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

Care Transformation Advisory Committee
Meeting Agenda
November 23, 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 November 13, 2015 Meeting

3. Finalize Implementation Timeline
    a. Cost Management Strategies

4. Finalize Initiatives for 2017 Care Transformation Plan

5. Finalize 2017 PCMH Target Approach

6. Public Comment

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November 23, 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
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Committee Members: Gus Manocchia, Mary Craig, David Brumley, Tracey Cohen, Gina Rocha, Beth Lange, Ed McGookin, Darlene Morris, Pano Yeracaris, Kathleen Calandra, Russell Corcoran, Peter Hollmann, Tina Spears, Pat Flanagan, Stephanie deAbreu (for Jim Fanale), Andrea Galgay, Mary Hickey

Not in Attendance:
Maria Montanaro, Christine Grey, Deb Hurwitz, Brenda Briden

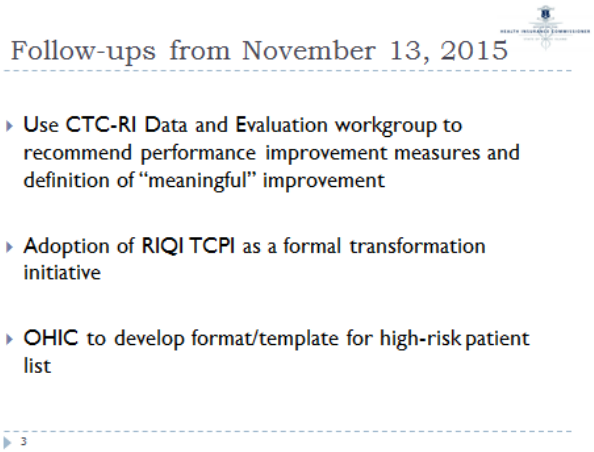
OHIC:
Kathleen Hittner, Sarah Nguyen, Cory King

1. **Introductions**

   Dr. Kathleen Hittner, Health Insurance Commissioner, welcomed Committee Members and emphasized the importance of getting feedback from all stakeholders represented on the Committee in the process. She thanked members for their participation to date.

2. **Follow-ups from November 13, 2015 Meeting**

   Sarah Nguyen, OHIC, reviewed the follow-ups from the November 13th meeting.

