Rhode Island 2018 Care Transformation Plan
Adopted by Health Insurance Commissioner Marie Ganim

January 24th, 2018

I. Background

This 2018 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 (OHIC), by Marie Ganim, 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 2018 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] This plan was developed over the course of three Committee meetings in the fall of 2017.

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, during 2015 the Committee developed and OHIC adopted a three-part definition of PCMH against which Rhode Island primary care practices are evaluated by OHIC. This definition is revisited annually by the Committee during its fall convening. The definition for 2018 is as follows:

1. Transformation Experience:
    a. Practice is participating for the first time in a formal transformation initiative[2] (e.g., CTC-RI, PCMH-Kids, TCPI, or an approved payer- or ACO-sponsored transformation program) with the expectation that the practice will obtain NCQA recognition within two years of entry into the transformation initiative.
    OR
    b. Practice holds current NCQA PCMH recognition status[3]. Practices meeting this requirement through achievement of NCQA recognition may do so independent of participating in a formal transformation initiative.

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[1] OHIC Regulation 2 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.

[3] If NCQA recognition was obtained according to 2014 standards, then NCQA level 3 must be obtained to meet this requirement.

2. Cost Management:
    a. Practice has implemented at least 80% of the following specific cost-management strategies according to the implementation timeline included in the Plan as Attachment A (strategy development and implementation at the group level rather than the practice site level is permissible)[4]:
        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. uses data to implement care management[5], focusing on high-risk patients and interventions that will impact ED and inpatient utilization;
        iii. implements strategies to improve access to and coordination with behavioral health services;
        iv. offers expanded access to services both during and after office hours;
        v. develops and implements service referral protocols informed by cost and quality data if provided by payers, and
        vi. develops and maintains an avoidable ED use reduction strategy. **OR**
    b. Practice is affiliated with an ACO that has contracts with its two largest commercial payers, and those contracts each meet the minimum downside risk requirements defined in the 2018 OHIC APM Plan.

3. Meaningful Performance Improvement:
    a. Practice has demonstrated meaningful performance improvement. For 2018, the measures for assessing performance are as follows:

        Adult practices

        - Adult BMI Assessment (HEDIS)
        - Screening for Clinical Depression and Follow-up Plan (NQF)
        - HbA1c Control (<8) (HEDIS)
        - Controlling High Blood Pressure (HEDIS)
        - Tobacco Cessation Intervention (NQF)

        Pediatric practices

        - Weight Assessment and Counseling for Nutrition and Physical Activity (HEDIS - all-or-nothing measure including 3 sub measures)
        - Developmental Screening (OHSU)

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[4] Practices shall attest to meeting the cost management strategies in the fall, which include a set of requirements that fall under the overarching strategies. Practices must meet at least 80% of these requirements to meet part 2(a) of the PCMH definition.

[5] 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.

b. Practice has reported performance relative to the following additional measures[6]:
   Adult practices
   - Colorectal Cancer Screening (HEDIS)
   - Comprehensive Diabetes Care: Retinal Eye Exam (HEDIS)

   Pediatric practices
   - Adolescent Well-Care Visits (HEDIS)

c. For 2018, "meaningful performance improvement" is defined as follows:
   i. For each measure: 3 percentage point improvement over one or two years **or** performance at or above the national 66th percentile[7], **or** performance at or above the state 25th percentile in the absence of an NCQA HEDIS rate[8];
   ii. Performance at or above the national 66th percentile alone if the practice did not previously report a prior year rate in addition to the performance measurement period rate;
   iii. First-time reporting practices: For practices submitting data for the first time, data will be recorded as baseline. Performance improvement in future years will be assessed against these first-year baseline rates.
   iv. Adult practices must achieve the above stated level of improvement on at least 3 of the 5 measures to achieve "meaningful performance improvement." Pediatric practices must achieve the above stated level of improvement on at least 1 of the 2 measures to achieve "meaningful performance improvement." Practices that report on both adult and pediatric measures must achieve the above stated level of improvement on at least 3 of the 5 adult measures *and* at least 1 of the 2 pediatric measures to achieve "meaningful performance improvement."

III. PCMH Financial Support Model

OHIC requires insurers to adopt the following two-stage payment model to sustain primary care transformation in practices. Insurers shall minimally apply this model to practices that have met the OHIC definition of a PCMH delineated in Section II above and are to be included in the calculation of the insurer's performance relative to its OHIC-defined PCMH annual target.

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[6] Recognizing that practices will not be able to report a full calendar year of data on the additional measures by October 2018, practices will get credit for reporting in 2018. Practices will then report baseline data in 2019, to analyze performance improvement in 2020, at which point measures in Section II(3)(a) with little room for improvement will be retired.

