

Rhode Island 2019 Care Transformation Plan
Adopted by Health Insurance Commissioner Marie Ganim
January 24, 2019

I. Background

This 2019 Care Transformation Plan is adopted pursuant to §4.10(C) of 230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner (OHIC), by Marie Ganim, Health Insurance Commissioner.

Pursuant to §4.10(C) of 230-RICR-20-30-4, the Care Transformation Advisory Committee submitted to the Health Insurance Commissioner a 2019 Care Transformation Plan which is designed to move primary care practice transformation activities towards achieving OHIC's 2019 target of 80% of Rhode Island primary care clinicians practicing in a Patient-Centered Medical Home (PCMH).¹ This plan was developed over the course of three Committee meetings in the fall of 2018.

II. Definition of Patient-Centered Medical Home

Cognizant that being recognized as a PCMH by an external organization does not mean that a practice has effectively implemented PCMH processes to improve cost and quality of care, during 2015 the Committee developed and OHIC adopted a three-part definition of PCMH against which Rhode Island primary care practices are evaluated by OHIC. This definition is revisited annually by the Committee during its fall convening. The definition for 2019 is as follows:

1. Transformation Experience:

- a. Practice is participating for the first time in a formal transformation initiative² (e.g., CTC-RI, PCMH-Kids, TCPI, or an approved payer- or ACO-sponsored transformation program) with the expectation that the practice will obtain NCQA recognition within two years of entry into the transformation initiative.

OR

¹ 230-RICR-20-30-4.10 (C)

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.

- b. Practice holds current NCQA PCMH recognition status³. Practices meeting this requirement through achievement of NCQA recognition may do so independent of participating in a formal transformation initiative.

2. Cost Management:

- a. Practice meets the following Cost Management requirement. This requirement places parameters around existing NCQA PCMH (2017 Edition) reporting requirements.
 - i. In meeting NCQA Element QI 09, practice develops and implements a quality improvement strategy that addresses one of the following menu items, from either the Care Coordination or Cost-Effective Use of Services categories:
 - Care Coordination:
 - Care coordination between facilities (including safe and effective care transitions)
 - Care coordination with specialists/other providers
 - Care coordination with patient⁴
 - Cost-Effective Use of Services:
 - ED utilization
 - Inpatient hospital utilization
 - Overuse/appropriateness of care (low-value care)
 - Pharmaceutical costs (including volume and/or use of high-value pharmaceuticals)
 - Specialist referral costs (including volume of referrals and/or referrals to high-value specialists)
 - ii. Practices that are NCQA-recognized PCMHs using the 2017 NCQA standards will be evaluated on this requirement during their annual NCQA reporting. Practices will be expected to specify the measure of resource stewardship they will track to monitor performance improvement in the selected menu item. All other practices will be evaluated based on responses to an OHIC-administered survey.

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

⁴ Care coordination with patient refers to measures of successful coordination or communication between members of the care team and the patient. Examples can include, but are not limited to: follow up to ensure ordered lab or imaging tests were completed, follow up to ensure referral has been completed, follow up after patient receipt of abnormal test results, outreach to patients not recently seen that results in an appointment, discussion to reduce the % of patients seeing multiple providers (3 or more), follow-up phone calls to check on the patient after an ER visit (or hospitalization), or following up on pediatric visits to after-hours care.

3. Meaningful Performance Improvement:

- a. Practice has demonstrated meaningful performance improvement. The measures for assessing performance are as follows:

Adult practices

- Colorectal Cancer Screening (NCQA HEDIS, modified by CTC-RI)
- Comprehensive Diabetes Care: Eye Exam (NCQA HEDIS, modified by CTC-RI)
- Comprehensive Diabetes Care: HbA1c Control (<8) (NCQA HEDIS, modified by CTC-RI)
- Screening for Clinical Depression and Follow-up Plan (CMS, modified by CTC-RI)
- Controlling High Blood Pressure (NCQA HEDIS, modified by CTC-RI)⁵

