OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

Care Transformation Advisory Committee
Meeting Agenda
November 13, 2015, 8:00 A.M. to 11:00 A.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

1. Introductions

2. Follow-ups from October 22, 2015 Meeting

3. PCMH Performance Improvement Requirements

4. Implementation Timeline and Cost Containment Strategies

5. Proposed Initiatives for 2017 Care Transformation Plan

6. 2017 PCMH Target

7. Public Comment

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Care Transformation Advisory Committee
Meeting Minutes
November 13, 2015, 8:00 A.M. to 11:00 A.M.
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Committee Members: Gus Manocchia, Mary Craig, Adam McHugh (for David Brumley), Tracey Cohen, Beth Lange, Ed McGookin, Andrea Galgay, Darlene Morris, Pano Yeracaris, Kathleen Calandra, Brenda Briden, Russell Corcoran, Peter Hollmann, Tina Spears

Not in Attendance:
Gina Rocha, Maria Montanaro, Pat Flanagan, Christine Grey, Mary Hickey, Jim Fanale, Deb Hurwitz

OHIC:
Kathleen Hittner, Sarah Nguyen

1. **Introductions**

2. **Follow-ups from October 22, 2015 Meeting**

   Sarah Nguyen, OHIC, informed the Committee that OHIC will be drafting a required format/template for high-risk patient reports. The template will be drafted from the information collected at PCMH-Kids.

   Ms. Nguyen also updated the Committee on the work of the Administrative Simplification Taskforce. The Taskforce is currently discussing the value and ease of implementation for certain plan design components, including:
   a. Requiring consumers to select PCP when purchasing a plan (this was the "winner" from survey participants in terms of value and ease of implementation);
   b. No prior authorization for care management program participants;
   c. Value-based network tiering;
   d. Standardization of network-tiering;
   e. Monthly/periodic co-pays for chronic disease categories; and
   f. Cost-sharing incentives for participation in care management programs.

3. **PCMH Performance Improvement Requirements**

Ms. Nguyen noted that the first step in this process was for the Committee to make a recommendation on data sources. Afterwards, the Committee (or a subset of the Committee) could discuss the measures and how to define "meaningful" performance improvement.

Michael Bailit, Bailit Health Purchasing, discussed the different options for performance improvement measure sources, along with their advantages and disadvantages. There are operational feasibility questions for both clinical data-based measures (which would mean that practices have to report the data themselves) and for claims-based measures which not all carriers can report at the practice site level.

Dr. McGookin, Coastal Medical, noted that small practices could have a process where they get a claims-based file, which they can then edit to correct inaccurate data. Dr. Lange, PCMH-Kids, suggested that a blend of both clinical and claims data be used. Claims-based measures could be used to start and the practices could transition to clinical measures. Dr. Hollmann, University Medicine, noted that there should be an ongoing body to determine the threshold for improvement, implementation of measurement, and any changes to the measure set. Dr. Manocchia, BCBSRI, noted that clinically-based measures would be a reporting burden on practices new to transformation.

Mr. Bailit suggested that there be a blend of clinical and claims-based measures. He suggested that the measures could be clinical the first year and that the APCD could produce the claims data.

Brenda Briden, Prospect Medical, asked about the ability to report these measures if the practice does not have an electronic health record. Dr. Manocchia noted that 25% of primary care providers do not have an EHR and that 35% of specialists do not have an EHR.

Mr. Bailit recommended that the OHIC PCMH performance improvement measures work off the to-be-completed SIM measure set and that an "assembly of the willing" look at the SIM measure set to identify measures for performance improvement.

Dr. Hollmann suggested using the existing CTC-RI Data and Evaluation Workgroup to start this conversation. Members of this committee can join the December meeting of that workgroup (December 1st 7:30-9:30am).

4. **Implementation Timeline and Cost Containment Strategies**

Cost Management Strategies
Marge Houy, Bailit Health Purchasing, summarized the cost management strategies and NCQA crosswalk. She explained:

a. 8 of the NCQA requirements were similar enough to the cost strategies to allow deeming.
b. 3 of the NCQA requirements were similar enough to the cost strategies to allow partial deeming.
c. 14 cost management strategies were substantially different from NCQA so deeming would not be allowed.
d. 6 requirements did not have an NCQA equivalent.

Due to the substantial differences between NCQA and the cost management strategies, OHIC has decided to allow new practices one extra year to implement the cost management strategies. Dr. Lange noted that PCMH-Kids and OHIC are currently discussing these strategies offline.

Next the Committee discussed the possibility of "spot audits" or monitoring of practice implementation of the cost management strategies. Some committee members raised concerns about the cost of this potential audit/monitoring program. Other committee members raised questions about the logistics of how such a program would work, e.g. would the program represent all of the payers?

Andrea Galgay, RIPCPC, suggested that OHIC align the "must pass" criteria for cost management with the "must pass" criteria for NCQA. Mary Craig, UnitedHealthcare, noted her concern about the level of attribution – it would hard to manage a P4P program or an ACO-type agreement if there are small attribution numbers. Dr. Yeracaris, CTC-RI, suggested OHIC look at the "How's Your Health" toolkit which is available free of charge. Ms. Galgay also brought up the topic of a communication strategy for implementation of these cost management strategies.

Next the Committee members discussed small practices. There was one suggestion that OHIC look at outcomes rather than cost management and another suggestion that OHIC focus on the things that small practices do well instead of the things that they don't do well. Mr. Bailit also suggested that some other states have brought small practices together (while still allowing them to maintain their independence) through approaches such as "podding" or "clumping" these practices together.

Some Committee Members raised their concerns over the payment amount for practices, for both new practices undergoing transformation and existing practices. Ms. Galgay suggested that OHIC tell the payers the timeline by which they must tell the practices the PMPM amount. Dr. Lange noted that there is a possibility that two different cohorts of practices

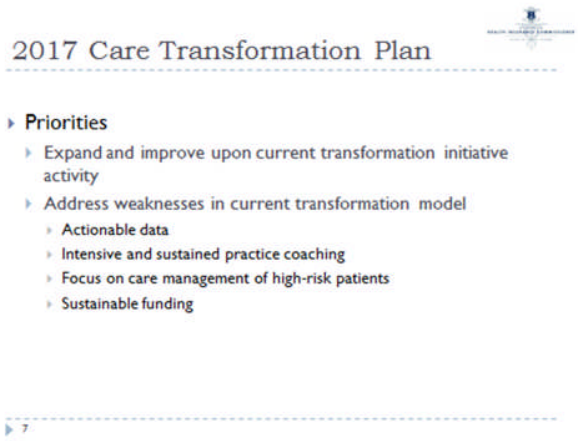
could exist with two different expectations and different PMPMs. Dr. Lange also noted that funding currently comes on the back-end instead of the front-end which can make transformation difficult. She suggested a pre-payment with reconciliation. Dr. Yeracaris noted that primary care practices should be protected within ACOs – do the care management dollars flow to the primary care practice and how would this be checked?