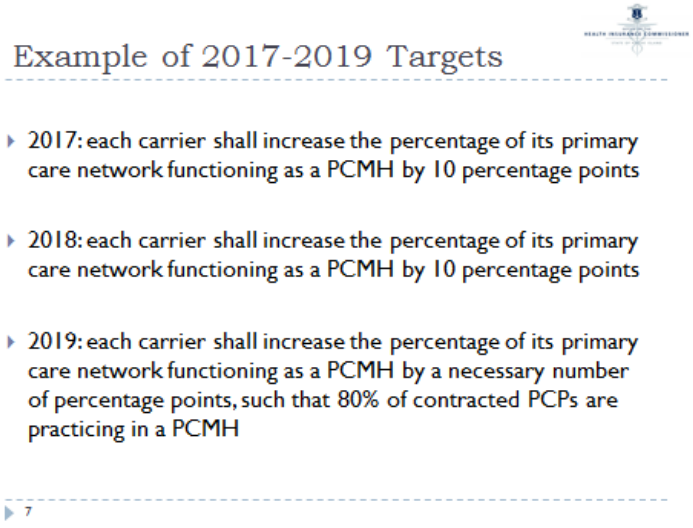


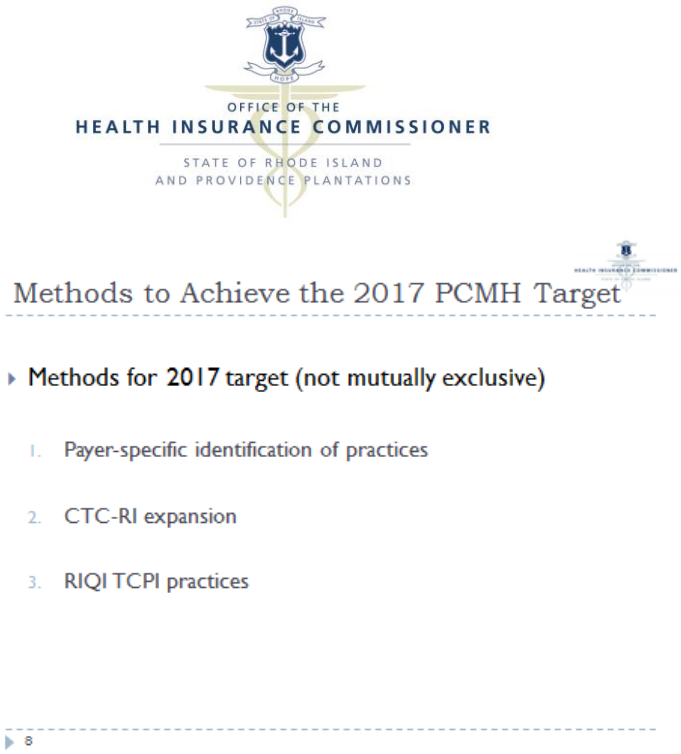
Ms. Nguyen also framed the discussion and reviewed the goals for this meeting: members will discuss discrete steps needed to achieve the 80% target by 2019. Discussion will begin with the 2017 target and initiatives to achieve the 2017 target. Committee members will then review the 2016 plan to talk about potential revisions and discuss the implementation timeline.

3. Finalize 2017 PCMH Target Approach

Cory King, OHIC, reviewed the baseline data with the Committee members (also presented at a previous meeting). Dr. Gus Manocchia, BCBSRI, asked "what will happen if payers do not achieve the target?" Dr. Hittner responded that OHIC will have to evaluate a payer's good faith efforts in achieving their targets and Mr. King added that a potential outcome could be a corrective action plan. Committee members voiced concern over the ability of payers to achieve the target given the number of small primary care practices in the state.

Ms. Nguyen presented example of future targets and the options for PCMH expansion.





Ms. Nguyen asked committee members to discuss the pros and cons of each approach to PCMH expansion.

a. All-payer vs. payer-specific approach
Dr. Peter Hollmann, University Medicine, noted that a payer-specific approach would allow for payer flexibility in approaching practices – for example, payers may have different kinds of relationships with certain types of provider entities. He also noted that a payer-specific approach would not make sense from the standpoint of a nurse care manager, most provider practices have a reasonable mix of payers. He also noted that Blue Cross had sent out a letter to their PCMH program practices that did not match up exactly with the OHIC standards.

Dr. Manocchia voiced his support that a combination of all three methods should be used. Dr. Pano Yeracaris, CTC-RI, noted that TCPI does not include NCQA recognition and that small practices need more NCQA support. Darlene Morris, RIQI, responded that the crosswalk between TCPI and NCQA requirements is being mapped out.

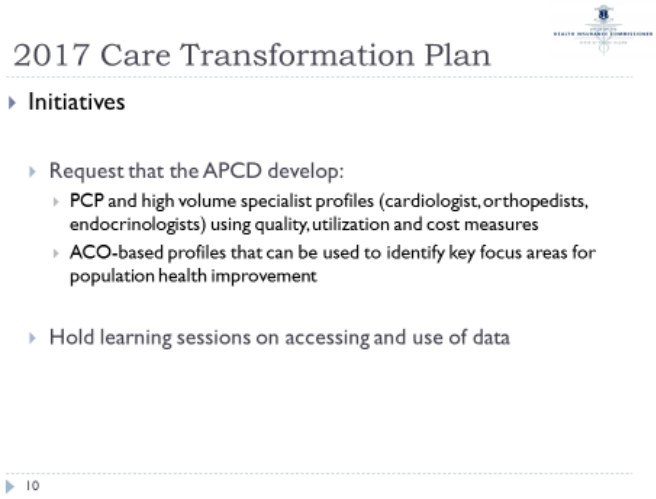
Committee members came to a consensus that there should be a common list of providers targeted for PCMH expansion but that also allows for some carrier flexibility. After OHIC sends out the provider list, OHIC will convene a meeting with the carriers and there will be one letter from all the insurers to the practices that the carriers would like to count towards their PCMH target. Members also discussed the benefits of having an educational campaign that would include carrots and sticks.