Pediatric practices

- Adolescent Well-Care Visits (NCQA HEDIS, modified by CTC-RI)
- Weight Assessment and Counseling for Nutrition and Physical Activity (NCQA HEDIS, modified by CTC-RI to be an all-or-nothing measure including 3 sub-measures)
- Developmental Screening in the First Three Years of Life (OHSU, modified by CTC-RI)

- b. "Meaningful performance improvement" is defined as follows for each measure:

- i. A 3-percentage point improvement over one or two years (if applicable);
or

- ii. Performance at or above:

1. The national commercial 75th percentile for Comprehensive Diabetes Care: HbA1c Control;
2. The New England commercial 90th percentile for commercial practices and the national Medicaid 75th percentile for Medicaid practices for Adolescent Well-Care Visits;
3. The New England commercial 90th percentile for commercial practices, less 5 percentage points, and the New England Medicaid 90th percentile for Medicaid practices, less 5 percentage points, for Controlling High Blood Pressure. These benchmarks will be re-assessed and finalized during CY2019 following consideration of CTC-RI practice quarterly submissions.

⁵ In 2019, Controlling High Blood Pressure (NCQA HEDIS, modified by CTC-RI) will be a report-only measure due to the significant changes in this measure's specifications.

4. The national 66th percentile for the remaining measures;⁶ or
 5. Performance at or above the state 25th percentile in the absence of an NCQA HEDIS benchmark rate;⁷ or
 6. First-time reporting practices: For practices submitting data for the first time, data will be recorded as baseline. Performance improvement in future years will be assessed against these first-year baseline rates.
- iii. Adult practices must achieve the above stated level of improvement on at least 3 of the 5 measures to achieve “meaningful performance improvement.” Pediatric practices must achieve the above stated level of improvement on at least 2 of the 3 measures to achieve “meaningful performance improvement.” Practices that report on both adult and pediatric measures must achieve the above stated level of improvement on at least 3 of the 5 adult measures *and* at least 2 of the 3 pediatric measures to achieve “meaningful performance improvement.”

III. PCMH Financial Support Model

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

- First Stage: Practices actively engaged in first-time PCMH transformation activity and without NCQA recognition⁸, or practices with NCQA recognition⁹, but which have not yet met the cost management strategies or performance improvement requirements within the timeframe outlined in Part II, receive both infrastructure and care management (CM) (care coordination for pediatrics) PMPM payments. Practices are eligible to receive infrastructure payment for a maximum of 24 months or until NCQA PCMH recognition is achieved,

⁶ For Colorectal Cancer Screening (HEDIS) and Comprehensive Diabetes Care: Eye Exam (HEDIS), all practices will be scored against the Commercial 66th percentile. All HEDIS benchmark rates will be from the version of Quality Compass for two years prior to the measurement period (e.g., Quality Compass 2018 with CY 2017 data for the 10/1/18 - 9/30/19 measurement period).

⁷ This includes Screening for Clinical Depression and Follow-up Plan, Developmental Screening, and Weight Assessment and Counseling for Nutrition and Physical Activity (HEDIS - all-or-nothing measure including 3 sub- measures), For the 10/1/18 - 9/30/19 performance period, all practices will be scored against the 25th percentile for the state from the prior performance period (10/1/17 - 9/30/18).

⁸ Here and elsewhere below, “NCQA recognition” means recognition at Level 3 for practices with current recognition status that was awarded prior to NCQA’s 4-3-17 implementation of its 2017 PCMH standards.

⁹ Ibid.

whichever occurs first. If the practice is part of an ACO, the payer may make the CM PMPM payment to the ACO, but the ACO must use that payment to finance CM services at the practice site earning the payment.

- Second Stage: Practices with NCQA recognition and which have implemented the cost management strategies and demonstrated performance improvement receive a CM PMPM payment and have an opportunity to earn a performance bonus. If the practice is part of an ACO, the payer may make the CM PMPM payment to the ACO, but the ACO must use that payment to finance the CM services at the site earning the payment.

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

The monetary levels of support for CTC-RI and for PCMH-Kids practices are determined by the program participants, subject to the approval of OHIC. The monetary levels of support of practices participating in other formal transformation initiatives or for practices that have graduated from such initiatives, and that are included in an insurer's count of PCMH practices should be independently determined by the insurers and the practices.

