Rhode Island 2016 Care Transformation Plan
As Adopted by the Health Insurance Commissioner Kathleen C Hittner
July 9th, 2015

I. Background

This 2016 Care Transformation Plan is adopted pursuant to Section 10(c)(2)(A) of Regulation 2: Powers and Duties of the Office of the Health Insurance Commissioner, by Kathleen C Hittner, Health Insurance Commissioner.

Pursuant to Section 10(c)(2)(A) of Regulation 2, the Care Transformation Advisory Committee submitted to the Health Insurance Commissioner a 2016 Care Transformation Plan which is designed to move primary care practice transformation activities towards achieving OHIC's 2019 target of 80% of Rhode Island primary care clinicians practicing in a Patient-Centered Medical Home (PCMH).[1] A plan was developed over the course of three Committee meetings by the Committee members, who are listed in Appendix A. The Committee's plan was then adopted with the following modifications (in red and underlined) by the Commissioner.

II. Definition of Patient-Centered Medical Home

Cognizant that being recognized as a PCMH by an external organization does not mean that a practice has effectively implemented PCMH processes to improve cost and quality of care, the Committee developed the following three-part definition of PCMH against which RI primary care practices will be evaluated:

a. Practice is participating in or has completed a formal transformation initiative[2] (e.g., CTC-RI, PCMH-Kids or a payer or ACO-sponsored program) and/or practice has obtained NCQA Level 3 recognition.
b. Within 12 months of seeking PCMH status under the Affordability Standards, Practice has implemented the following specific cost-containment strategies (strategy development and implementation at the practice level rather than the practice site level is permissible):
    i. develops and maintains a high-risk patient registry that tracks patients identified as being at risk of avoidable intensive service use in the near future;
    ii. practice uses data to implement care management[3], focusing on high-risk patients and interventions that will impact ED and inpatient utilization;

[1] Affordability Standards Section 10(c)(1)
[2] A formal PCMH transformation initiative is a structured training program for primary care providers and support staff with a pre-defined curriculum and technical assistance based on an evidence-based PCMH transformation model and designed to systematically build the skills within the practice to function as a PCMH.

iii. implements strategies to improve access to and coordination with behavioral health services;
iv. expands access to services both during and after office hours;
v. develops service referral protocols informed by cost and quality data provided by payers; and
vi. develops/maintains an avoidable ED use reduction strategy.

c. Practice has demonstrated meaningful performance improvement. Using a two-year lookback period with a 6-months' claims lag, initial performance improvement must be demonstrated based on the claims data covering the first 24-months after seeking PCMH status under the Affordability Standards. Practice must continue to demonstrate improvement annually thereafter, using a rolling two-year look-back period with a 6-months' claims lag. OHIC shall define "meaningful performance improvement" in consultation with the Advisory Committee.

Under this definition, the Practice will be considered a PCMH so long as the Practice is participating in a formal transformation initiative and/or has attained NCQA Level 3 recognition. In addition, by the end of the first year, the Practice must also meet the cost containment strategy implementation requirements, and by the end of the second year, following a 6-month claims run-out, the practice must meet all three requirements in the definition of PCMH. These requirements are displayed in the following chart:

Practice Responsibility	Initial PCMH designation	End of Year One	End of Year Two
Participating in formal initiative and/or attained NCQA Level 3 recognition	x	x	x
Implemented cost containment strategies		x	x
Demonstrated required performance improvement			x

The recommended process for operationalizing this definition is outlined in Appendix B.

[3] Practices shall implement "care coordination" for children, which is a broader set of services not exclusively focused on high-risk patients. 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.

III. PCMH Target for 2016

OHIC requires that by December 31, 2016 each insurer subject to the Affordability Standards shall increase the percentage of its primary care network functioning as a PCMH by 5 percentage points, compared to the baseline rate calculated by OHIC pursuant to the process outlined in Appendix B. OHIC intends to calculate a baseline percentage by September 1, 2015 or soon thereafter. This baseline will not include the practices associated with PCMH-Kids that are slated to begin receiving PCMH payments starting January 1, 2016.