Ms. Houy ended this part of the agenda by telling Committee Members that OHIC would solicit feedback on the deeming part of the cost management crosswalk and then solicit recommendations on how many strategies practices must meet in order to "pass".

Letter from Insurers to Practices
Committee Members next discussed the letter from insurers to practices. Dr. Lange noted that fall is a very busy time for physicians and Dr. Yeracaris noted that this letter could be confusing for people who are currently in CTC-RI contracts. Ms. Houy explained that this letter would not go out to brand new practices. It would be distributed to practices that are needed to meet the 2016 PCMH target, including PCMH-Kids. Committee members discussed the content of the letter (e.g. including specific details vs. a more generalized letter) and the tone of the communication. Tina Spears, RIPIN, suggested that the letter be high-level, then have information that is catered to specific types of practices and that the letter have a clear point of contact. Ms. Galgay suggested that the letter should come from OHIC rather than the payers.

5. **Proposed Initiatives for 2017 Care Transformation Plan**

Ms. Nguyen solicited feedback from Committee Members on the proposed priorities for the 2017 Care Transformation Plan.



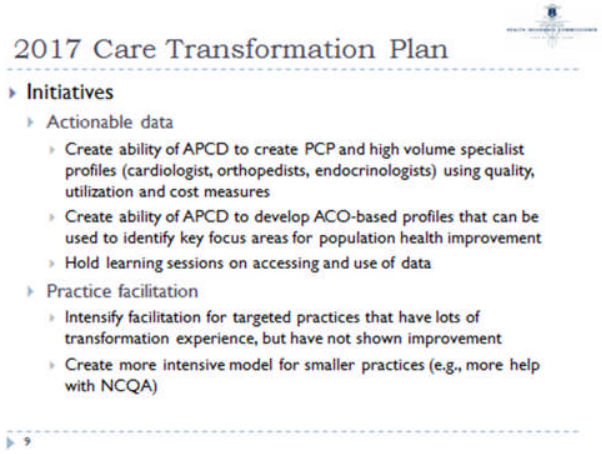
Committee members suggested that "integration of specialists", "data and reporting capabilities", and "behavioral health" be added to the list of priorities.

Dr. Hollmann noted that all of this work should be put into context in a communication to

the practices. He brought up an example communication to a practice: "Three years from now, you will have a 10% fee reduction unless you are operating in a PCMH". Dr. Manocchia noted that BCBSRI is rolling out a formal communication plan for the primary care community which discusses the potential impact on income.

Next, Ms. Nguyen asked the Committee Members to endorse RIQI's Transforming Clinical Practice Initiative as a "formal transformation initiative" in the context of the Care Transformation Plans. There was general consensus from the Committee Members that this was appropriate but Dr. Yeracaris noted that there is no reference to NCQA accreditation in the TCPI program.

Committee members then discussed potential initiatives:



Ms. Galgay asked the question "what do we want practices to do with this data?" Dr. Hollmann noted that he liked bullet points 2 and 3 under "actionable data" but that he didn't believe the specialist profile was attainable at this time.

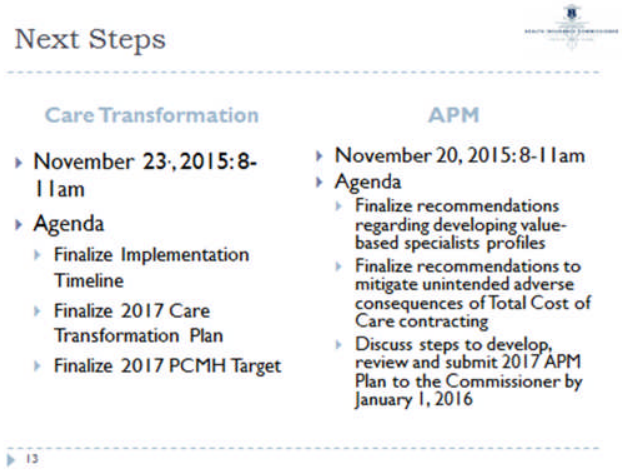
Committee members noted the need to integrate specialists into the cost management conversation and into initiatives such as the Community Health Teams. Ms. Galgay brought up the topic of workforce development and Dr. Yeracaris mentioned the Department of Health's Heath Equity Zone effort.

6. **2017 PCMH Target**

Next, Ms. Nguyen asked the Committee Members for feedback around options to reach a 2017 PCMH target.

Dr. Lange thought that any approach should be an all-payer approach. Dr. Manocchia asked about the consequences for payers if they do not meet the target and Dr. Yeracaris suggested that the RIQI TCPI program could train practices that could then enter CTC.

Ms. Nguyen concluded the meeting, noting that the final meeting for the Care Transformation Advisory Committee was on November 23rd.



7. Public Comment

There was no public comment.

OFFICE OF THE
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STATE OF RHODE ISLAND

Care Transformation Advisory Committee

Fall 2015 Convening
November 13, 2015

Agenda

1. Introductions
2. Follow-ups from October 22, 2015 Meeting
3. Performance Improvement Requirement
4. Implementation Timeline and Cost Containment Strategies
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Follow-ups from October 22, 2015

- High-risk patient list sub-committee
- Plan design and Administrative Simplification Workgroup

Performance Improvement Requirement

- "Practice has demonstrated meaningful performance improvement. Using a 2-year lookback period with a 6 month 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 2 year lookback period with a 6 month claims lag. OHIC shall define "meaningful performance improvement" in consultation with the Advisory Committee."

Performance Improvement Requirement

- Goal: Recommendation to the Commissioner on how to proceed

- Discussion Questions:
  - Use claims-based, clinical data, or a combination of both?
  - If clinical data, how will practices submit data?

Implementation Timeline and Cost Containment Strategies

- Goal: finalize implementation timeline and cost containment strategies

2017 Care Transformation Plan

- Priorities
  - Expand and improve upon current transformation initiative activity
  - Address weaknesses in current transformation model
    - Actionable data
    - Intensive and sustained practice coaching
    - Focus on care management of high-risk patients
    - Sustainable funding

2017 Care Transformation Plan

- Consideration of RIQI Transforming Clinical Practice Initiative (TCPI) as a "formal transformation initiative" starting in 2016.

