Primary Care Payment Reform in Rhode Island

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Health Insurance Commissioner, State of RI
CHCS Briefing
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Agenda

- RI Context
- Public Sector Initiatives to Reform Primary Care Payment
- Final Thoughts
Background

• Office of the Health Insurance Commissioner
  – Four Standards, including: Fair TX of Providers and Directing Health Plans Towards System Improvement

• Medicaid Program in Rhode Island
  – What’s different – Mature Medicaid Managed Care Program with broad support and good results
  – What’s the same – five percent drive fifty percent and too much reliance on institutional care

• Health Policy Making in Rhode Island
  – Executive Committee on Health Care Reform chaired by Lieutenant Governor
OHIC’s Affordability Standards

• Opportunity:
  – Use OHIC statute (decisions based on affordability) and comprehensive rate review process to focus on delivery system reform – true cost driver of health insurance premiums

• Standards
  – Developed by Health Insurance Advisory Council
  – Must be adhered to by insurers as condition of getting rates.
  – Implemented in 2010

• Regulatory Enforcement:
  – Rate Review

http://www.ohic.ri.gov/Committees_HealthInsuranceAdvisoryCouncil_Affordability%20Report.php
OHIC’s Affordability Standards

• Standards
  1. Increase portion of commercial medical spend going to primary care
     • From average of 5.5% to 10.5% over five years
  2. Support and expand all payer patient-centered medical home initiative
     • Chronic Care Sustainability Initiative - mid-wifed by CHCS
  3. Maintain EHR adoption incentives
     • Supplemental payments to providers
  4. Hospital Payment Reform
     • Six contract elements which must be included in commercial contracts
Where are they Spending this Money?
Categories of Primary Care Spend – 2011 Forecast

<table>
<thead>
<tr>
<th>Category</th>
<th>BCBSRI</th>
<th>UHCNE</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS Improvements</td>
<td>10%</td>
<td>39%</td>
</tr>
<tr>
<td>Medical Home (CSI &amp; Proprietary)</td>
<td>60%</td>
<td>13%</td>
</tr>
<tr>
<td>EMR subsidy</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>Other Allowable</td>
<td>19%</td>
<td>38%</td>
</tr>
</tbody>
</table>

(Tufts’ member is 5% of market and is not included for planning purposes)

Other Notes
- BCBSRI has proprietary Patient Centered Medical Home Program
- Ongoing issue – balancing consistency and specificity of guidance with plan flexibility (role of state oversight)
Implementing Affordability Standard One: Primary Care Spend (first you have to define it…)

**Actual Primary Care Spend (Percent)**

<table>
<thead>
<tr>
<th>Year</th>
<th>BCBSRI</th>
<th>United</th>
<th>Tufts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008 (Base Year)</td>
<td>6.8%</td>
<td>5.5%</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>6.3%</td>
<td>5.8%</td>
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<tr>
<td>2011 Spend Target</td>
<td>7.8%</td>
<td>7.5%</td>
<td></td>
</tr>
<tr>
<td>2012 Spend Target</td>
<td>8.8%</td>
<td>8.5%</td>
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Compounding Increases Impact of Primary Care Spend Requirement
What are the best Investments?

• (Will Insert Table Here)
Implementing Affordability Standard Two: All Payer Medical Home

Chronic Care Sustainability Initiative Principles:
- State as Convener
- Common Contract Terms
  - PCMH in round one. More in Round Two
- Common Payment Terms
- Common measures of three chronic conditions:
- Shared Governance

To Date
- Thirteen Practices, 70,000 patients, (Commercial full and self insured, Medicare and Medicaid Risk) Medicare participation Through MAPCP
- Core of RI Quality Institute’s “Beacon Communities” Project
- “Leading Primary Care Xformation in the State

www.pcmhri.org
Implementing Affordability Standard Two: All Payer Medical Home (cont’d)

CAD Active Patients, Age 35+ Years, Prescribed a Beta Blocker In Measurement Year

Similar results for other measures in CAD, Diabetes and Depression Screening

Challenges with pooling utilization information
OHIC’s Affordability Standard Two – Cont’d

• Future
  – Using the contract to drive change
    • ER Incentives
    • Practice Compacts
    • Fast enough to bend the curve?
  – Focus and impact—deep (in practices) vs broad (e.g. affordability spend)?
    • What is your change model?
  – Better performance measurement
  – Leadership transition
  – Transformation Fatigue
    • Beacon project
    • CMS work
    • Affordability monies

• Truly Engaging Patients

• But these are good problems to have…
• Much less emphasis here
  – All health plans have incentives to adopt electronic health records
  – As “Regional ExtensionCenter” RI QualityInstitute is doing most of this work.
  – Even with meaningful use monies – there seems to be a plateau in provider adoption rates.
  – Advisory Council will consider possibility of shifting this incentive to focus on funding for health information exchange ("currentcare") which connects the EHR’s (needs a funding plan)
OHIC’s Affordability Standard Four
Hospital Contracting Conditions

• Standards for rates of increase (Medicare CPI), units of payment (DRG’s), inclusions of quality incentives, joint work between hospital and health plan on care coordination and admin simplification, transparency

• Indirect Effect on Primary Care:
  – Trying to influence relationship with primary care docs and hospitals to one of greater collaboration and shared goals
  – ACA payment reforms could provide more opportunities here.
Some final thoughts in the state role in facilitating primary care payment reform

• What is the vision for the delivery system(s) in the state? Is it shared across branches of government and state agencies? Is it (too) population specific?

• Community Culture eats strategy for lunch. Leadership and “Accountable measurement” can change community culture. This is a role for State Government.

• Aligning payment to build towards the vision is both a huge barrier and opportunity.
  – Essential for change but takes time and work

• Where is the consumer?
  – “Patient Centered” sounds nifty but what does it really mean?
  – With some notable exceptions we have not figured out how to make high quality primary care valued by patients and consumers (role for benefit design?)