For 2016, the baseline and target percentages will be calculated based on the practice achieving NCQA PCMH Level 3 recognition or receiving sustainability payments consistent with the Sustainability Financial Model, detailed in Section VI of the Care Transformation Plan. Beginning January 1, 2017, to be considered a PCMH for the purposes of this calculation, a practice must meet all requirements specified in the definition of PCMH delineated in Section II of the Care Transformation Plan, and be receiving sustainability payments from insurers that are consistent with the Sustainability Financial Model, detailed in Section VI of the Care Transformation Plan.

IV. Stakeholder Activities in 2015 to Promote PCMH Adoption

OHIC will require the following activities during the balance of 2015 to advance PCMH transformation by Rhode Island primary care practices. The activities are designed to both engage new primary care practices in practice transformation and to improve the performance of practices currently undergoing PCMH transformation.

1. PCP Educational Campaign

Insurers have reported that there are a large number of small primary care practices that are not currently engaged in practice transformation activities. To increase practice understanding of the benefits and expectations associated with practice transformation, The Commissioner shall request CTC-RI to conduct an educational campaign directed towards unaligned primary care practices. The leadership of CTC-RI should lead the outreach efforts to practices sites and include an open forum to all practices who are interested. The campaign's messaging and communications vehicles should be informed by OHIC-convened provider focus groups and likely include:

- Educational sessions: in-person and webinars
- Written materials, explaining how PCMHs differ from usual practice
- Articles in payer and professional association newsletters

The campaign should run in the Fall of 2015.

Estimated cost: $6,190, to be funded by insurers:

- Hold 10 breakfast meetings for 20 participants @ $25.00 each = $5,000

- WebEx webinars: $100 per month for 6 months = $600
- One-page, two-sided, color handout summarizing PCMH benefits/expectations: 500 copies at $1.18 each = $590

The estimated cost for this insurer-funded PCP education campaign shall count as indirect primary care spending.

2. Care Manager Academy

Clinical care managers have a major role in controlling costs and improving patient health. To build their skill set, the Commissioner shall request CTC-RI to hold a one day-long learning academy for all current and new practice-based care managers, including care managers functioning within the context of an Accountable Care Organization. The learning academy should be staffed by experienced, skilled payer care managers and experienced, skilled practice-based care managers. The focus should be on 1) enhancing identification and management of high risk patients for whom care management interventions will have a significant impact on future costs and patient well-being 2) functioning within an integrated behavioral health environment, and 3) coordinating care management services among provider and payer organizations. To implement the learning academy, CTC-RI should solicit input from practice-based care managers regarding their areas of concern. Additionally, this effort could have multiple tracks – one for beginning care managers and one for more advanced care managers.

The learning academy should be held no later than September or October 2015.

Estimated cost: $8000, to be funded by insurers:

- Conference for 150 participants
- Light breakfast
- Lunch: sandwiches and salads
- AV equipment
- Room rental

3. Care Management Coordination Work Group

As an increasing number of care managers are practice-based or functioning within the ACO structure, there is a greater need to coordinate care management activities between practices and payers. The Commissioner shall request CTC-RI to expand its current work in this area by expanding participation on its work group to non-CTC-RI practices in order to develop a standard protocol(s) for coordinating activities. It is anticipated that the work group would meet monthly for a year, beginning in June 2015, to develop coordinating protocols. The work group should present its work at future care manager learning academies.

Estimated Cost: participants' time

4. Annual Care Transformation Advisory Committee Meetings
Pursuant to the Affordability Standards, Section 10(c)(2)(A), the Care Transformation Advisory Committee will reconvene on or around October 1, 2015 to develop the next annual Care Transformation Plan. The stakeholders anticipate holding between three and four meetings to develop the Care Transformation Plan for 2017.

5. Standard 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 will 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 that takes into account existing multi-payer measure sets.