4. Finalize Initiatives for 2017 Care Transformation Plan

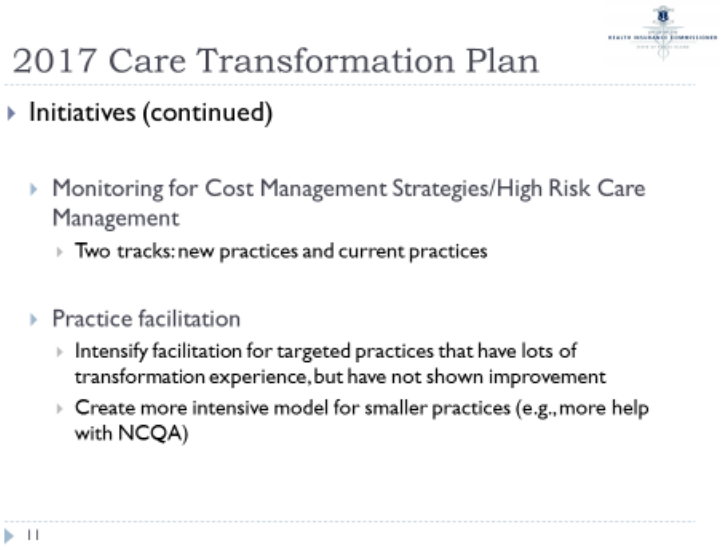
Ms. Nguyen started off this section of the agenda by reviewing the revised priorities for the 2017 Care Transformation Plan.

Committee members questioned the meaning of "sustainable funding" and how the payments would work.

Next, Committee Members discussed the request for the All-Payer Claims Database (APCD) to develop provider profiles:



Dr. Hollmann suggested that the APCD work with both primary care providers and specialists to help providers better understand the data that they would receive. Michael Bailit, Bailit Health Purchasing, noted that ideally, CurrentCare data would be merged with APCD data which would allow for one place to hold both claims-based and clinical data.



a. Monitoring for Cost Management Strategies/High Risk Care Management

Committee members discussed the financial and resource implications of a monitoring program for the cost management strategies. Mr. Bailit suggested that this be a pilot program and a test run could be done with some of the larger practices.

b. Practice facilitation

Dr. Manocchia noted that the ratio of practices coaches to practices is not at the level it should be at. Dr. Yeracaris said that CTC-RI currently performs some of that work – all practices in the developmental contract are offered facilitation and some can refuse it.

Dr. Lange noted that providers get paid for outcomes (versus "team huddles") and that outcomes should be examined. She also noted that practice facilitation support to practices should be helpful and not punitive. Mr. Bailit noted that the practices in need of support could be identified so that a more focused approach to resources could be deployed.

Committee members also discussed giving practices recognition for the good work that is being done and that additional reporting burden could discourage providers from working in primary care.

Ms. Nguyen reviewed the proposed revisions to the 2016 plan, including the addition of a RIQI as a formal transformation initiative.

5. Finalize Implementation Timeline

Marge Houy, Bailit Health Purchasing, reviewed the implementation timeline with the Committee Members.

Andrea Galgay, RIPCPC, suggested that a timeline for payers should be included in the implementation timeline (e.g. payers inform practices of the amount of payment by a certain date). Dr. Manocchia responded that he had no problem including a timeline for payers within the document as long as the payment amount and specifics were not dictated by the document. It was suggested that language be added to the plan to say that payers should inform practices of their payment by April 1st for 2016 and by October 1 for every year thereafter.

Mr. King asked "what steps will payers take to make sure that there is a reasonable payment to practices?" Committee members then discussed contracting difficulties that small practices could experience given t heir small size and inexperience in negotiations. Some committee members thought that approaches could differ by practice size.