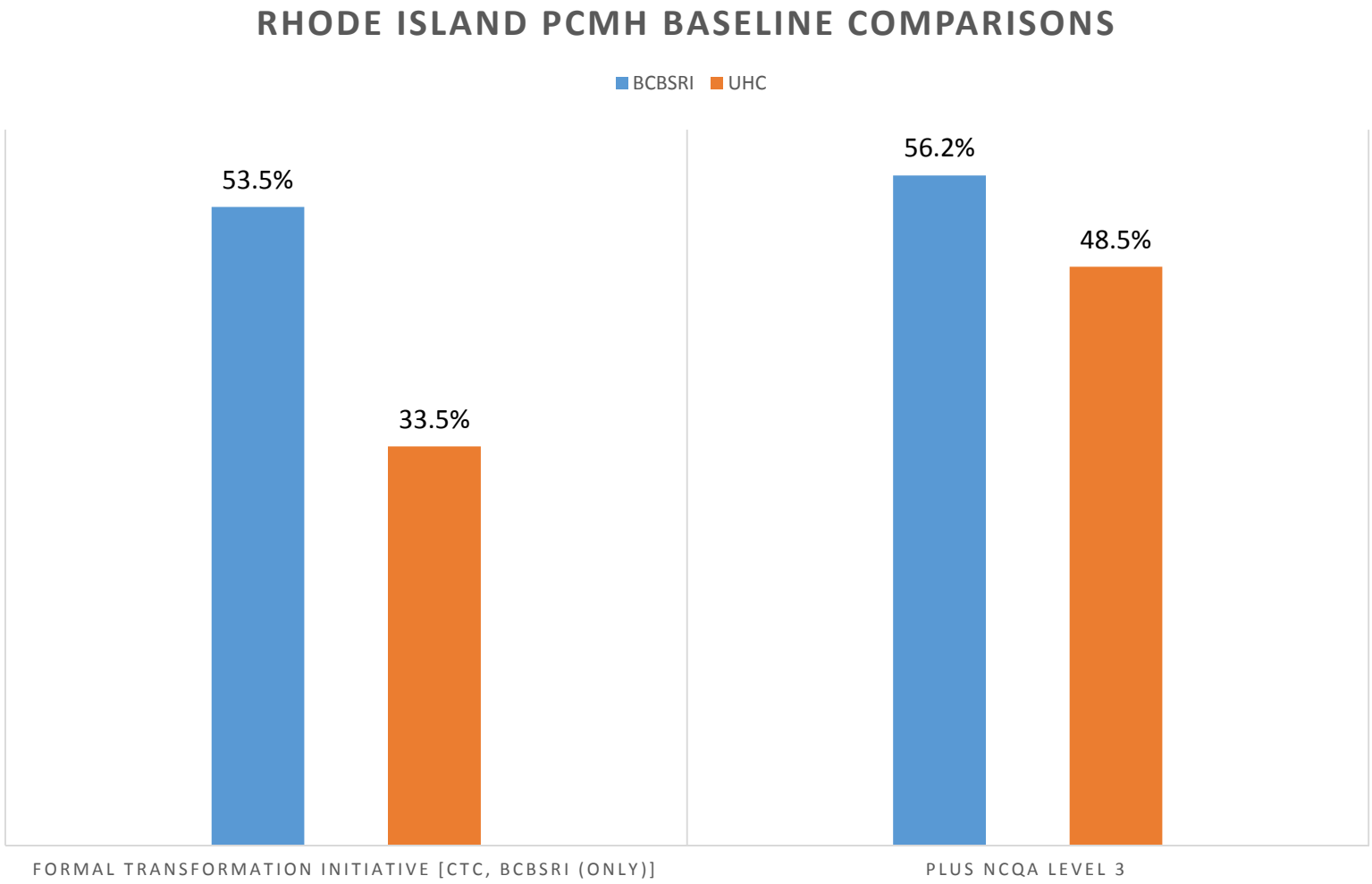
- Consider a two-track approach for practice support
  - Current PCMHs
  - New PCMHs

2017 Care Transformation Plan

- Initiatives
  - Actionable data
    - Create ability of APCD to create PCP and high volume specialist profiles (cardiologist, orthopedists, endocrinologists) using quality, utilization and cost measures
    - Create ability of APCD to develop ACO-based profiles that can be used to identify key focus areas for population health improvement
    - Hold learning sessions on accessing and use of data
  - Practice facilitation
    - Intensify facilitation for targeted practices that have lots of transformation experience, but have not shown improvement
    - Create more intensive model for smaller practices (e.g., more help with NCQA)

Review of 2016 PCMH Targets

- 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 a baseline rate calculated by OHIC.
  - Baseline does not include practices associated with PCMH-Kids.


RHODE ISLAND PCMH BASELINE COMPARISONS
BCBSRI
UHC
53.5%
33.5%
56.2%
48.5%
FORMAL TRANSFORMATION INITIATIVE [CTC, BCBSRI (ONLY)]
PLUS NCQA LEVEL 3

2017 PCMH Target

- Options for 2017 target
  1. Set numerical target (like for 2016)
  2. CTC-RI expansion
  3. Use RIQI TCPI work

Next Steps

Care Transformation

- November 23', 2015: 8-11am
- Agenda
  - Finalize Implementation Timeline
  - Finalize 2017 Care Transformation Plan
  - Finalize 2017 PCMH Target

APM

- November 20, 2015: 8-11am
- Agenda
  - Finalize recommendations regarding developing value-based specialists profiles
  - Finalize recommendations to mitigate unintended adverse consequences of Total Cost of Care contracting
  - Discuss steps to develop, review and submit 2017 APM Plan to the Commissioner by January 1, 2016

Claims-Based Measures for Use in OHIC PCMH Assessment of Performance

Performance Measure	Performance Rates		Corresponds to a SIM Measurement Priority?	# of RI Plans Using	Rationale for Inclusion
	NE Regional PPO 90th Percentile	Nat'l PPO 90th Percentile			
Breast Cancer Screening (BCS)	76.68	75.74	Yes	3	above 90th percentile regionally & nationally but absolute rate is low
Adolescent Well Care Visits (AWC)	64.08	60.57	Yes	1	above 90th percentile regionally & nationally but absolute rate is low
Comprehensive Diabetes Care: Eye Exam (retinal) performed	59.96	58.88	Yes	2	above 90th percentile regionally & nationally but absolute rate is very low
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)	29.00	32.02	No	2	below 90th percentile regionally and nationally, and absolute rate is very low
Comprehensive Diabetes Care: Medical Attention for Nephropathy	82.73	85.40	Yes	3	half the plans below 90th percentile regionally and nationally, and absolute rate is low
Use of Imaging Studies for Low Back Pain	77.10	81.79	No	2	below 90th percentile regionally and nationally, and absolute rate is low
Antidepressant Medication Management (AMM): Effective Acute Phase Treatment	95.88	74.75	No	1	below 90th percentile regionally and nationally, and absolute rate is low
Antidepressant Medication Management (AMM): Effective Continuation Phase Treatment	52.96	63.46	No	1	below 90th percentile regionally and nationally, and absolute rate is low

Potential PCMH Performance Improvement Measures:
Tentative Endorsements from the SIM Measure Alignment Work Group
November 3, 2015

Measure Name	NQF Number	Steward	Description	Domain	Population	Data Source
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	0004	NCQA	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Behavioral health	Adult	Claims

Potential PCMH Performance Improvement Measures:
Tentative Endorsements from the SIM Measure Alignment Work Group
November 3, 2015