V. Stakeholder Activities in 2016 to Promote PCMH Adoption

The following activities in 2016 will help advance PCMH transformation by Rhode Island primary care practices. The activities are designed to both engage new primary care practices in practice transformation and to improve the performance of practices previously engaged in PCMH transformation.

1. PCP Transformation Support Activities
Supports will need to be expended in order to help practices transform to and operate effectively as PCMHs. The Commissioner shall request CTC-RI to continue to support previously identified and engaged practices, including those pediatric practices identified through the PCMH-Kids initiative. The Commissioner shall also request the Executive Office of Health and Human Services, OHIC, CTC-RI and major Rhode Island payers coordinate transformation approaches in order to maximize the impact of payer, CTC-RI and SIM-funded activities to provide transformational support. In the event that RIQI receives a PTN grant, The Commissioner shall request RIQI to also coordinate its transformation activities for primary care practices with CTC-RI, PCMH-Kids and major Rhode Island payers. Transformation supports should be aimed at building and sustaining high performance in access, quality of care, patient experience, and cost management and position PCMHs to participate in ACO arrangements to the extent that they may not be doing so already.

Estimated Costs:

- CTC-RI administrative funding support from insurers (currently being funded).
- CMS grant to RIQI, if awarded.

2. Care Manager Academy
To continue building care managers' skill sets, the Commissioner shall request CTC-RI to hold two day-long learning academies for all CTC-RI and non-CTC-RI, practice-based care

managers, including care managers functioning within the context of an Accountable Care Organization. The learning academy should be staffed by experienced, skilled payer care managers and experienced, skilled practice-based care managers. The focus should be on enhancing identification and management of high risk patients for whom care management interventions will have a significant impact on future costs and patient well-being, as well as on coordinating care management services among provider and payer organizations and on working within an integrated behavioral health environment. To implement the learning academy, CTC-RI should solicit input from practice-based care managers regarding their areas of concern.

The learning academies should be held in April and October 2016.

Estimated cost: $8000 per session; $16,000 for two sessions, to be funded by insurers:

- Conference for 150 participants
- Light breakfast
- Lunch: sandwiches and salads
- AV equipment
- Room rental
- Printed materials

3. Community Health Team (CHT) Pilot

The Commissioner shall request that the SIM Steering Committee use the proposed SIM funds allocated to CHTs be used to expand CTC-RI's current CHT program.

The CHT pilot should run from September 1, 2015 through August 31, 2017.

Estimated cost: $290,000 per year; $580,000 for two years, to be funded by SIM grant funds, if approved by the SIM Steering Committee:

- Community Health Team including behavioral health care manager, social worker, and community health workers: $290,000
- Office space: in-kind contribution by payer or other host organization
- Telephone: in-kind contribution by payer or other host organization

4. Annual Care Transformation Advisory Committee Meetings

Pursuant to the Affordability Standards, Section 10(c)(2)(A), the Care Transformation Advisory Committee will reconvene on or around October 1, 2016 to review the success of the prior year's plan while learning from the past year's experience, develop the next annual Care Transformation Plan. The stakeholders anticipate OHIC holding between three and four meetings to develop the Care Transformation Plan for 2018.

VI. Sustainable PCP Financial Model

OHIC shall require insurers to adopt the following two-stage payment model to sustain primary care transformation in practices beginning January 1, 2016. Insurers shall minimally apply this model to practices that have met the OHIC definition of a PCMH delineated in Section II, above. This includes those practices participating in a formal transformation initiative (e.g., CTC-RI, PCMH-Kids or a payer or ACO-sponsored program).