[7] For *outcome* measures with an NCQA HEDIS rate, practices with more than 50% of patients in Medicaid or uninsured will be scored against the Medicaid 66th percentile, while the rest of practices will be scored against the Commercial 66th percentile. For *process* measures, all practices will be scored against the Commercial 66th percentile. All rates will be from the version of Quality Compass for two years prior to the measurement period (e.g., Quality Compass 2017 with CY 2016 data for the 10/1/17 - 9/30/18 measurement period).

[8] For the 10/1/17 - 9/30/18 performance period, all practices will be scored against the 25th percentile for the state from the prior performance period (10/1/16 - 9/30/17).

- First Stage: Practices actively engaged in first-time PCMH transformation activity and without NCQA recognition[9], or practices with NCQA recognition[10], but which have not yet met the cost management strategies 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 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 recognition and which have implemented the cost management 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.

The CM PMPM payment shall support development and maintenance of a care management function within that practice and is not limited to supporting a care manager, per se. The infrastructure payment shall compensate practices for the time and effort involved in achieving NCQA PCMH 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 practices are determined by the program participants, subject to the approval of OHIC. The monetary levels of support of practices participating in other formal transformation initiatives or for practices that have graduated from such initiatives, and that are included in an insurer's count of PCMH practices should be independently determined by the insurers and the practices.

Insurers shall not impose a minimum attribution threshold for making CM PMPM or infrastructure payments to a PCMH that is counted toward the insurer's PCMH target.

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[9] Here and elsewhere below, "NCQA recognition" means recognition at Level 3 for practices with current recognition status that was awarded prior to NCQA's 4-3-17 implementation of its 2017 PCMH standards.

[10] Ibid.

Example Scenarios for Practices Engaged in Practice Transformation:

PCMH Achievements				Applicable Payment Model Components		
Example	**NCQA Recog.**	**80% of Required Cost Management Activities Implemented**	**Performance Improvement Achieved**	**Care Mgt PMPM**	**Infrastructure Payment PMPM**	**Performance Bonus Opportunity**
1	Yes	yes	yes	yes	no	yes
2	Yes	no (but still within 12-month timeframe for implementation)	no (but still within 24-month timeframe for implementation)	yes	yes	no
3	Yes	yes (but still within 12-month timeframe for implementation)	no (but still within 24-month timeframe for implementation)	yes	yes	no
4	Yes	no (but still within 12-month timeframe for implementation)	yes (but still within 24-month timeframe for implementation)	yes	yes	no
5	Yes	no (and 12-month timeframe for implementation has passed)	no (and 24-month timeframe for implementation has passed)	no	no	no

6	No (newly partici-pating in a formal trans-formation initiative)	no (but still within 12-month timeframe for implementa-tion)	no (but still within 24-month timeframe for implementa-tion)	yes	yes	no
7	No	no (and 12-month timeframe for implementa-tion has passed)	no (and 24-month timeframe for implementa-tion has passed)	no	no	no

IV. PCMH Target for 2018

The 2018 PCMH Target is meant to facilitate insurers' achievement of the target stated in Section 10(c)(1) of Regulation 2 as 80% of an insurer's contracted primary care practices functioning as PCMH by 12/31/19[11].

Based on work conducted in 2017 to understand and engage the remaining non-PCMH practices, OHIC is directing each insurer subject to the Affordability Standards to increase the percentage of its PCMH practices above its 12/31/17 performance level by focusing on non-PCMH, ACO-affiliated practices.

- 2018 Target: 50% of an insurer's contracted non-PCMH, ACO-affiliated practices as of 12/31/17 are recognized by OHIC as a PCMH by 11/30/18.
- 2019 Target: 90% of an insurer's contracted non-PCMH, ACO-affiliated practices as of 12/31/17 are recognized by OHIC as a PCMH by 11/30/19.

Beginning January 1, 2018, 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 this Plan and consistent with the Implementation Timeline included as Attachment A and be receiving support payments from the insurer that are consistent with the PCMH Financial Support Model, detailed in Section III of this Plan.

[11] OHIC Regulation 2 Section 10(c)(1)

V. Activities to Promote and Support PCMH Adoption

The following activities to be carried out in 2018 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. Evaluation of Additional Formal Transformation Initiatives

   Section II of this Plan recognizes the transformation experience of practices participating in a "Formal Transformation Initiative." That term is defined to mean:

   > "a comprehensive 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."

   To recognize ACOs' role in transforming primary care, OHIC invited organizations to submit documentation describing the supports and services provided to practices such that OHIC could evaluate and potentially recognize these programs as Formal Transformation Initiatives. OHIC will apply a set of criteria, detailed in Attachment B, that have been reviewed by the Care Transformation Advisory Committee to systematically evaluate submissions and recognize those ACO-led initiatives that meet these criteria.