Measure Name	NQF Number	Steward	Description	Domain	Population	Data Source
Anti-depressant Medication Management	0105	NCQA	The percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported: A. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). B. The percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	Behavioral health	Adult	Claims
Follow-Up After Hospitalization for Mental Illness	0576	NCQA	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: 1) the percentage of members who received follow-up within 30 days of discharge, 2) the percent of members who received follow-up within 7 days of discharge	Behavioral health	Adult and Pediatric (6 years and older)	Claims

Potential PCMH Performance Improvement Measures:
Tentative Endorsements from the SIM Measure Alignment Work Group
November 3, 2015

Measure Name	NQF Number	Steward	Description	Domain	Population	Data Source
30-day Psychiatric Inpatient Readmission	NA	State of WA DSHS	For members 18 years of age and older, the number of acute inpatient psychiatric stays during the measurement year that were followed by an acute readmission for a psychiatric diagnosis within 30 days	Behavioral health	Adult	Claims
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	0059	NCQA	The percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Chronic illness care: diabetes	Adult	Claims and Clinical Data
Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	0061	NCQA	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg during the measurement year.	Chronic illness care: diabetes	Adult	Claims and Clinical Data
Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	NCQA	The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Chronic illness care: diabetes	Adult	Claims and Clinical Data
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	0575	NCQA	The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is <8.0% during the measurement year.	Chronic illness care: diabetes	Adult	Claims and Clinical Data

Potential PCMH Performance Improvement Measures:
Tentative Endorsements from the SIM Measure Alignment Work Group
November 3, 2015

Measure Name	NQF Number	Steward	Description	Domain	Population	Data Source
Controlling High Blood Pressure	0018	NCQA	The percentage of patients 18 to 85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	Chronic illness care: hypertension	Adult	Claims and Clinical Data
Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI	The percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	Preventive Care	Adult	Claims and Clinical Data
Cervical Cancer Screening	0032	NCQA	The percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	Preventive Care	Adult	Claims and Clinical Data
Chlamydia Screening	0033	NCQA	The percentage of women ages 16 to 24 that were identified as sexually active and had at least one test for Chlamydia during the measurement year	Preventive Care	Adult	Claims
Colorectal Cancer Screening	0034	NCQA	The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Preventive Care	Adult	Claims and Clinical Data
Breast Cancer Screening	2382	NCQA	The percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.	Preventive Care	Adult	Claims

Potential PCMH Performance Improvement Measures:
Tentative Endorsements from the SIM Measure Alignment Work Group
November 3, 2015

Measure Name	NQF Number	Steward	Description	Domain	Population	Data Source
Adult Body Mass Index (BMI) Assessment	0421	CMA	The percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	Preventive Care	Adult	Clinical Data
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents	0024	NCQA	The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender	Preventive Care	Pediatric	Claims and Clinical Data
Childhood Immunization Status	0038	NCQA	The percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday (Group is using Combo 10)	Preventive Care	Pediatric	Claims and Clinical Data

Potential PCMH Performance Improvement Measures:
Tentative Endorsements from the SIM Measure Alignment Work Group
November 3, 2015

Measure Name	NQF Number	Steward	Description	Domain	Population	Data Source
Immunization Status for Adolescents	1407	NCQA	The percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday	Preventive Care	Pediatric	Claims and Clinical Data
Human Papillomavirus (HPV) Vaccine for Female Adolescents	1959	NCQA	The percentage of female adolescents 13 years of age who had three doses of the human papillomavirus (HPV) vaccine by their 13th birthday.	Preventive Care	Pediatric	Claims and Clinical Data
Adolescent Well Care Visits	NA	NCQA	The percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Preventive Care	Pediatric	Claims

Summary Statistics

- Total number of PCMH-relevant measures: 21
- Adult measures: 15
    - Behavioral health: 4
    - Preventive: 6
    - Chronic Illness: 5
        - Diabetes: 4
        - Hypertension: 1
- Pediatric measures: 6

- Claims-only: 6
    - Adult: 5
    - Pediatric: 1
- Clinical or Hybrid: 15
    - Adult: 10
    - Pediatric: 5

Implementation Timeline for Sustainable Payment Model, Cost Containment Strategies and Performance Improvement Requirements
November 6, 2015

I. Cost Management Strategies

	2016	
A. Practices Engaged in First-time Transformation Activities or Participated in a Transformation Initiative for Less than Two Years		
Date	**Activity**	**Comment**
Practice Notification	• On or before January 1, 2016, insurers notify their primary care networks of OHIC PCMH standards and specific insurer's requirements to receive sustainability payments. • By December 1, 2015, OHIC has identified a transformation agent capable of creating and monitoring an on-line application available to primary care practices that want to "self-identify" for OHIC PCMH status.	• At a minimum, each insurer must notify practices that it wants to count towards achieving its PCMH 2016 target. To avoid duplicate notices being sent to practices, OHIC recommends that insurers coordinate with CTC to send one notice to each practice on behalf of all insurers. • OHIC anticipates that practices currently participating in a recognized transformation initiative will constitute most, if not all, of the practices being evaluated under the OHIC PCMH standards. However, OHIC believes that it is important to provide other practices with the opportunity to self-identify. • The location of the web application has not been identified, but it could be an entity supporting practice transformation.
Requirement 1: Transformation	The practice's participation status in the transformation initiative is determined either actively or passively by September 30, 2016:	• OHIC is currently receiving NCQA data directly from NCQA. • The website maintained by CTC or some other entity supporting practice transformation will provide "self-

	2016	
	• active: online submission through a website • passive: OHIC gathers data from transformation agents (e.g., CTC-RI, PCMH-Kids) Practice's NCQA Level 3 status is determined by OHIC as of September 30, 2016.	identified" practices with an opportunity to report transformation information.
Requirement 2: Cost Strategies	Implement Year 1 cost strategy requirements by September 30, 2016; submit self-assessment by September 30, 2016.	• Practices newly engaged in practice transformation will have at least nine months to implement Year 1 cost strategies. OHIC anticipates that most practices seeking PCMH designation in the first year of the program will be practices with significant transformation experience. Therefore, OHIC believes that the timeframe in 2016 for this requirement is reasonable. Most "new" practices will be PCMH-Kids practices, which began transformation activities in the fall of 2015. • The self-assessment will be submitted to OHIC via a web-based program, such as SurveyMonkey. • This information is needed by the end of September to give OHIC sufficient time to analyze all data received, to determine which practices meet the definition and to notify practices and insurers of the results of its analysis.
Requirement 3: Performance Improvement regarding quality measures	Submit data[1] by September 30, 2016, but no requirement to show improvement during look-back period.	• OHIC has determined that meaningful performance data must be practice-wide. Therefore, data must come either from practice submissions or from the All- Payer Claims Database (APCD). Because the

[1] The measurement data and data sources are yet to be defined.