Regarding the cost management strategies, Ms. Houy explained that a pass for NCQA would be considered a "pass" for the OHIC cost management strategies and that if a practice completed 80% of the activities in a particular year, they would be compliant with the standard.

Ms. Nguyen concluded the meeting by discussing next steps: a draft plan will be sent out for comment.

6. Public Comment

There was no public comment.

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Care Transformation Advisory Committee

Fall 2015 Convening
November 23, 2015

Agenda

1. Introductions
2. Follow-ups from November 13, 2015 Meeting
3. Finalize 2017 PCMH Target Approach
4. Finalize Initiatives for 2017 Care Transformation Plan
5. Finalize Implementation Timeline and Cost Management Strategies
6. Public Comment

Follow-ups from November 13, 2015

- Use CTC-RI Data and Evaluation workgroup to recommend performance improvement measures and definition of "meaningful" improvement
- Adoption of RIQI TCPI as a formal transformation initiative
- OHIC to develop format/template for high-risk patient list

2017 PCMH Target

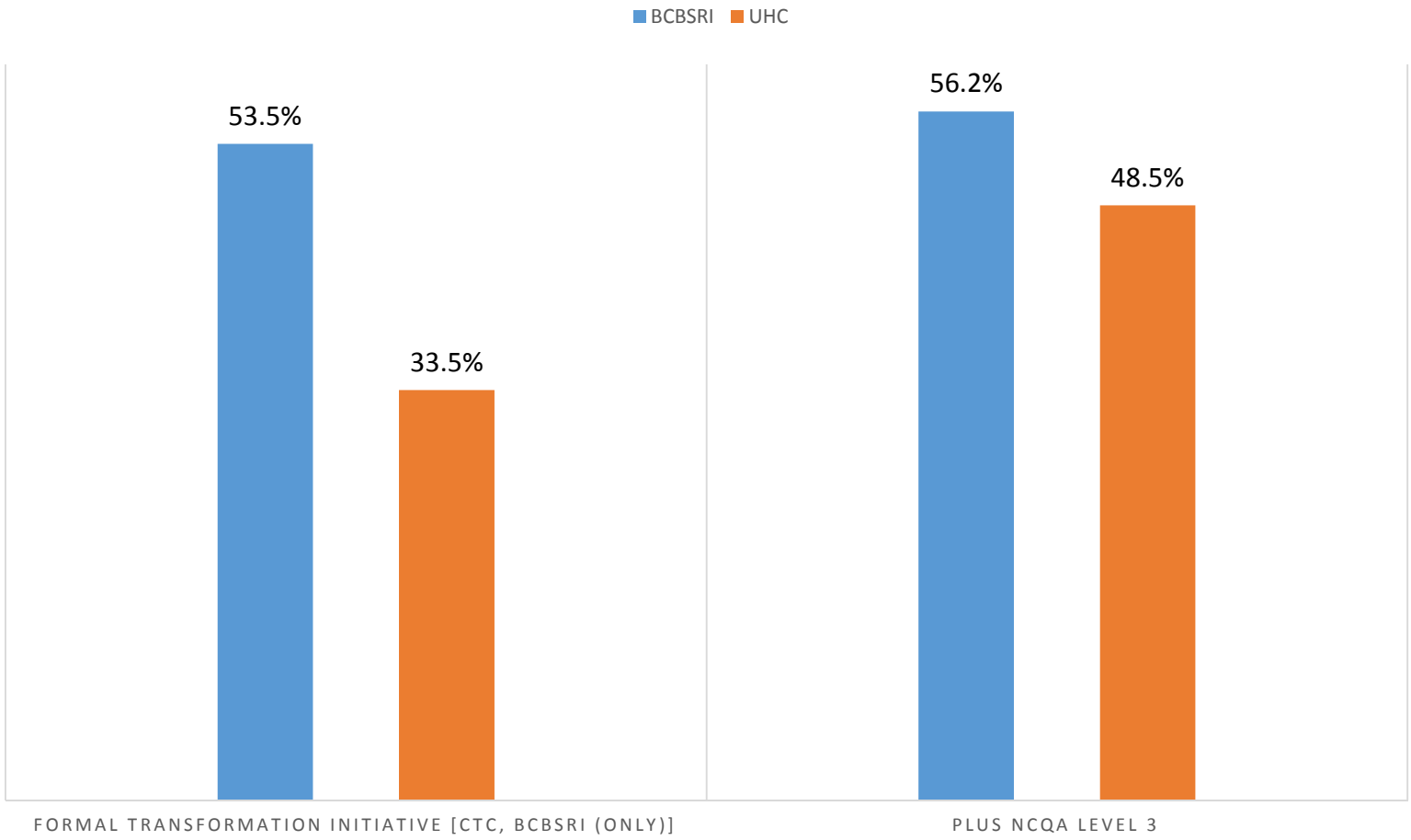
- Overall target: 80% of contracted primary care clinicians in an insurer's network are operating in a PCMH by 2019

