committee members discussed the role of a common contract to harmonize measures across payers. Members suggested that the SIM project consider using CTC-RI measures for primary care.

4.6 Other Support

Members expressed concern that ACOs are still a relatively new experience in the RI market and that care should be taken to not stifle the role of ACOs in promoting transformation and system integration. The need for systems development to shift the current focus of ACOs from short term savings to population health was also noted. Additionally, committee members expressed that ACOs may have too much responsibility placed on them before they have developed sufficient infrastructure to do population management. Members suggested including in the presentation that RIQI applied for a CMS Practice Transformation Network grant that focuses on

providing support for small practices and specialists. A question was raised about the time frame for moving toward value based payments.

4.7 2016 PCMH Target

Members discussed feasible targets for PCMH expansion by 2016. The proposed target was clarified to be a five percentage point increase and there was general consensus that this was an appropriate target. Committee members discussed the level at which to measure the target: clinician level, practice site, or covered lives. The need was expressed to keep the focus on small practices to drive statewide transformation and although there may not be a return on the investment immediately, there will be long term benefits. The concern was raised about what to do with the roughly 200 adult PCPs that do not have EMRs (out of approximately 900). Setting a network target of 50% raised concerns, since some ACOs are trying to transform their own practices.

5. Next Steps

The next meeting will take place on April 27, 2015 from 8am to 11am at the same location. A draft care transformation plan based on today's feedback and members are asked to fill out a survey in advance of the April 27th meeting.

6. Public Comment

There was no public comment.