The Rhode Island Chronic Care Sustainability Initiative (CSI-RI): Translating Medical Home Principles into a Payment Pilot

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Advancing Excellence in Healthcare
Overview

• Update on RI Medical Home Pilot

• Role of the State in a multi-payer PCMH program

• Policy Implications
What is CSI RI?

• Collaboration resulting in a 2 year multi-payer payment pilot and demonstration of the Patient-Centered Medical Home

• Funded by CHCS’ Regional Quality Improvement Initiative to RI Office of the Health Insurance Commissioner and RI QIO

• Began July 2006
Participants in CSI Collaboration:

**Payers** (representing 67% of insured residents)
- Medicaid; all RI-based commercial payers (Blue Cross & Blue Shield of Rhode Island, United HealthCare – New England, Tufts Health Plan) Neighborhood Health Plan of Rhode Island

**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 Overview: Why An All-Payer Initiative?

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

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

Sufficient dollars, aligned measures and standards, technical assistance
CSI Overview: Why An All-Payer Initiative?

• In RI PCMH pilot, Medicaid accounts for 15-20% of non-Medicare practice members

• In markets with multiple public/private payers, providers respond to incentives that account for significant share of their revenue

• Re-shaping care delivery at the provider level requires coordinated effort across multiple payers
Scope of the Pilot

- 5 sites
  - One CHC
  - Two Family Medicine
    - One large-volume Medicaid
  - Two Internal Medicine
    - One Academic practice
    - Includes Nurse practitioners who bill independently
- 28 Providers (3-8 per site)
- 28,000 patients
- Standard contract language across plans and sites
- 2 years, beginning October 2008
CSI – Commitments

• Providers:
  – Implement components of patient-centered medical home (NCQA PPC-PCMH standards)
  – Achieve Level II PCMH recognition by 18 months
  – Participate in local chronic care collaborative (Wagner Model)
  – Measure and report quality in 3 chronic conditions using registry or EMR
  – Patient engagement and education

• Plans:
  – Supplemental payment of $3 pmpm for all members ($125k -$325k per site per year)
  – Pay costs of nurse care managers – employed by sites
  – Using a common format, feedback data on patient panels, chronic conditions and cost/utilization
  – $1.2 mil total annual investment
CSI – Commitments:

• Everybody:
  – Participate in on-going monitoring, oversight and future planning

• Large self insured employers:
  – Pay for programs for their workers

• Third Party Evaluation
  – Drs. Schneider and Rosenthal, Harvard School of Public Health, funded by Commonwealth
Genesis of State’s Involvement:

• National
  – Work of many in resuscitating Primary Care
  – Evidence of success in Chronic Care Model Medical Home and emerging standards

• 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

• Existing practice assistance infrastructure and chronic care improvement collaborative. History of multi-stakeholder collaboration in RI – “Line of site trust”

• Funding Opportunity: Center for Health Care Strategies’ “Regional Quality Improvement Initiative”
Office of Health Insurance Commissioner: Statutory Direction

- Created in 2004
- Direction:
  - Consumer Protection and Financial Solvency (consistent with other insurance lines, enforced through RI DBR – co-located)
  - Fair Treatment of Providers
  - View Health Care System as whole and direct insurers towards policies that improve system access, affordability and quality.
- Tools:
  - Contract and Rate Review, Exams, Hearings etc.
Potential Role of States

- Convener of interested parties
- Regulatory
- Legislative action
- Executive involvement
Role of Purchasers in CSI
(see Purchaser Guide to PCMH)

1. Prioritization of Issue
2. Endorsement and Permission to Plans
3. Focus on Site performance (need for change)
4. (future) Consumer/Employee engagement
5. (future) Coalition Building – Primary Care Agenda
Role of Purchasers in CSI
(see Purchaser Guide to PCMH)

Tensions:
• Change is at delivery system (Primary Care site). Patients spread across many employers
• The ROI question
• Timing- two years to implement
## 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!!! Need Self Insured!!
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
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
9. Basis for a broader primary care agenda.
This is transformative:
Focus on common goals!

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