- First Stage: Practices actively engaged in first-time PCMH transformation activity and without NCQA recognition Level 3 or practices with NCQA recognition Level 3, but which have not yet met the cost containment strategy or performance improvement requirements within the timeframe outlined in Part II, receive both infrastructure and care management (CM) (care coordination for pediatrics) PMPM payments. Practices are eligible to receive infrastructure payment for a maximum of 24 months or until NCQA PCMH Level 3 recognition is achieved, whichever occurs first. If the practice is part of an ACO, the payer may make the CM PMPM payment to the ACO, but the ACO must use that payment to finance CM services at the practice site earning the payment.
- Second Stage: Practices with NCQA Level 3 recognition and which have implemented the cost containment strategies and demonstrated performance improvement receive a CM PMPM payment and have an opportunity to earn a performance bonus. If the practice is part of an ACO, the payer may make the CM PMPM payment to the ACO, but the ACO must use that payment to finance the CM services at the site earning the payment.

Example Scenarios for Practices Engaged in Practice Transformation:

Example	NCQA Level 3	All Required Cost Containment Activities Implemented	Performance Improvement Achieved	Care Management PMPM	Infrastructure Payment PMPM	Performance Bonus Opportunity
1	✓	✓	✓	✓	X	✓
2	✓	X (but still within 12-month timeframe for implementation)	X (but still within 24-month timeframe for implementation)	✓	✓	X
3	✓	X (but still within 12-month timeframe for implementation)	✓ (but still within 24-month timeframe for implementation)	✓	✓	X
4	✓	✓ (but still within 12-month timeframe for	X (but still within 24-month timeframe for	✓	✓	X

		implementation)	implementation)			
5	✓	X (and 12-month timeframe for implementation has passed)	X (and 24-month timeframe for implementation has passed)	X	X	X
6	X (newly participating in a formal transformation initiative)	X but still within 12-month timeframe for implementation)	X (but still within 24-month timeframe for implementation)	✓	✓	X
7	X	X (and 12-month timeframe for implementation has passed)	X (and 24-month timeframe for implementation has passed)	X	X	X

The purpose of the CM PMPM payment is to support development and maintenance of a care management function within that practice and is not limited to supporting a care manager, per se. The purpose of the infrastructure payment is to compensate practices for the time and effort involved in achieving NCQA PCMH Level 3 recognition and establishing basic policies and procedures necessary for PCMH function, including developing clinical data capture, reporting and analysis capacity.

The monetary levels of support for CTC-RI and for PCMH-Kids are determined by the program participants, subject to the approval of OHIC. The monetary levels of support for practices with NCQA Level 3 recognition not currently participating in a formal transformation initiative (e.g., CTC-RI, PCMH-Kids, and payer or ACO-sponsored program) should be independently determined by the payers.

To assure that the care management function is being implemented as effectively as possible, payers should conduct regular CM evaluations. OHIC shall work with the payers to follow the Committee recommendation that large volume practices and ACOs have an evaluation annually and that other practices receive evaluations on a rotating basis, possibly every two-to-three years. The evaluations should be designed to provide helpful, real-time feedback to the care managers.

The sustainability model shall become effective in 2016.

Estimated minimum cost, to be funded by insurers:

- CTC-RI
- PCMH-Kids: ~18,000 covered children at $TBD pmpm, effective January 1, 2016

- Care manager evaluations: evaluators' time (this estimate will be revised as conversations continue with payers to develop the scope and model for this evaluation)

VII. Conclusion

The Commissioner has adopted the Care Transformation Advisory Committee's plan with modifications as meeting the requirement of Regulation 2 to develop a Care Transformation Plan. This plan sets an achievable PCMH goal for 2016 and draws upon the resources and commitment of a range of stakeholders while creating a solid foundation for more aggressive steps in future years.

Dated at Cranston, Rhode Island this 9th day of July, 2015.

Kathleen C Hittner, MD.
Health Insurance Commissioner
Office of the Health Insurance Commissioner

Appendix A

List of Care Transformation Advisory Committee Members and Organizational Affiliations

Committee Member	Affiliation
Gus Manocchia	BCBSRI
Kevin Callahan	UnitedHealthcare
David Brumley	Tufts Health Plan
Alison Croke	NHPRI
Gina Rocha	HARI
Mary Hickey	Lifespan
James Fanale	Care New England
Brenda Briden	CharterCare
Russell Corcoran	South County Hospital
Beth Lange Pat Flanagan	PCMH-Kids
Ed McGookin	Coastal Medical
Andrea Galgay	RIPCPC
Peter Hollmann	University Medicine
Christine Grey	Blackstone Valley CHC
Tina Spears	RIPIN
Maria Montanaro	BHDDH
Darlene Morris	RIQI
Deb Hurwitz Pano Yeracaris	CTC-RI
Kathleen Calandra	HealthCentric Advisors
Deidre Gifford	Medicaid

Appendix B
Operational Definition of PCMH

The following definition applies only to Rhode Island-based primary care practices.

