

The Rhode Island Chronic Care Sustainability Initiative (CSI-RI):

Translating the Medical Home Principles into a Payment Pilot



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Rhode Island Health Care Landscape

Purchasing:

- State Government is largest employer
- Few large, self-insured employers-market dominated by many small business purchasers
- Employer-based insurance coverage eroding
- Two large insurers – BCBSRI and United.

Regulation:

- Under OHIC statute, Insurers are held accountable for solvency, consumer protection, fair tx of providers, and efforts to improve affordability, accessibility and quality of health care system

Genesis of Program: National and Local factors

- National – already discussed. (why do we pay worst to the only part of medical service associated with improved population health and lower costs???)
- State interest in primary care sustainability:
 - Governor’s initiative in “balanced healthcare”
 - Medicaid interest in developing primary care infrastructure and reducing costs for chronic disease: PCCM model
 - Health Insurance Regulation includes affordability focus
- History of multi-stakeholder collaboration – “Line of site trust”
- Existing practice assistance infrastructure and chronic care improvement collaborative
- Funding Opportunity:
 - Center for Healthcare Strategies’ “Regional Quality Initiative”

What is CSI Rhode Island?

A statewide, multi-stakeholder collaborative effort designed to:

- **Align** quality improvement **goals** and financial **incentives** among Rhode Island’s health plans, purchasers and providers, in order to develop and support a **sustainable** model for the delivery of chronic illness care in primary care settings.
- **Enhance payment** to primary care providers for the delivery of high quality chronic illness care and establishment of Medical Home” based on external standards.

CSI Rhode Island – Underlying Principles

- *Improving chronic illness care requires re-design of the delivery system (i.e., the Patient-Centered Medical Home)*
- *For successful delivery system change:*
 - *External standards and training*
 - *incentives and disincentives aimed at the provider site must be aligned across payers*
 - *Measurement: Feedback and comparisons*

Why An All-Payer Initiative?

Make the numbers work for practices: enough dollars and patients and standard reqt's



Investment in New Delivery Systems at the Practice Level (not Health plan or Provider)



Fundamental Changes in Care Delivery (The PCMH) Improved Quality, Reduced Costs, Stronger Primary Care

Participants in CSI Rhode Island

Payers (representing 67% of insured residents)

- Medicaid; all RI-based commercial payers (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, United HealthCare – New England)

Purchasers (including 70,000 self-insured residents)

- The two largest private sector employers (Care New England, Lifespan) Rhode Island Medicaid, State Employees - health benefits program, Rhode Island Business Group on Health

Providers

- Largest primary care provider organizations (including Community Health Centers and hospital based clinics), Rhode Island Medical Society, RI AAFP, RI ACP

State

- Office of the Health Insurance Commissioner, Department of Human Services, Department of Health,

Technical Experts

- Department of Health; Quality Improvement Organization



CSI – the Commitments

Providers:

- Implement components of advanced medical home (NCQA PPC standards)
- Go through local chronic care collaborative (Wagner Model)
- Self measurement (structure and selected chronic conditions) and public reporting
- Patient engagement and education

