# Rhode Island 2016-2017 Care Transformation Plan
# Recommended to the Health Insurance Commissioner Kathleen C Hittner
# Adopted February 10, 2016

The Care Transformation Advisory Committee recommends that Health Insurance Commissioner Kathleen C Hittner adopt the following Care Transformation Plan for 2016-2017. This plan is intended to supersede the previously adopted 2016 plan.

## I. Background

This 2016-2017 Care Transformation Plan is adopted pursuant to Section 10(c)(2)(A) of Regulation 2: Powers and Duties of the Office of the Health Insurance Commissioner (OHIC), by 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 2017 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 four Committee meetings in the fall of 2015.

## 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, RIQI'S TCPI, or a payer- or ACO-sponsored program) or practice has obtained NCQA Level 3 recognition. Practices meeting this requirement through achievement of NCQA Level 3 recognition may do so independent of participating in a formal transformation initiative.

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

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

b. Practice has implemented the following specific cost-management strategies according to the implementation timeline included in the Plan as Attachment A (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;
   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. During 2016 OHIC shall define the measures for assessing performance and the precise definition of "meaningful performance improvement" in consultation with the Advisory Committee. To promote measure alignment across statewide initiatives, measures selected to measure performance improvement will be selected from the multi-payer measure set adopted pursuant to CMS State Innovation Model (SIM) grant activity.

## III. PCMH Target for 2017

OHIC requires that by December 31, 2017 each insurer subject to the Affordability Standards shall increase the percentage of its primary care network functioning as a PCMH by 10 percentage points from the level achieved as of December 31, 2016.

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 consistent with the Implementation Timeline included as Attachment A, and be receiving support

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[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.

payments from the insurer that are consistent with the PCMH Financial Support Model, detailed in Section V.

## IV. Stakeholder Activities Promote PCMH Adoption

The following activities in 2016 and 2017 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. High-Risk Patient List

   The Commissioner will adopt a standard high-risk patient list, including list format, elements, and mode of delivery, to be implemented by insurers, in consultation with interested stakeholders.

2. All-Payer Claims Database (APCD) Provider Profiles

   The Commissioner will work with the APCD to develop:
   a. PCP and high volume specialist profiles (e.g., cardiologists, orthopedists, endocrinologists) using quality, utilization and cost measures, and
   b. ACO-based profiles that can be used to identify key focus areas for population health improvement.

   Estimated cost:
   APCD Analytics Vendor: $20,000
   In-kind contribution from existing state staff

   Potential/Tentative Funding Source: State Innovation Model (SIM) Grant Funds

3. Data Access and Use Learning Sessions

   During the fall 2015 Advisory Committee convening, Committee members noted that transforming practices still continue to face challenges with data use. Therefore, the Commissioner shall arrange with CTC-RI and RIQI to hold two full-day joint learning sessions specific to data access and use. These learning activities can consist of in-person learning sessions, a series of monthly webinars, or a

combination of in-person learning sessions and webinars with a comparable number of "contact hours" as two full-day learning sessions.

Estimated cost: $8000 per session; $16,000 for two sessions: Conference for 150 participants

- Light breakfast
- Lunch: sandwiches and salads
- AV equipment
- Room rental
- Printed materials

Funding source: insurers, in an amount proportionate to their insured book of business in Rhode Island

4. Care Management Learning Activities

The Commissioner shall request the transformation initiatives (CTC-RI, RIQI, and PCMH-Kids) continue to provide and to coordinate their care management/care coordination learning activities. These learning activities can consist of in-person learning sessions or a series of monthly webinars or a combination of in-person learning sessions and webinars with a comparable number of "contact hours" as two full-day learning sessions.

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

Funding source: insurers, in an amount proportionate to their insured book of business in Rhode Island

5. Monitoring for Cost Management Strategies/High-Risk Care Management

The Commissioner shall work with payers, CTC-RI and RIQI to develop a pilot program to focus on monitoring of the implementation of the cost management strategies, and high-risk care management activities.

Estimated cost: N/A
In-kind contributions from OHIC, CTC-RI, RIQI, providers, and insurers.

6. Practice Facilitation

In order to support practices effectively during the transformation process, the Committee recognizes the value of providing consistent, on-going practice facilitation resources, particularly to practices that are having difficulty with the transition. Since an increasing number of organizations, including payers, CTC-RI and RIQI, are providing practice facilitation resources to practices, the Commissioner shall work with all such organizations to develop a plan to coordinate the deployment of those scarce resources. OHIC shall work with CTC-RI, the payers, and RIQI to identify and target resources for practice facilitation deployment to maximize the impact of these resources.

Estimated cost: N/A
In-kind contributions from OHIC, CTC-RI, RIQI, providers, and insurers.

7. 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 and to learn from the past year's experience, and develop the next annual Care Transformation Plan. OHIC shall hold between three and four meetings to develop the Care Transformation Plan for 2018.

## V. PCMH 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 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 recognition at Level 3, or practices with NCQA recognition at Level 3, 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 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 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.

Example Scenarios for Practices Engaged in Practice Transformation:

| **PCMH Achievements** | | | | **Applicable Payment Model Components** | | |
|---|---|---|---|---|---|---|
| **Example** | **NCQA Level 3** | **All 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 | no (but still within 12-month timeframe for implementation) | no (but still within 24-month timeframe for implementation) | yes | yes | no |

| | | | | | | |
|---|---|---|---|---|---|---|
| 4 | yes | yes (but still within 12-month timeframe for implementation) | no(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 |

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. All other monetary levels of support of practices participating in RIQI's TCPI or other transformation

programs and being included in an insurer's count of PCMH practices should be independently determined by the insurers and the practices.

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.

Costs are determined by insurers and practices and are subject to OHIC review:

- CTC-RI
- PCMH-Kids: ~18,000 covered children at $TBD pmpm, effective January 1, 2016
- NCQA or TCPI practices not engaged in CTC-RI or PCMH-Kids
- Care manager evaluations: evaluators' time (this estimate will be revised as conversations continue with payers to develop the scope and model for this evaluation)

## VI. Conclusion

This 2016-2017 Care Transformation Plan is informed by the recommendations 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 10th day of February, 2016

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Health Insurance Commissioner
Office of the Health Insurance Commissioner