1. Identify practice sites participating in a formal transformation initiative
    a. OHIC requests the following information:
        i. Obtain from CTC-RI: list of CTC-RI providers, providers' National Provider Identifier (NPI) numbers, names of practice sites, and practice site contact information;
        ii. Obtain from PCMH-Kids: list of PCMH-Kids providers, providers' NPI numbers, names of practice sites and practice site contact information;
        iii. Obtain from RIQI: in the event that RIQI receives a PTN grant, list of participating PCPs, providers' NPI numbers, names of practice sites, and practice site contact information;
        iv. Obtain from BCBSRI: list of non-CTC-RI providers in PCMHs, providers' NPI numbers, names of practice sites and practice site contract information; list of all contracted PCPs in the BCBSRI network, providers' NPI numbers, names of practice sites and practice site contact information.
        v. Obtain from UnitedHealthcare: list of all contracted PCPs in the United network, providers' NPI numbers, names of practice sites and practice site contact information.
    b. OHIC obtains from NCQA the names of providers, names of practice sites and practice addresses that have NCQA PCMH recognition, including Level 3 recognition
        i. As necessary, OHIC obtains from either United or BCBSRI the providers' names, practice addresses, and national ID numbers.
    c. OHIC creates a master database based on BCBSRI's and United's contracted network.
    d. OHIC indicates in its database which of the practice sites is participating in which formal care transformation initiative and which have NCQA PCMH Level 3 recognition.

2. Practice sites participate in specific cost-containment strategies
    a. OHIC creates a targeted self-reported survey targeting the specific cost-containment strategies that either:
        i. requires yes/no responses, or
        ii. requires scaled responses that indicate relative level of strategy implementation.

b. OHIC works with the Care Transformation Advisory Committee to determine minimum standards for meeting the PCMH definition.
c. OHIC distributes the survey electronically to practice sites participating in a formal practice transformation initiative or have NCQA PCMH Level 3 recognition.
d. OHIC collects and analyzes the results compared to pre-determined minimum requirements to qualify as PCMH.
e. OHIC incorporates the results into its tracking system.

3. Practice sites demonstrate meaningful improvement over an annual two-year look-back period.
   a. Selection of measures and establishing performance/improvement targets:
      i. Until the SIM committee has created a core measure set, OHIC will use a limited number of adult and pediatric HEDIS measures it selects, after consultation with payers and practices. After the SIM committee has created a core measure set, OHIC will select a limited number of measures to use, after consultation with payers and practices.
      ii. OHIC will work with the Care Transformation Advisory Committee to establish performance improvement targets, taking into consideration the population being served by the provider, minimum denominator size, and also decision rules for determining whether sufficient improvement has been demonstrated across the measure set.
   b. Data Collection
      i. OHIC will investigate if the APCD could be used for this project.
      ii. Until the APCD is available, OHIC will ask payers to submit numerators and denominators for each measure by practice site for all its commercially enrolled covered lives.
   c. Data Reporting
      i. OHIC will obtain the data from the payers and aggregate it by practice site.
      ii. OHIC will incorporate the results into its tracking system.

4. Calculating the percentage of RI primary care practice sites that are PCMHs
   a. OHIC will use the information it has collected regarding each of the three parts of the definition of PCMH to calculate the percentage of RI primary care practice sites qualifying as PCMHs.
   b. OHIC will share the calculated percentage, as well as the practice site-specific assessment for each of the three components of the definition, with the plans and practice sites.