	2016	
		APCD is not yet fully functional, OHIC would like to assess the feasibility of practices submitting data to CTC or some other organization promoting practice transformation. • Regardless of the source of the data, practices would not be required to demonstrate improvement until September 30, 2017. • The 2016-submitted data will help to set a baseline for measuring transformation.
Payment Model (*for practices meeting the three PCMH definition requirements and included in the insurer's PCMH count for OHIC target compliance purposes*)	Eligible to receive infrastructure and CM/CC payments as of January 1, 2016, so long as the practice is participating in a transformation initiative.	• The payment model outlines minimum requirements for payers to meet. Payers may have existing (or future) contracts with providers whose terms exceed these minimum standards. • Once a practice attains NCQA Level 3 recognition, the payer is not required to make infrastructure payments. • In 2016, payers would be expected to make sustainability payments to practices that participate in a recognized transformation initiative. The payer is expected to continue making sustainability payments as of January 1, 2017, only if the practice 1) participates in a transformation initiative, and 2) was successful in implementing the Year 1 Cost Strategies. The payer is expected to continue making sustainability payment as of January 1, 2018, only if the practice, 1) achieved NCQA Level 3 recognition, 2) was successful in implementing Year 2 Cost Strategies, and 4) was able to show improvement based on data submitted on September 30, 2017. • Payment levels are either those agreed upon under a specific transformation initiative or those negotiated between the insurer and the provider.

B. Practice Having Completed, or Having Been Engaged for Two or More Years in a Transformation Initiative, as of January 1, 2016		
Practice notification	• On or before January 1, 2016, insurers notify their primary care networks of OHIC PCMH standards and specific insurer's requirements to receive sustainability payments.	• At a minimum, each insurer must send a notice to each practice that it wants to count towards achieving its PCMH 2016 target. To avoid duplicate notices being sent to practices, OHIC recommends that insurers coordinate with CTC to send one notice to CTC and PCMH-Kids practices on behalf of all insurers.
Requirement 1: Transformation	The practice's participation status in the performance initiative is determined either actively or passively by September 30, 2016: • active: online submission through a website • passive: OHIC gathers data from transformation agents (e.g., CTC-RI, PCMH-Kids) Practice's NCQA Level 3 status determined by OHIC by September 30, 2016. To meet the PCMH definition, practices must achieve NCQA Level 3 recognition by the beginning of the third year of participation in a transformation initiative.	• While it is highly unlikely that there will be any self-identified practices in this group, OHIC would like to provide the opportunity for practice-generated applications. • The location of the web application has not been identified, but it could be an entity supporting practice transformation. • All practices must have achieved NCQA Level 3 by September 30, 2016, 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	Implement Year 1 cost strategy requirements by September 30,	• Practices will have nine months to implement Year 1 Cost Strategies, if they have not already done so.

	2016; submit self-assessment by September 30, 2016.	OHIC believes this is reasonable in light of the practices' prior involvement in transformation strategies. • The self-assessment will be submitted to OHIC via a web-based program, such as SurveyMonkey. • This information is needed by the end of September to give OHIC sufficient time to analyze all data received, to determine which practices meet the definition and to notify practices and insurers of the results of its analysis.
<u>Requirement 3:</u> **Performance improvement regarding quality measures**	Submit data[2] by September 30, 2016, but no requirement to show improvement during look-back period.	• OHIC has determined that meaningful performance data must be practice-wide. Therefore, data must come either from practice submissions or from the All- Payer Claims Database (APCD). Because the APCD is not yet fully functional, OHIC would like to assess the feasibility of practices submitting data to CTC or some other organization promoting practice transformation. • If obtaining data from all practices is not feasible, OHIC recommends waiving this requirement until the APCD is fully functional ready for this function. • Regardless of the source of the data, practices would not be required to demonstrate improvement until September 30, 2017. • The 2016-submitted data will help to set a baseline for measuring transformation.
Payment Model (*for practices meeting the three PCMH definition requirements and included in the insurer's*	Eligible to receive CM/CC payment as of January 1, 2016 and have a performance-based payment opportunity in 2016.	• In 2016, payers would be expected to make sustainability payments to practices that have achieved NCQA Level 3 recognition and are being counted towards the plan's PCMH target.

[2] The measurement data and data sources are yet to be defined.

PCMH count for OHIC target compliance purposes)[3]		• Payers would be expected to make sustainability payments to these practices in 2017 only if the practices demonstrated compliance with NCQA Level 3 and Year 1 Cost Strategy implementation requirements by September 30, 2016. • Payers would be expected to make sustainability payments to these practices in 2018 only if the practices demonstrated compliance with all three definitional requirements by September 30, 2017.

C. OHIC Activities
Initiative Launch: Between November 1, 2015 and April 30, 2016: • 12/1/2015: Coordinate with CTC and payers to create list of practices that payers want to include in PCMH target calculation for 2016. • 12/15/2015: payers work with CTC and among themselves to send letter to practices informing them of opportunity for Sustainability Payments. • 4/30/16: Create OHIC webpage with PCMH information. • 4/30/16: Work with transformation program to create physician application portal and application process. • On-going: Advertise PCMH initiative. By September 30, 2016 and annually thereafter: • Determine applicant practices' participation status in transformation initiatives. • Collect and analyze NCQA Level 3 recognition information. By November 1, 2016 and annually thereafter: • Create and maintain website to collect Cost Strategies Survey results and to upload performance measurement data (if practice-reported). Obtain performance measurement data from APCD, when functional. • Collect and analyze Cost Strategies Survey results. • Collect and analyze performance improvement data. • Add practices' participation status and NCQA Level to database. • Identify practices that meet the OHIC PCMH definition; respond to inquiries regarding methodology.

[3] The payment model outlines minimum requirements for payers to meet. Payers may have existing (or future) contracts with providers with terms that exceed these minimum standards.

- Calculate insurance compliance with OHIC target.
- Notify practices of the results of OHIC's assessment.
- Notify insurers of the results of OHIC's assessment of practices and target compliance calculation.
- Obtain information from payers, transformation initiatives and through practice applications to identify and notify insurers of new applicant practices.

Ongoing

- Maintain and update webpage with PCMH information and monitor application portal.
- Promote awareness of PCMH initiative.
- Obtain insurer and provider input regarding OHIC definition of PCMH and implementation processes.

II. Practices Qualifying to be Included in the Calculation of PMCH Targets

Target Year/ Practice Category	**As of December 31, 2016**	**As of December 31, 2017**	**As of December 31, 2018**
Practices with less than 2 years of transformation experience as of September 30, 2016	Practices achieving NCQA PCMH Level 3 recognition OR receiving Sustainability Payments consistent with the Sustainability Financial Model	Practices that meet the following requirements: • Participated in a transformation initiative from January 1 through September 30, 2017 • Completed Cost Strategy self-assessment and met Year 1 requirements • Submitted performance measurement data and demonstrated improvements.	Practices that meet the following requirements: • Participated in a transformation initiative from January 1 through September 30, 2018 OR achieved NCQA PCMH Level 3 recognition • Completed Cost Strategy self-assessment and met Year 2 requirements • Submitted performance measurement data and demonstrated improvements.
Practices with more than 2 years of transformation	Practices achieving NCQA PCMH Level 3 recognition OR receiving	Practices that meet the following requirements:	Practices that meet the following requirements:

Target Year/ Practice Category	As of December 31, 2016	As of December 31, 2017	As of December 31, 2018
experience as of September 30, 2016	Sustainability Payments consistent with the Sustainability Financial Model **AND** implemented Year 1 Cost Management Strategies	• Participated in a transformation initiative from January 1 through September 30, 2017 OR achieved NCQA PCMH Level 3 recognition. • Completed Cost Strategy self-assessment and met Year 2 requirements. • Submitted performance measurement data and demonstrated improvements.	• Participated in a transformation initiative from January 1 through September 30, 2018 OR achieved NCQA PCMH Level 3 recognition • Completed Cost Strategy self-assessment and met Year 3 requirements • Submitted performance measurement data and demonstrated improvements.