2. Review and Revision of the Cost Management Strategies Survey

   The Cost Management Strategies were first written with robust input from stakeholders in 2015 and implemented beginning January 1, 2016, as stipulated in the 2016 Care Transformation Plan. Now that they have been in practice and reported on for two years, OHIC will convene a work group to consider collective experiences in implementing the Cost Management Strategies, and pursue the following:

   a. Review the existing Cost Management Strategies elements and revise as necessary to reflect current clinical best practices and cost trend drivers, to be operationalized and articulated in a clear manner, and to be non-duplicative of 2017 NCQA standards.
   b. Consider development of a high-performer waiver policy to recognize practices that have demonstrated high cost management strategy adoption through prior submissions of the Cost Management Strategies Survey or other measures.
   c. Consider and address opportunities for improvement of practice Cost Management Strategies adoption revealed through responses to the 2017 Cost Management Strategies Survey and the audit conducted by CTC in 2017.

3. Improve Data Sharing and Communication Across Providers
   Investigate the nature and extent of reported challenges associated with care coordination and the sharing of information across clinical settings and organizational entities. OHIC will engage in an information gathering process to clarify the specific challenges, and work with the Department of Health, the Executive Office of Health and Human Services, the Department of Behavioral Health, Developmental Disabilities, and Hospitals, providers, insurers, RIQI and other key stakeholders, as needed. OHIC will convene an inter-agency discussion to obtain a common understanding of regulatory and system levers for addressing the challenges uncovered, and identify strategies to address these challenges. OHIC will report back to the Care Transformation Advisory Committee with findings and recommendations for reaction.

4. Improve Processes for Behavioral and Physical Health Integration
   Entities in Rhode Island have begun to implement integrated behavioral health initiatives, including CTC-RI, which has a pilot underway that incorporates behavioral health providers into the primary care team. Equally, other efforts in the state are integrating primary care services in behavioral health settings. In response to feedback indicating that participants in these models of care are experiencing administrative challenges with regard to coding, billing, and other processes, and because of the Advisory Committee's expressed interest in improving behavioral and physical health integration, OHIC will work closely with CTC-RI, providers, and insurers to identify the specific barriers that are being experienced as part of these or other initiatives. OHIC will then facilitate a conversation between payers and providers to address these administrative challenges.

5. Statewide Strategy for Health Care Data
   In recognizing the potential of the All Payer Claims Database (APCD), Health Information Exchange (HIE), and other data systems to support care coordination and integration, measure variation in care delivery patterns and cost, reduce delivery of low value care, and demonstrate the value of transformed care, the Advisory Committee has articulated a need for a statewide strategic plan on health care data. While OHIC does not oversee the APCD, HIE or their applications, OHIC will support the Executive Office of Health and Human Services in engaging in formalized strategic planning and the establishment of a governance structure that includes representation of members of the Care Transformation Advisory Committee.

VI. Conclusion

This 2018 Care Transformation Plan is informed by the deliberations of the Care Transformation Advisory Committee. It advances progress towards the goals set forth in the OHIC Affordability Standards.

Dated at Cranston, Rhode Island this 24th day of January, 2018.

Marie Ganim

Marie Ganim, PhD
Health Insurance Commissioner
Office of the Health Insurance Commissioner

Attachment A
Implementation Timeline for the OHIC PCMH Transformation, Cost Management Strategies and Performance Improvement Requirements

I. 2018 Requirements for Primary Care Practices Seeking Designation as a PCMH under OHIC's Affordability Standards

Date	Activity	Comment
Practice Notification	By April 1st insurers must notify contracted primary care practices *without* OHIC PCMH designation of: • OHIC PCMH standards and specific insurer requirements to receive PCMH financial support payments, and the specifics regarding the financial support payments, including amount and timing.	• At a minimum, each insurer must notify new practices that it wants to count towards achieving its PCMH 2018 target. To avoid duplicate notices being sent to practices, OHIC recommends that insurers coordinate with CTC-RI, PCMH-Kids, and RIQI to send one notice to each practice on behalf of all insurers. Insurers are encouraged to work with OHIC around development of a common list of practices to be targeted for transformation and to rely on existing multi-payer forums, including CTC-RI and PCMH Kids to drive transformation.
Requirement 1: Transformation	Each practice's participation status in the transformation initiative is determined by October 15th: Practice's NCQA status is obtained by OHIC from NCQA as of October 1st. Participation in formal transformation initiatives will be obtained by OHIC from such initiatives by October 1st.	• All practices with 2 or more years of transformation experience in a program making infrastructure payment must have achieved NCQA by September 30th, since they will have already received infrastructure payments for at least two years and will be in at least their third year of transformation activity.
Requirement 2: Cost Strategies	• Submit data on implementation of Cost Management Strategies. • Practices that join a transformation initiative during 2018 are expected to report only. • Practices that joined a transformation initiative or independently achieved	• The self-assessment will be submitted to OHIC via a web-based survey no later than October 15th annually. • This information is needed to give OHIC sufficient time to analyze all data received, determine which