- Today's goals:
  - Consensus on 2017 target
  - Initiatives to achieve 2017 target

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



Example of 2017-2019 Targets

- 2017: each carrier shall increase the percentage of its primary care network functioning as a PCMH by 10 percentage points
- 2018: each carrier shall increase the percentage of its primary care network functioning as a PCMH by 10 percentage points
- 2019: each carrier shall increase the percentage of its primary care network functioning as a PCMH by a necessary number of percentage points, such that 80% of contracted PCPs are practicing in a PCMH

Methods to Achieve the 2017 PCMH Target

- Methods for 2017 target (not mutually exclusive)

1. Payer-specific identification of practices
2. CTC-RI expansion
3. RIQI TCPI practices

2017 Care Transformation Plan

- (Revised) Priorities
  - Expand and improve upon current transformation initiative activity
  - Address weaknesses in current transformation model
    - Actionable data and data and reporting capabilities
    - Intensive and sustained practice coaching
    - Focus on care management of high-risk patients
    - Sustainable funding
    - Integration with specialists and behavioral health

2017 Care Transformation Plan

- Initiatives
  - Request that the APCD develop:
    - PCP and high volume specialist profiles (cardiologist, orthopedists, endocrinologists) using quality, utilization and cost measures
    - 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

2017 Care Transformation Plan

- Initiatives (continued)
  - Monitoring for Cost Management Strategies/High Risk Care Management
    - Two tracks: new practices and current practices
  - 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)

Proposed Revisions to 2016 Plan

- Addition of RIQI as a formal transformation initiative.
- Care Manager Academy
- Community Health Team Expansion

Implementation Timeline and Cost Management Strategies

- Discussion:
  - All-payer process to notify practices of new transformation requirements?
  - Consensus on "pass" level for cost management strategies

Next Steps

- Final APM Committee Meeting
  - November 30, 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
- Performance Improvement Measures
  - CTC-RI Data and Evaluation Workgroup
    - Tuesday 12/1: 7:30-9am at Memorial Hospital Center for Primary Care (111 Brewster Street, 2nd floor, Pawtucket)

Implementation Timeline for Sustainable Payment Model, Cost Containment Strategies and Performance Improvement Requirements
November 23, 2015

I. Cost Management Strategies Requirements

	2016	
A. Primary Care Practices Seeking Designation as a PCMH under OHIC's Affordability Standards		
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: • active: online submission through a website • passive: OHIC gathers data from	• OHIC is currently receiving NCQA data directly from NCQA. • The website maintained by CTC or some other entity supporting practice transformation will provide "self-identified" practices with an opportunity to report transformation information. • All practices with 2 or more years of transformation

	2016	
	transformation agents (e.g., CTC-RI, PCMH-Kids, RIQI's TPCI initiative) Practice's NCQA Level 3 status is determined by OHIC as of September 30, 2016.	experience 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, 2016; submit self-assessment by September 30, 2016.	• Practices with more than 2 years of transformation experience will be required to meet Year 1 requirements as of September 30, 2016. Practices with less than 2 years of transformation experience will be expected to meet Year 1 requirements by September 30, 2017. • The self-assessment will be submitted to OHIC via a web-based program, such as SurveyMonkey, no later than September 30 annually. • 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. • 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[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 APCD is not yet fully functional, OHIC would like to assess the feasibility of practices submitting data to CTC or some

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

	2016	
		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.	Practices with Less than 2 Year of Transformation Experience • 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 meeting the Cost Management Strategies requirements. 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 meeting Cost Management Strategies requirements, and 3) 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. Practices with More Than 2 Years of Transformation

	2016	
		Experience • 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. • 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.