Crosswalk of Rhode Island PCMH Cost Containment Strategies to NCQA PCMH Standards
November 5, 2015

The following standards must be met by primary care practices seeking PCMH designation from Rhode Island payers in order to qualify for medical home financial support, consistent with terms of the OHIC-approved 2016 Care Transformation Plan.

Practices that have received NCQA PCMH Level 3 designation will be deemed to have met all requirements listed below that are substantially the same as one or more NCQA PCMH requirements.

Requirement #1: The practice develops and maintains a high-risk patient registry:

The practice must perform all of the following functions:		
Cost Containment Requirement	**2011 NCQA Level III Requirement**	**OHIC Deeming Recommendation**
1. The practice has developed and implemented a methodology for identifying patients at high risk for future avoidable use of high cost services (referred to as "high-risk patients).	NCQA PCMH 4, Element A identifies high cost/high utilization as one of the process requirements.	Allow deeming
2. Using information from a variety of sources, including payers and practice clinicians, the practice updates the list of high-risk patients at least quarterly.	NCQA PCMH 4, Element A requires a systematic process and in the explanation lists a variety of possible sources for identifying patients, but is not as specific as the OHIC requirement.	The NCQA requirement is not as specific regarding sources for names of high-risk patients and regarding the time period for updating the high-risk patient list. Do not allow deeming
3. To identify high-risk patients, the practice has developed a risk assessment methodology that includes at a minimum the consideration of the following factors: a. assessment of patients based on co-morbidities; b. inpatient utilization c. emergency department utilization	NCQA PCMH 4, Element A details factors a practice must consider in determining the patient's risk status, including specific types of co-morbidities such as behavioral health conditions, and social determinants of health. 'Poorly controlled or complex conditions' is also listed as a factor. The factors also include consideration of high cost/high utilization. ED and IP utilization is specifically mentioned in the explanation section.	Allow deeming

Requirement #2: The practice offers Care Management/Care Coordination Services with a focus on high-risk patients enrolled with the carriers that are funding the care management/care coordination services. Care Management/Care Coordination services include services provided by practice staff other than the designated care manager or care coordinator when services provided promote care management and care coordination and are provided under the direct supervision of the Care Manager or Care Coordinator.

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
1. The practice has a designated resource(s) that at the minimum includes a trained licensed Registered Nurse or trained licensed RN or social worker care coordinator for pediatric practices to provide care management/care coordination services that focuses on providing services to high-risk patients.	NCQA PCMH 4 requires practices to systematically identify patients and plans, manages and coordinates care based on needs (NCQA does not require that it is a RN/LPN or social worker).	The NCQA requirement does not specify that the CM/CC be an RN/LPN or social worker. Do not allow deeming.
2. The practice has an established methodology for the timely assignment of levels of care management/care coordination service needed by high-risk patients based on risk level, clinical information including disease severity level and other patient-specific characteristics. The purpose of the assessment is to promptly identify which high-risk patients should be in the care manager's/care coordinator's active caseload at any point in time.	No NCQA requirement.	N/A
3. The care manager/care coordinator completes within a specified period of time (from the time that the high-risk patient is placed in the care manager's/care coordinator's active caseload)[1] a patient assessment based on the patient's specific symptoms, complaints or situation, including the	NCQA is not prescriptive about time frame for completing the patient assessment and care plan. NCQA PCMH 4, Element B: The care team and patient family/caregiver collaborate (at relevant visits) to develop and update an individual care plan for at least 75% of high risk patients; Care plan	Allow deeming regarding content of patient assessment. Separately verify that the practice has established and implemented a process

[1] Assessment is initiated within one week, with at least three contact attempts (if needed) within two weeks. Assessment must be completed within two weeks of caseload assignment, unless patient is non-responsive to outreach.

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
patient's preferences and lifestyle goals, self-management abilities and socioeconomic circumstances that are contributing to elevated near-term hospitalization and/or ED risk. For children and youth, the care coordinator shall complete a family assessment that includes: a. a family status and environment assessment (i.e., assessment of medical/behavioral/dental health status; social supports of family and friends; financial needs; family demands, relationships, and functioning; cultural beliefs and values of family; strengths/assets of child, youth, family/caregivers, and current goals of child, youth & family), and b. a growth and development assessment (i.e., assessment of child/youth developmental progress/status; child/youth strengths/assets; school performance and needs, and emotional/behavioral strengths and needs).	incorporates the patient preferences and functional lifestyle goals, identifies treatment goals, assesses and addresses potential barriers to meeting goals, includes a self-management plan and is given in writing to the patient/family/caregiver	within specified timeframes for assessing and adding new patients onto the High Risk Patient List, based on care manager capacity.
4. Working with the patient and within two weeks of completing the patient assessment, the care manager/care coordinator completes a written care plan, that includes: a. a medical/social summary b. risk factors c. treatment goals d. patient-generated goals e. barriers to meeting goals f. an action plan for attaining patient's goals	NCQA PCMH 4, Element B: Care plan incorporates the patient preferences and functional lifestyle goals, identifies treatment goals, assesses and addresses potential barriers to meeting goals, includes a self-management plan and is given in writing to the patient/family/caregiver. NCQA PCMH 4 does not indicate a timeline, but requires that 75% of patients on high risk list have a care plan.	Allow deeming regarding content of written patient care plan. Separately verify that the practice is meeting the timeline.
5. The care management/care coordination resources update the written care plan on a regular basis, based on patient needs to affect progress towards meeting existing goals or to modify an existing goal,	NCQA PCMH 4 does not indicate a timeline, but requires regular updating and that 75% of patients on high risk list have a care plan.	The NCQA requirements allow practices to develop care plans for less than all patients on the high-risk