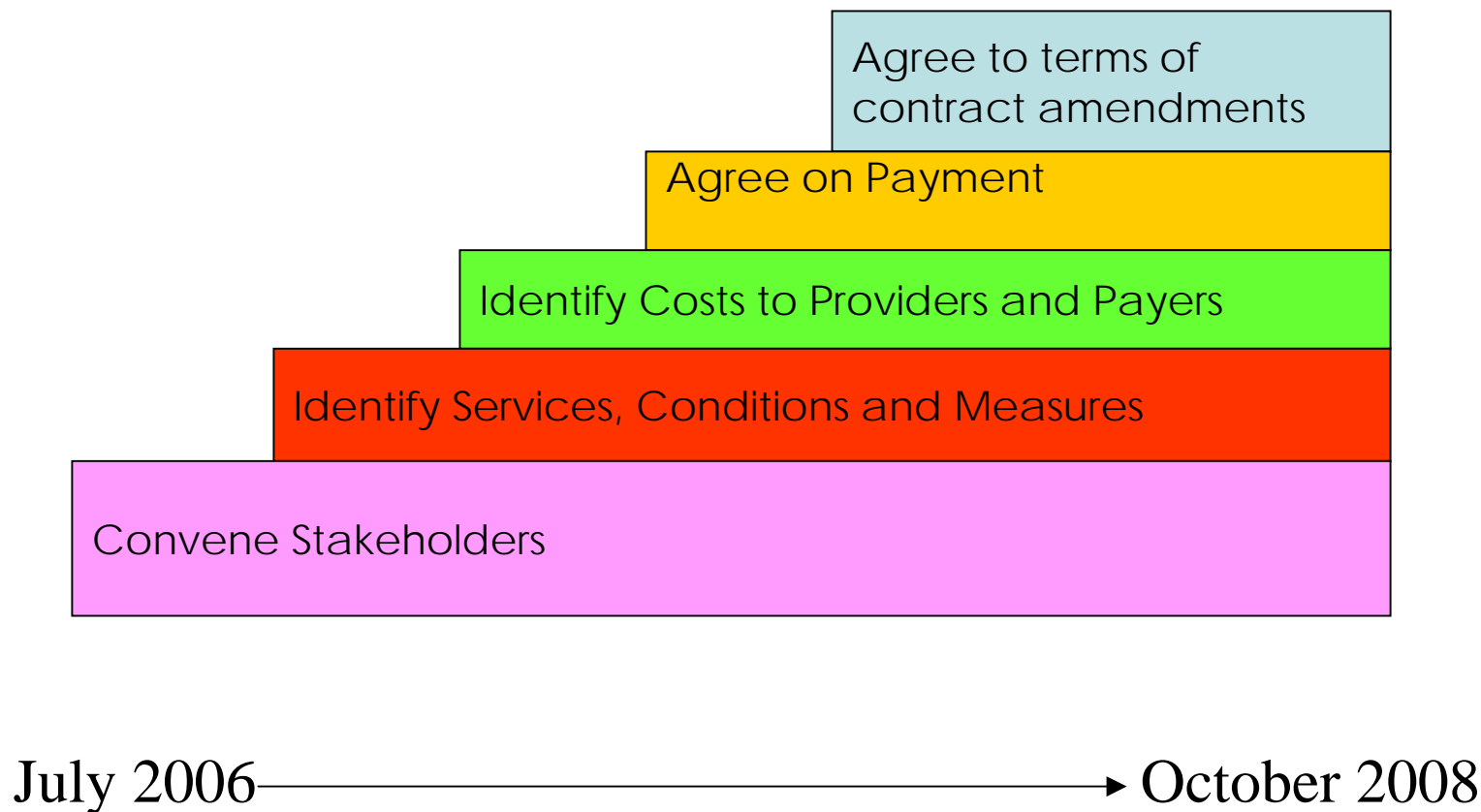
Plans:

- Supplemental payment
- Pay for nurse care manager
- Shared data and common measures for utilization measurement and feedback loop

Commemorate with contract – standard language

Large self insured employers – pay for programs for their workers

Building the Payment Pilot: Process and Timeline



How do you build an All-Payer Initiative?

Elements of the CSI RI Pilot

1. *Common Practice Sites*

- All payers will select the same core group of practice sites in which to administer their pilot. Requires common set of practice qualifications.

2. *Common Services*

- All payers will agree to ask the pilot sites to implement the same set of new clinical services, drawn from the PCMH Principles.

3. *Common Conditions*

- Pilot sites will not be asked by payers to focus improvement efforts on different chronic conditions

4. *Common Measures*

- All payers will agree to assess practices using the same measures, drawn from national measurement sets.

5. *Consistent Payment*

- Method and intent of incentive payments will be consistent across all payers

1. Common Practices

5 pilot practices

- ❖ *25,000 “covered” lives*
- ❖ *28 physician FTE’s*
- ❖ *Private practices, University faculty practice, community health center*
- ❖ *All patients except FFS Medicare (high acuity FFS Medicaid)*

Training for participating practices and care management teams through RI Chronic Care Collaborative

Duration – 2 years

2. Common Services:

- Sites commit to establish Medical Home. Use NCQA PPC standards. Require self audited progress to:
 - Level 1, 9 months in
 - Level 2, 18 months in
- Sites agree to go through training in Chronic Care Model (existing program at state DOH and QIO)
- Sites agree to hire and use Nurse Care Manager

Care Management Activities: CSI Nurse Care Manager

- Located within practices: *Provides services to ALL patients, regardless of payer*
- Provided through cash payments from health plans
- Care Manager “college:” Collaboration of NCMs across sites and with Medicaid NCMs
- Activities:
 - Initial patient assessment and risk stratify severity of chronic illnesses
 - Maintain registry/generate reports
 - Gather and maintain educational information
 - Education of patient on disease and treatment
 - Monitor quality measures
 - Access health plan resources

3. Common Conditions: Prevalence, Cost, Ability to Impact

1. *Coronary artery disease*

2. *Diabetes mellitus*

3. *Depression*

- *outcome measures for each, to be drawn
from registries (not claims)*

4. Common Measures:

1. Structural Measures: NCQA's "Physician Practice Connections: (PPC – PCMH) Tool – self assessment at beginning and end of pilot
2. Outcome measures: for 3 chronic conditions – from practices
3. Cost and Utilization measures – ER, RX and inpatient admissions – from plans.