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

Example Scenarios for Practices Engaged in Practice Transformation:

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

| | | | | | | |
|---|--|---|---|-----|-----|----|
| 6 | No (newly participating in a formal transformation initiative) | no (but still within 12-month timeframe for implementation) | no (but still within 24-month timeframe for implementation) | yes | yes | no |
| 7 | No | no (and 12-month timeframe for implementation has passed) | no (and 24-month timeframe for implementation has passed) | no | no | no |

IV. PCMH Target for 2019

The 2019 PCMH Target is meant to facilitate insurers' achievement of the target stated in §4.10(C)(1) of 230-RICR-20-30-4 as 80% of an insurer's contracted primary care practices functioning as PCMH by 12/31/19¹⁰.

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

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

Beginning January 1, 2019, to be considered a PCMH for the purposes of this calculation, a practice must meet all requirements specified in the definition of PCMH delineated in Section II of this Plan and consistent with the Implementation Timeline included as Attachment A and be receiving support payments from the insurer that are consistent with the PCMH Financial Support Model, detailed in Section III of this Plan.

¹⁰ 230-RICR-20-30-4(C)(1)

V. Integrated Behavioral Health Work Group

During 2019, OHIC will develop new regulatory requirements for insurers to follow, the object of which are to improve the efficiency, quality, and accessibility of health care. An important dimension of Rhode Island's health care system, which is in dire need of support, is behavioral health care. Behavioral health care refers to services for mental health and substance use treatment. One promising strategy to whole person care is integrated behavioral health care. Primary care settings have become a gateway for many individuals with behavioral health and primary care needs. To address these needs, many primary care providers are integrating behavioral health care services into their settings. This is an important model of care for the following reasons:

- Primary care settings provide about half of all mental health care for common psychiatric disorders;
- Adults with serious mental illnesses and substance use disorders (SUD) also have higher rates of chronic physical illnesses and die much earlier than the general population; and
- People with common physical health conditions also have higher incidence of mental health conditions.

Integrated behavioral health care utilizes the expertise of mental health, substance use, and primary care clinicians, with feedback from patients and their caregivers. This creates a team-based approach where mental health care and primary care can be offered in the same setting. Coordinating primary care and mental health care in this way can help address the physical health problems of people with mental illnesses. Integrated models of care show promise for improving the patient-centeredness of care, the ability to treat the whole person, and the potential for reducing cost of care.

In May and June of 2018, Bailit Health interviewed individuals from six organizations, identified by OHIC, who were knowledgeable about administrative barriers to behavioral health integration. Bailit issued a memo in September 2018 that summarized their findings. Bailit categorized the administrative barriers into three main topics: (1) copayments, (2) billing and coding; and (3) credentialing and made the following recommendations:

- i. Two co-payments on the same day for behavioral health and primary care services: A solution needs to recognize the different models of integration and perhaps identify ways to differentiate between two services provided in an integrated environment versus in two independent appointments on the same day.
- ii. Coding for integrated services: The work group should identify whether there is a need or benefit to using HABI codes or other screening codes that support

integration and how the use of these codes might differ depending on the model of integration.

- iii. Variation in payer practice with credentialing providers practicing in an integrated environment: The work group should identify what barriers certain payers have to credentialing these types of providers and what solutions might exist.

OHIC shall convene a work group in February 2019 to identify potential solutions to these administrative barriers. If time permits, the group may also consider other related topics that will improve the efficiency, quality, and accessibility of health care. The work group shall issue a set of recommendations to the Commissioner no later than June 30, 2019.

- VI. In 2019, OHIC will be undertaking a comprehensive review of the Affordability Standards and the current requirements for primary care practice transformation and payment reform. As a part of that evaluation, OHIC will consider the 2018 recommendations made by participants in the Care Transformation Advisory Committee.

VII. Conclusion

This 2019 Care Transformation Plan is informed by the deliberations of the Care Transformation Advisory Committee. It advances progress towards the goals set forth in the OHIC Affordability Standards.