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
but no less frequently than semi-annually.		patient list and does not specify a timeframe for updating the care plan. Do not allow deeming.
6. For high-risk patients known to be hospitalized or in a SNF, the care management/care coordination resources shall contact the patient and/or the hospital discharge planner and begin transition-of-care planning at least 24-hours prior to the patient's discharge.	NCQA PCMH 5, Element C, Factor 4 requires practices to proactively contact patient/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit. No timeframes are specified.	The NCQA standard is less specific as to when TOC planning is to begin. Do not allow deeming.
7. The care management/care coordination resources contact every high-risk patient who has been discharged from hospital inpatient services after discharge to determine care management needs.[2]	NCQA PCMH 5, Element C, Factor 4 requires practices to proactively contact patient/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit. No timeframes are specified.	The NCQA standard does not include specific timeframe for completing the outreach contacts. Do not allow deeming.
8. The care management/care coordination resources contact every known high-risk patient who has had an Emergency Department visit for a situation or condition that is related to or contributes to the patient's high-risk status.[3]	NCQA PCMH 5, Element C, Factor 4 requires practices to proactively contact patient/families for appropriate follow-up care within an appropriate period following a hospital admission or ED visit. No timeframes are specified.	The NCQA standard does not include specific timeframe for completing the outreach contacts. Do not allow deeming.
9. The care management/care coordination resources complete a medication reconciliation after a high-risk patient has been discharged from inpatient services; to the extent possible the medication reconciliation is conducted in person.[4]	NCQA PCMH 4, Element C (Critical Factor): practice reviews and reconciles medications for more than 50% of patients received from care transitions (factor 1); with patients/families for more than 80% of care transitions (Factor 2). Medication reviews must occur at least annually, at	The NCQA standard does not include as specific a timeframe for completing the medication reconciliations.

[2] During Year 1 contact must occur within 72 hours of discharge and in Years 2 and 3 contact must occur within 48 hours.
[3] During Year 1 contact must occur within 72 hours of an ED visit and in Years 2 and 3 contact must occur within 48 hours.
[4] During Years 1 and 2 reconciliation must be completed within 7 days of discharge. During year 3, reconciliation must be completed within 72 hours of discharge.

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
	transitions of care and at relevant visits, as defined by the practices.	Do not allow deeming.
10. The care management/care coordination resources arrange for, and coordinate all medical, developmental, behavioral health and social service referrals and tracks[5] referrals and test results on a timely basis for high-risk patients.	NCQA PCMH 5, Element A requires practices to systematically track tests and coordinate are across specialty care, facility-based care and community organizations. NCQA PCMH 5 Element B, (Must Pass) requires practices to track and follow-up on referrals. Practices are to track referrals that are "determined by the clinician to be important to a patient's treatment, or as indicated by practice guidelines.	Allow deeming
11. The care management/care coordinator resources provide health and lifestyle coaching for high-risk patients designed to enhance the patient's/caregiver's self/condition-management skills.	NCQA PCMH 4, Element E requires practices to use materials to support patients, families/caregivers in self-management and shared decision making.	Allow deeming
12. Practices shall provide patient-engagement training to care managers/care coordinators, as necessary, to achieve these requirements	No NCQA requirements	N/A
13. The care management/care coordination resources have in-person or telephonic contact with each high-risk patient at intervals consistent with the patient's level of risk.	NCQA PCMH 4, Element B requires care plans for 75% of high risk patients, but includes no contact requirements	The NCQA standards do not include a contact requirement. Do not allow deeming
14. The care management/care coordination resources participate in relevant team-based care meetings to assure whole-person care is provided to high-risk patients. For pediatric practices, participants in practice-	NCQA PCMH 2, Element D (Must Pass) the practice uses a team to provide a range of patient services by holding a scheduled patient care team meeting or structured communication process focused on individual patient care (CRITICAL factor). NCQA states that all clinical staff are members of the team.	Allow deeming

[5] Consistent with 2014 NCQA PCMH recognition Standard 5, Element B, "tracking" here means that the practice "tracks referrals until the consultant or specialist's report is available, flagging and following up on overdue reports."

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
initiated team meetings may include primary care and specialist providers, school liaisons, behavioral health providers, developmental specialists, government support program representatives (e.g., SSI), and social service agency representatives.		
15. The care management/care coordination resources use HIT to document and monitor care management service provision.	No NCQA requirement.	N/A
16. The care management/care coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery	NCQA PCMH 2, Element D (Must Pass): The practice uses the team to provide a range of patient services by involving the care team in the practice's performance evaluation and quality improvement activity; NCQA PCMH 6 Element B; At least annually, the practice measures or receives quantitative data on at least 2 measures related to care coordination; 6 Element D: acts to improve at least one measure from measures resources use and care coordination	Allow deeming

Requirement #3: The practice improves access to and coordination with behavioral health service.

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
The practice has implemented one of the following approaches to behavioral health integration		
1. To promote better access to and coordination of behavioral health services, the practice has developed preferred referral arrangements with community behavioral health providers such that appointments are available consistent with the urgency of the medical and behavioral health needs of the practice's patients and there is an operational protocol adopted by the PCP and the preferred specialists for the exchange of information. The	NCQA PCMH 5, Element B, Factor 3: the practice maintains agreements with behavioral health provider. Agreements typically indicate the type of information that will be provided when referring a patient to a specialist and expectations regarding timeliness and content of response from the specialist.	NCQA requirements address only exchange of information, not timely access to services. Do not allow deeming.

terms of the preferred arrangement are documented in a written agreement.		
2. To promote better access to and coordination of behavioral health services, the practice has arranged for a behavioral health provider(s) to be co-located (or virtually located) at the practice for at least one day per week and assists patients in scheduling appointments with the on-site provider(s).	No NCQA requirement.	N/A
3. To promote better access to and coordination of behavioral health services, the practice is implementing or has implemented a co-located (or virtually located), integrated behavioral health services model that is characterized by licensed behavioral health clinicians serving on the care team; the team sharing patients, and sharing medical records, and the practice promoting consistent communications at the system, team and individual provider levels that includes regularly scheduled case conferences, and warm hand-off protocols.	No NCQA requirement.	N/A

Requirement #4: The practice expands access to care both during and after office hours (defined as access beyond weekdays between 9am and 5pm).

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
The practice must perform the following functions:		
1. The practice has a written policy to respond to patient telephone calls within the following timeframes: a. For urgent medical/behavioral calls received during office hours, return calls are made the same day. b. For urgent calls received after office hours, return calls are made within 1 hour. c. For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.	NCQA PCMH 1, Element B: 24/7 access to clinical advise: The practice has a written process and defined standards for providing access to clinical advise and continuity of medical record information at all times and regularly assesses its performance on providing timely clinical advise (CRITICAL factor); providing continuity of medical record information for care and advice when the office is closed; Time frame is defined by the practice to	NCQA standards are less specific than the proposed requirements. Retain specific timeframes. Do not allow deeming.