B. 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.
- 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 PCMH 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	Practices achieving NCQA	Practices that meet the following	Practices that meet the following

Target Year/ Practice Category	As of December 31, 2016	As of December 31, 2017	As of December 31, 2018
2 years of transformation experience as of September 30, 2016	PCMH Level 3 recognition OR receiving Sustainability Payments consistent with the Sustainability Financial Model **AND** implemented Year 1 Cost Management Strategies	requirements: • 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.	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 3 requirements • Submitted performance measurement data and demonstrated improvements.

Crosswalk of Rhode Island PCMH Cost Containment Strategies to NCQA PCMH Standards
November 23, 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	**NCQA 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).	2011 NCQA PCMH 3, Element B requires the practice to have specific criteria and a process based on these criteria to identify patients with complex or high-risk medical conditions for whole-person care planning and management. Criteria may include high level of resource use, frequent visits for urgent or emergent care, frequent hospitalizations, multiple co-morbidities, psychosocial status, advanced age with frailty and multiple risk factors. 2014 NCQA PCMH 4, Element A requires practices to establish a systematic process for identifying patients who may benefit from care management services. Factors to consider include behavioral health conditions, high cost/high utilization and poorly controlled or complex conditions.	Allow deeming
2. Using information from a variety of sources, including payers and practice clinicians, the practice	2011 NCQA PCMH 3, Element B lists in the explanation a variety of possible sources for	Allow partial deeming. Separately verify that

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**OHIC Deeming Recommendation**
updates the list of high-risk patients at least quarterly.	identifying patients. 2014 NCQA PCMH 4, Element A requires a systematic process and in the explanation lists a variety of possible sources for identifying patients.	practices are using payers and practice clinicians to update high-risk patient lists and that the time period for updating the high-risk patient list is being met.
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	2011 NCQA PCMH 3, Element B in the explanation lists factors a practice must consider, including co-morbidities, high level of resources, and frequent hospitalizations. 2014 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.	2011 NCQA PCMH 3 requires practices to systematically identify patients and to manage and coordinate care based on their condition, needs and on evidence-based guidelines. 2014 NCQA PCMH 4 requires practices to systematically identify patients and to manage and coordinate care based on their needs.	Allow partial deeming. Separately verify that the practices are employing an RN/LPN or social worker as CM/CC.
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 patient's preferences and lifestyle goals, self-management abilities and socioeconomic	2011 PCMH 3, Element C, (Must Pass) requires the care team to collaborate with the patient/family to develop an individual care plan, including treatment goals that are reviewed and updated at each relevant visit for at least 75% of high-risk patients. NCQA PCMH 4, Element B: The care team and	The 2011 and 2014 NCQA requirements are not prescriptive about time frame for completing the patient assessment and care plan. Allow deeming regarding content of patient assessment. Separately

[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**
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).	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 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	verify that the practice has established and implemented a process 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	2011 NCQA PCMH 3, Element C requires the practice to complete a care plan for at least 75% of the patients identified as high risk. The care plan must include relevant treatment goals. 2014 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.	2011 NCQA PCMH requirements do not specify the content of the care plan in sufficient detail and do not specify a time table for completing the care plan. Do not allow deeming. 2014 PCMH NCQA requirements do not specify a time table for completing care plans. Allow deeming regarding content of written patient care plan.