	NCQA during 2017 are expected to meet Year 1 requirements as of October 15, 2018. • Practices that joined a transformation initiative during 2015 or 2016, or independently achieved NCQA during 2015 or 2016 are expected to meet Year 2 requirements as of October 15, 2018. • Practices that joined a transformation initiative or independently achieved NCQA prior to 1/1/2015 are expected to meet Year 3 requirements by October 15, 2018.	practices meet the definition and notify practices and insurers of the results of its analysis. • Practices will earn a "pass" if they have implemented **80% or more** of the Cost Management Strategies required for the year for which they are reporting.
Requirement 3: **Performance Improvement regarding quality measures**	• Submit data on performance measures, and show meaningful performance improvement (as defined in the OHIC Care Transformation Plan (3.)) by October 15th. • For practices submitting quality measures to OHIC for the first time, meaningful performance improvement need not be demonstrated until the second year of submission.	• OHIC has determined that meaningful performance data must be practice-wide. Data must come from practice submissions until another source if available. A web-survey has been developed for this purpose.

OHIC Activities
By October 15th: • Determine applicant practices' participation status in transformation initiatives. • Collect and analyze Cost Management Strategies and quality measures data from practices. • Collect and analyze NCQA PCMH Level 3 recognition information from NCQA. By December 1st: • Obtain information from insurers, transformation initiatives and through practice applications to identify and notify insurers of new applicant practices. • Identify practices that meet the OHIC PCMH definition. • Calculate insurer compliance with OHIC PCMH target. • Notify insurers of the results of OHIC's assessment of practices and of the insurer PCMH target compliance calculation. Ongoing • Maintain and update the OHIC webpage with PCMH information and monitor application submittals and survey responses. • Promote awareness of OHIC's PCMH initiative. • Obtain insurer and provider input regarding the OHIC PCMH definition about PCMH recognition implementation process.

Attachment B

Rhode Island Office of the Health Insurance Commissioner
Review Criteria for PCMH Formal Transformation Initiatives

I. Introduction

The 2017-18 OHIC Care Transformation Plan requires that Patient-Centered Medical Homes (PCMHs), in part, participate in or complete a "formal transformation initiative." That term is defined to mean:

> "a comprehensive 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."

The Plan further states that "OHIC shall determine whether a training program meets this definition."

II. Review Criteria

1. Engages practices leadership. The transformation initiative engages and maintains practice leadership involvement in practice transformation.

2. Comprehensively addresses the core elements of a PCMH[12]. The transformation initiative addresses core elements of the PCMH, including the following:
    a. empanelment
    b. team-based care
    c. evidence-based care
    d. patient-centeredness
    e. enhanced access
    f. care management for adults/care coordination for children
    g. application of a quality improvement strategy
    h. obtaining and using data at the patient and population level from the practice EHR, ACO and health plans, including patient exception (gaps-in-care) reports
    i. OHIC-defined cost management strategies, in addition to care management/care coordination, including:
        i. access to and coordination with behavioral health services
        ii. referral of patients to specialty and ancillary providers who are known to provide high quality, efficient services

[12] Most of these core elements are found in the "Change Concepts for Practice Transformation" developed by the Safety Net Medical Home Initiative. See www.safetynetmedicalhome.org/change-concepts.

3. Prepares practices for NCQA PCMH recognition. The initiative by explicit design puts the practice on a pathway to achieve NCQA PCMH recognition within 24 months of commencing participation in the initiative.

4. Structured with a pre-defined curriculum designed to systematically build the skills within the practice to function as a PCMH. There is a well-defined multi-part curriculum, based on an evidence-based PCMH transformation model, that helps practices gain mastery of the PCMH core elements by moving in step-wise fashion, first covering foundational competencies, and then covering advanced competencies that build on the foundation.

5. Involves primary care providers and support staff. The initiative should be built around practice teams. Physician leaders and key non-physician practice team members (e.g., nurse, medical assistance, office manager) who work together day-to-day at the practice site should participate together.

6. Provides technical assistance. The initiative should use one or more of the following modalities, but should not rely primarily on practice self-teaching and data submission. It should also not rely upon financial performance incentives. The modalities are:
    - self-teaching through review of guides (e.g., the NCQA PCMH recognition requirements), online presentations and videos;
    - practice coaching (facilitation) on-site, remotely, or both, and
    - learning collaborative, including a mix of didactic and peer-led group learning, typically in-person in a multi-practice convening.

7. Holds practices accountable for demonstrating transformation. The initiative requires practices to demonstrate the implementation of modified care processes and improved quality of care through a) document and or data submission, and/or b) practice audit. The initiative also tracks practice performance on key performance indicators against benchmarks.