CSI-RI Evaluation – Overview

- Conducted by 3rd party: Harvard School of Public Health
- Funded by Commonwealth Fund
- Will look for:
 - ✓ *Evidence that*
 - ✓ *Organizations providing care adopt components of the patient-centered medical home model*
 - ✓ *Intervention has an impact on patients, including changes in care processes, outcomes and experiences of care*
 - ✓ *Intervention is associated with changes in the cost of care*
 - ✓ *Qualitative information on experience of PCMH adoption*

5. Consistent Payment

Current FFS model remains in place

Monthly \$3 pmpm fee to each practice for enhanced PCMH services, plus cash to support Care Managers

Plans and providers agree to attribution methodology

(commercial: claims based - any one with last visit to site in 2 year time period and member at end of period)

No clinical performance incentives

CSI RI Approach to Negotiations

Be transparent. Share as much information as possible across stakeholders. Need a broker.

Put objective assessment of costs on the table (developed by CSI members based on local market conditions)

Compare to PMPM on table from United Health Care National Project

Focus on non-monetary benefits to providers (training, enhanced efficiency, etc.)

Balance consensus and use the hammer to call the question

The Numbers: Who Gets What

Practice Name (all physicians combined)	PCP FTEs	# of Patients											grand total X \$3PMPM X 12	Nurse Care Manager Allocation (annual)	
		United					BCBSRI					NHPRI			
		United Commercial 24month	United RiteCare 06/08	United Medicare	UHC total	annual \$\$	BCBSRI Commercial 24month	BCBSRI RiteCare 06/08	BCBSRI Medicare 06/08	BCBSRI Total	annual \$\$	06/08			Annual \$\$
Coastal Medical - Family Health & Governor Street	3	805	10	66	871	\$31,356	2321	8	445	2766	\$99,576	0	\$0	\$130,932	\$54,549
Hillside Family & Thundermist Health	6.5	1553	228	205	1986	\$71,496	4748	127	242	4990	\$179,640	1,316	\$47,376	\$298,512	\$89,001
TOTAL =	27.5	4659	692	448	5799	\$208,764	13577	0	1827	15404	\$554,544	3,399	\$122,364	\$885,672	\$330,000
			797					330				61			

* Ritecare Counts that did not reach 200 Members for a Physician Group were excluded per data gathering requirements.

24 months of claims data (1/ 1/06 to 12/31/07) using the agreed to attribution methodology for commercial products to determine unique patients last seen by NPs and MD's in each practice. These patients names were run against a 12/31/07 eligibility file

Cumulative of >\$4 pmpm (overstated if members are undercounted)

Convening Stakeholders: Barriers

1. Large national payers have little incentive to participate in regional or state-level programs
2. Payers fear losing competitive advantage and not accustomed to collaborating with other plans
3. Anti-trust concerns
4. Medicaid and commercial plans often not aligned
5. Need Medicare!!!
6. The PPO (how to count members) and FFS (how to count revenue) mindsets – both diametrically opposed to this work
7. Measuring outcomes – what does success look like?
8. ROI? Maybe but balance with JDI (Just Do It)
9. Planning and implementation:
 1. Staff time
 2. Getting private practices to do this non-reimbursed work
 3. Death by a thousand unforeseen cuts
10. Trust trust trust

Convening Stakeholders: Opportunities

1. Government as convener – the stick and the antitrust soother.
2. Engage major purchasers as advocates (at least initially)
3. Involve consumers as advocates (Could be stronger)
4. Developing Physician leadership and collaboration.
5. Educate stakeholders regarding need for delivery system-level reform
6. Increased awareness of conflict between medical home model and dominant PPO benefit plan models.
7. Participate in national PCMH efforts
8. Greater alignment in PCP contracting beyond this project

This is transformative: Focus on common goals!

Reduce overall costs of care
Improve quality and access
Strengthen primary care



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