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
	2014 NCQA PCMH 4 requires that 75% of patients on high risk list have a 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, but no less frequently than semi-annually.	2011 NCQA PCMH 3, Element C requires the care team to review and update treatment goals at each relevant visit. 2014 NCQA PCMH 4 requires regular updating and that 75% of patients on high risk list have a care plan.	Allow partial deeming and separately verify that practices are developing care plan for all patients on the high-risk patient list and are meeting the timeframe for updating the care plan.
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.	2011 and 2014 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.	Allow partial deeming and separately verify that the practices are beginning TOC planning within the required timeframe.
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]	2011 and 2014 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.	Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the outreach contacts.
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]	2011 and 2014 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.	Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the outreach contacts.

[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.

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
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]	2011 NCQA PCMH 3, Element D specifies percentages of care transitions for which medication reconciliations are to be done. 2014 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 transitions of care and at relevant visits, as defined by the practices.	Allow partial deeming and separately verify that the practices are meeting the specific timeframe for completing the medication reconciliations.
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.	2011 and 2014 NCQA PCMH 5, Element A requires practices to systematically track tests and coordinate care across specialty care, facility-based care and community organizations. 2011 and 2014 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. This includes referrals to medical specialists, mental health and substance abuse specialists and other services.	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	2011 NCQA PCMH 4, Element A (Must Pass) requires the practice to conduct activities to support patient/families in self-management, including providing educational resources and referrals to	Allow deeming

[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.

[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**
skills.	educational resources, using self-management tools, providing healthy behaviors coaching, and developing and document self-management plans and goals. 2014 NCQA PCMH 4, Element E Factors 2, 3 and 4 require practices to use materials to support patients, families/caregivers in self-management and shared decision making.	
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.	2011 NCQA PCMH 3, Element C requires the practice to develop care plans for at least 75% of high-risk patients and to follow-up with patients/families who have not kept important appointments. 2014 NCQA PCMH 4, Element B requires care plans for 75% of high risk patients, but includes no contact requirements	The 2011 and 2014 NCQA standards do not include specific contact requirements. 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-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.	2011 NCQA PCMH 1, Element G requires the practice to use a team to provide a range of patient care services. 2014 NCQA PCMH 2, Element D (Must Pass) requires that 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 (Factor 3, CRITICAL factor). NCQA Explanation states that all clinical staff are members of the team.	Allow deeming
15. The care management/care coordination resources	No NCQA requirement.	N/A

The practice must perform all of the following functions:		
Cost Containment Requirement	**NCQA Requirement**	**Deeming Recommendation**
use HIT to document and monitor care management service provision.		
16. The care management/care coordination resources participate in formal practice quality improvement initiatives to assess and improve effectiveness of care management service delivery	2011 NCQA PCMH 1, Element G, Factor 8 and 2014 NCQA PCMH 2, Element D, Factor 9 (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. 2014 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 terms of the preferred arrangement are documented in a written agreement.	2011 NCQA PCMH 1, Element E requires a PCMH to coordinate patient care across multiple settings, including behavioral health. 2014 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.	2011 PCMH NCQA requirements lack specificity around better coordinating behavioral health services. 2014 PCMH NCQA requirements address only exchange of information, not timely access to services. 2014 NCQA

	2014 NCQA PCMH 5, Element B, Factor 4: Integrates behavioral healthcare providers within the practice site.	PCMH 5, Factor 4 is not a critical factor. Do not allow deeming.
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.	2011 NCQA PCMH 1, Element B: requires the practice to have a written process and defined standards, and demonstrates that it monitors performance against the standards for providing timely clinical advice by telephone when the office is not open.	Allow partial deeming. Separately verify that the practices have written policies that meet the specified time frames for responding to patient calls.

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
c. For all non-time-sensitive calls, return calls are made within 2 business days of receiving the call.	2014 NCQA PCMH 1, Element B: requires the practice to have 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. The time frame is defined by the practice to meet the clinical needs of the patient population.	
2. The practice has implemented same-day scheduling, such that patients can call and schedule an appointment for the same day.[6]	2011 NCQA PCMH has a written process and defined standards for providing same-day appointments (Factor 1). 2014 NCQA PCMH 1, 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 if the practice passes Factor 1. 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.	2011 does not include QI initiatives to improve access. 2014 NCQA PCMH 1, Element A, Factor 6 requires practices to act "on identified opportunities to improve access." The Explanation for Factor 6	Do not allow deeming. 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."