Dated at Cranston, Rhode Island this 24th day of January 2019.



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

Attachment A

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

I. 2019 Requirements for Primary Care Practices Seeking Designation as a PCMH under OHIC's Affordability Standards

| Date | Activity | Comment |
|---------------------------------------|---|---|
| Practice Notification | <p>By April 1st insurers must notify contracted primary care practices <i>without</i> OHIC PCMH designation of:</p> <ul style="list-style-type: none"> • OHIC PCMH standards and specific insurer requirements to receive PCMH financial support payments, and the specifics regarding the financial support payments, including amount and timing. | <ul style="list-style-type: none"> • At a minimum, each insurer must notify new practices that it wants to count towards achieving its PCMH 2019 target. To avoid duplicate notices being sent to practices, OHIC recommends that insurers coordinate with CTC-RI, PCMH-Kids, and RIQI to send one notice to each practice on behalf of all insurers. Insurers are encouraged to work with OHIC around development of a common list of practices to be targeted for transformation and to rely on existing multi-payer forums, including CTC-RI and PCMH Kids to drive transformation. |
| Requirement 1: Transformation | <p>Each practice's participation status in the transformation initiative is determined by October 15th:</p> <p>Practice's NCQA status is obtained by OHIC from NCQA as of October 1st. Participation in formal transformation initiatives will be obtained by OHIC from such initiatives by October 1st.</p> | <ul style="list-style-type: none"> • All practices with 2 or more years of transformation experience in a program making infrastructure payment must have achieved NCQA by September 30th, since they will have already received infrastructure payments for at least two years and will be in at least their third year of transformation activity. |
| Requirement 2: Cost Strategies | <ul style="list-style-type: none"> • The Cost Management Strategies requirement is now a component of the annual NCQA process for recognized PCMH practices. • Submit data to NCQA according to NCQA's on implementation of Cost | <ul style="list-style-type: none"> • OHIC will receive these data directly from NCQA for NCQA-recognized practices. • OHIC will collect these data via practice survey for non-NCQA-recognized practices. |

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|---|--|---|
| | <p>Management Strategies per NCQA PCMH QI09 according to NCQA's schedule.</p> <ul style="list-style-type: none"> • If the practice is not NCQA-recognized as a PCMH, or was recognized using standards in place prior to April 3, 2017, submit data in response to an OHIC-distributed survey by October 15, 2019. | |
| <p>Requirement 3:</p> <p>Performance Improvement regarding quality measures</p> | <ul style="list-style-type: none"> • Submit data on performance measures and show meaningful performance improvement (as defined in the OHIC Care Transformation Plan (3.)) by October 15th. • For practices submitting quality measures to OHIC for the first time, meaningful performance improvement need not be demonstrated until the second year of submission. | <ul style="list-style-type: none"> • OHIC has determined that meaningful performance data must be practice-wide. Data must come from practice submissions until another source is available. A web-survey has been developed for this purpose. |

| OHIC Activities |
|---|
| <p>By October 15th:</p> <ul style="list-style-type: none"> • Determine applicant practices' participation status in transformation initiatives. • Collect and analyze quality measures data from practices. • Collect and analyze NCQA PCMH recognition information from NCQA, including with regard to implementation of cost management strategies. • Collect and analyze cost management strategy implementation from non-NCQA-recognized practices. <p>By December 1st:</p> <ul style="list-style-type: none"> • Obtain information from insurers, transformation initiatives and through practice applications to identify and notify insurers of new applicant practices. • Identify practices that meet the OHIC PCMH definition. • Calculate insurer compliance with OHIC PCMH target. • Notify insurers of the results of OHIC's assessment of practices and of the insurer PCMH target compliance calculation. <p>Ongoing:</p> <ul style="list-style-type: none"> • Maintain and update the OHIC webpage with PCMH information and monitor application submittals and survey responses. • Promote awareness of OHIC's PCMH initiative. • Obtain insurer and provider input regarding the OHIC PCMH definition about PCMH recognition implementation process. |