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
	meet the clinical needs of the patient population. Policy can define routine calls responded to by next business day.	
2. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day.[6]	NCQA PCMH, Element A, Factor 1: Patient centered access: (Must Pass): The practice has a written process and defined standards and regularly assesses its performance on : Providing same day appointments for routine and urgent care (Critical Factor)	Allow deeming.
3. The practice has an agreement with (or established) an urgent care clinic or other service provider which is open during evenings and weekends when the office is not open as an alternative to receiving Emergency Department care.	No NCQA requirement.	N/A
4. The practice utilizes formal quality improvement processes to assess and improve the effectiveness of its programs to expand access.	NCQA PCMH 1, Element A, Factor 6 requires practices to act "on identified opportunities to improve access." The Explanation for Factor 6 states: The practice may participate in or implement a rapid-cycle improvement process, such as Plan-Do-Study-Act (PDSA), that represents a commitment to ongoing quality improvement and goes beyond setting goals and taking action.	Allow deeming.
The practice must perform *at least* 2 of the following functions:		
1. The practice has created a secure web portal that enables patients to: • send and receive secure messaging • request appointments • request referrals • request prescription refills • review lab and imaging results[7]	NCQA PCMH 1, Element C, Factor 6: Patients can request appointments, prescription refills, referrals and test results; this is also a core meaningful use requirement	Allow deeming.

[6] During Years 1 and 2, same-day scheduling must be available for urgent care. In year 3, same-day scheduling must be available for urgent and routine care. Consistent with the AHRQ definition contained within the CAHPS survey, routine care is defined by OHIC to mean care that patients believe they need, but not "right away."

[7] All functions, except lab and imaging, must be functional in Years 1 and 2. All functions must be functional in Year 3.

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
The practice clearly communicates to patients that the portal should not be used for urgent matters and that patients should call the practice under such circumstances.		
2. The practice has expanded office hours so that services are available at least two mornings or two evenings a week for a period of at least 2 hours beyond standard office hours.[8]	NCQA PCMH 1, Element A, Factor 2: providing routine and urgent care appointments outside of regular business hours: practices are encourages to assess the needs of its practice for appointments outside normal business hours and then to evaluate if these appointment times meet the needs of the patient. If a practice is not able to provide care beyond regular business hours (e.g., small practice with limited staffing), it may arrange for patients to receive care from other (Non-ER) facilities or clinicians. NCQA examples of extended access include: •Offering daytime appointments when the practice would otherwise be closed for lunch (on some or most days). •Offering daytime appointments when the practice would otherwise close early (e.g., a weekday afternoon or holiday).	The NCQA standard is not specific regarding expanded office hours. Do not allow deeming.
3. The practice has expanded office hours so that services are available at least four hours over the weekend. Services may be provided by practice clinicians or through an affiliation of clinicians, so long as the affiliated physicians are able to share medical information electronically on a near real-time basis through either a shared EMR system or	Same as above. NCQA is less specific regarding to what extent hours must be expanded.	The NCQA standard is not specific regarding expanded office hours. Do not allow deeming.

[8] During Year 1 these requirements are waived. During Year 2, expanded office hours must be available for urgent care. During Year 3, expanded office hours must be available for urgent and routine care.

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
by ready access to a patient's practice physician who has real-time access to patient's medical records.[9]		

Requirement #5: The practice refers patients to referral service providers who provide value-based care.

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
1. The practice has developed referral protocols for its patients for at least two of the following: a. one high-volume specialty, such as cardiovascular specialist, pulmonary specialist, orthopedic surgeon or endocrinologist; b. laboratory services; c. imaging services; d. physical therapy services, and e. home health agency services.	NCQA PCMH 5, Element B, Factor 2: practice maintains formal and informal agreements with a subset of specialists based on established criteria. Agreements typically indicate the type of information that will be provided when referring a patient to a specialist and expectations regarding timeliness and content of response from the specialist.	NCQA does not address the factors that should be considered in creating referral arrangements and views the requirement as relating to the exchange of information. Do not allow deeming.
2. Should one or more payers provide the practice with readily available, actionable data, the practice has used such data and any other sources to identify referral service providers who provide higher quality services at costs lower than or the same as their peers (i.e., "high-value referral service providers") and prioritizes referrals to those providers.	NCQA PCMH 5, Element B, Factor 1 requires the practice to consider available performance information on consultants/specialists when making referral recommendations. (Must-Pass)	Allow deeming.

[9]During Year 1 these requirements are waived. During Year 2, expanded office hours must be available for urgent care. During Year 3, expanded office hours must be available for urgent and routine care.

Dear [Provider]:

The Rhode Island Office of the Health Insurance Commissioner (OHIC) has implemented several initiatives designed to promote the transformation of primary care practices into Patient-Centered Medical Homes. One of those initiatives is to require Rhode Island insurers to contract with an increasing number of PCMHs each year and to pay those designated primary care practices in a manner that sustains their PCMH transformation efforts as long as the practices meet OHIC's definition of PCMH.

At least one Rhode Island insurer has identified your practice as one it wants to designate as a PCMH to meet the OHIC regulation. As a result, your practice may be eligible for ongoing "sustainability payments" if you meet the following three requirements:

<u>By September 30, 2016</u>

1. Participate in or complete a transformation initiative (e.g., CTC, PCMH-Kids, or BCBSRI's PCMH program) OR achieve NCQA PCMH Level 3 recognition.
2. Complete a self-assessment regarding your practice's status with regard to implementing the cost management strategies detailed in Attachment 1. If your practice has been participating in a transformation initiative for at least 2 years as of September 30, 2016 or has achieved NCQA PCMH Level 3 recognition, your practice must have implemented Year 1 cost management strategy requirements by September 30, 2016. Practices with less transformation experience must implement Year 1 cost management strategies by September 30, 2017.
3. Submit a small set of performance measurements, which are detailed in Attachment 2. This set of performance measurements will serve as a baseline. Practices must begin to demonstrate improvement in the measures by September 30, 2017.

If your practice meets these three requirements and Rhode Island insurers want to count your practice as a PCMH in order to meet their state-required PCMH target, in 2017 they must pay the practice under either a current contract that supports practice transformation or under a new arrangement that includes:

- an infrastructure payment during the first 2 years of transformation, and performance improvement payment thereafter;
- a care management payment.

After two years in a transformation initiative (e.g., CTC, PCMH-Kids, or BCBSRI's PCMH program) or after the practice has achieved NCQA PCMH Level 3 recognition, the insurer may stop infrastructure payments, but must offer the practice the opportunity to earn a performance improvement payment. OHIC does not specify the level of payment or performance improvement terms, which are determined via negotiations between your practice and your payers.

To continue to be eligible for sustainability payments beyond 2016 and be counted as a PCMH under OHIC regulations, a practice must continue to participate in or complete a transformation initiative, continue to implement required cost management strategies and demonstrate improvement on some of the quality measures. Practices must also achieve NCQA Level 3 recognition by the end of two years of participation in a transformation initiative.

Although these requirements are in the future, you are receiving this letter now so that you will have time to implement the cost management strategies and data collection processes so that you will be able to qualify for Sustainability Payments. You will be receiving information prior to September 30, 2016 regarding how to submit your practice's cost management strategies assessment and your practice's performance data.

If you have any questions or wish additional information, please contact any of the health plan representatives who have signed below.

Sincerely,

United

BCBSRI

Tufts

NHPRI