Cost Containment Requirement	NCQA Requirement	Deeming Recommendation
	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.	
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] 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.	2011 NCQA PCMH 1, Element C, Factors 5 and 6 requires practices to have electronic access, including requesting appointments or prescription refills (Factor 5) and referrals or test results (Factor 6). 2014 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.
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]	2011 NCQA PCMH 1, Element BG, Factor 2 requires practices to provide access to routine and urgent-care appointments outside regular business hours. 2014 NCQA PCMH 1, Element A, Factor 2: requires practices to provide 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	The 2011 and 2014 NCQA standards are not specific regarding expanded office hours. Do not allow deeming.

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

[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
	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).	
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 by ready access to a patient's practice physician who has real-time access to patient's medical records.[9]	2011 and 2014 NCQA PCMH standards: Same as above. NCQA is less specific regarding to what extent hours must be expanded.	The 2011 and 2014 NCQA standards are not specific regarding expanded office hours. Do not allow deeming.

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;	2011 NCQA PCMH 5, Element B, Factor 4: practice establishes and documents agreements with specialists in the medical record if co-management is needed. 2014 NCQA PCMH 5, Element B, Factor 2: practice maintains formal and informal agreements with a	The NCQA 2011 and 2014 standards do not address the value-based care as a factor that should be considered in creating referral arrangements and views the requirement as

[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.

d. physical therapy services, and e. home health agency services.	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.	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.	2011 NCQA PCMH 5 does not address use of data to make specialty referrals. 2014 NCQA PCMH 5, Element B, Factor 1 requires the practice to consider available performance information on consultants/specialists when making referral recommendations. (Must-Pass)	The NCQA 2011 and 2014 standards list potential sources of performance information, but does not focus on information related to "high-value referral service providers." Do not allow deeming.

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

I. Background

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

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

II. Definition of Patient-Centered Medical Home

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

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

[1] Affordability Standards Section 10(c)(1)

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

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

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

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

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

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

[3] Practices shall implement "care coordination" for children, which is a broader set of services not exclusively focused on high-risk patients. See R Antonelli, J McAllister, J. Popp. "Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework." The Commonwealth Fund, publication number 1277, May 2009.

III. PCMH Target for 2016

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

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

IV. Stakeholder Activities in 2015 to Promote PCMH Adoption

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

1. PCP Educational Campaign

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

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

The campaign should run in the Fall of 2015.

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

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

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

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

2. Care Manager Academy

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

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

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

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

3. Care Management Coordination Work Group

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

Estimated Cost: participants' time

4. Annual Care Transformation Advisory Committee Meetings

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

5. Standard Core Measure Set

The Committee recognizes the need to coordinate measures payers use to reward performance so that providers are receiving a consistent, coherent message regarding priorities for change. The Commissioner will formally request that the SIM HIT and Measurement Work Group be convened and develop a core measure set for use by all Rhode Island public and private payers that takes into account existing multi-payer measure sets.

V. Stakeholder Activities in 2016 to Promote PCMH Adoption

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

1. PCP Transformation Support Activities

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

Estimated Costs:

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

2. Care Manager Academy

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

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

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

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

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

3. Community Health Team (CHT) Pilot

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

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

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

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

4. Annual Care Transformation Advisory Committee Meetings

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

VI. Sustainable PCP Financial Model

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

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

Example Scenarios for Practices Engaged in Practice Transformation:

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

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

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

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

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

The sustainability model shall become effective in 2016.

Estimated minimum cost, to be funded by insurers:

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

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

VII. Conclusion

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

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

Kathleen C Hittner, MD

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

Appendix A

List of Care Transformation Advisory Committee Members and Organizational Affiliations

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

Appendix B
Operational Definition of PCMH

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

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

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

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

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

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