CHCS Center for Health Care Strategies, Inc.

Case Study
Rhode Island Pilots Innovative, Cross-Payer Patient-Centered Medical Home Model

July 2009

An aging population, increasing rates of chronic illness, and a shortage of new primary care physicians are placing growing, and sometimes unmanageable, demands on primary care practices.[1,2] As their need for support — particularly in the area of chronic disease management — has increased, the shortcomings of the current health care system for supporting and paying for primary care have become vividly apparent.

To the extent that they exist, current efforts to support primary care practices administered by multiple health plans and purchasers are typically fragmented and uncoordinated. This can create an administrative burden for practices, while failing to support them effectively in improving care delivery.

Cross-payer collaborations that offer uniform practice support are emerging to address this disconnect between practice needs and payer/purchaser activities to improve health care quality. Aligning public and private payers can drive practice site improvement through aggregated performance data, consistent quality improvement support, and meaningful financial incentives. Cross-payer efforts, which do not require providers to alter their business and clinical practices for different patient panels, can reduce administrative burden while enhancing practice management and clinical effectiveness.

The state of Rhode Island is using this cross-payer approach to pilot a new patient-centered medical home (PCMH) model. The resulting Chronic Care Sustainability Initiative for Rhode Island (CSI-RI) is testing the power of cross-payer alignment to support a sustainable model for chronic care delivery in primary care settings. As described below, the program is part of the Center for Health Care Strategies' (CHCS) *Regional Quality Improvement (RQI)* initiative to improve chronic care at the primary care site.

CSI-RI: An Overview

Through an innovative cross-payer pilot, Rhode Island is providing five physician practices with financial and technical assistance to achieve patient-centered medical home recognition from the National Committee for Quality Assurance. Support is helping the practices evaluate and improve their processes for managing patients with coronary artery disease, depression, and/or diabetes. The program is part of CHCS' *Regional Quality Improvement* initiative, funded by the Robert Wood Johnson Foundation, to improve chronic care at the primary care site.

CSI-RI is one of four regional programs (others are in Arkansas, North Carolina, and Rochester, N.Y.) participating in *RQI*. CHCS designed the initiative to align purchasers — Medicaid, state employers, commercial, self-insured, and others — and health plans to target common chronic conditions, adopt common performance measures, and develop consistent reimbursement to support a uniform set of provider interventions. *RQI* is built on the premise that states, as dominant health care purchasers covering Medicaid beneficiaries and state employees, are natural and neutral leaders in bringing public and private purchasers together in regional health care improvement efforts.

Project Overview

CSI-RI, one of the nation's first multi-payer, public-private PCMH pilots, was designed to strengthen Rhode Island's primary care infrastructure for chronic care delivery. As defined by the National Committee for Quality Assurance (NCQA), the PCMH is a team-based model of care that replaces episodic treatment based on illness with coordinated care and a long-term relationship with providers.[3] Through this model, health professionals work together to provide high levels of care, access, communication, care coordination and integration.[4]

> In every state, there is interest in these kinds of initiatives, but state efforts are not always well-coordinated with the private sector […] By working with payers and providers to agree on a single approach to the medical home, [CSI-RI] maximizes the investment from the payers. In order to make real change, providers need the same support from everyone who is sending them patients and money.
> *– Deidre Gifford, MD, Quality Partners*

Under the leadership of Rhode Island Health Insurance Commissioner Christopher Koller, the state designed the two-year CSI-RI pilot to:

1. Align quality improvement and financial incentives among Rhode Island's health plans, purchasers and providers;
2. Improve the care of patients with chronic conditions in primary care settings; and
3. Enhance the attractiveness and viability of primary care as a specialty in Rhode Island.

Rhode Island is supporting five physician practices with financial and technical assistance to achieve PCMH recognition from NCQA. Each practice receives a per-member-per-month (PMPM) payment from all participating health plans to help cover the costs of implementing and maintaining the PCMH. The practices also receive technical assistance to evaluate and improve processes for managing chronically ill patients. The targeted conditions — chosen based on high prevalence and existence of recognized clinical measures — are coronary artery disease, depression, and diabetes.

A Collaborative Approach

Koller drove the program's marriage of public and private payers, facilitating the multi-stakeholder collaboration needed to influence fundamental changes in care delivery. The state engaged its largest payers, purchasers, and provider organizations in its effort. All of Rhode Island's commercial payers (Blue Cross & Blue Shield of Rhode Island, Neighborhood Health Plan of Rhode Island, and United HealthCare - New England), representing 67% of the state's insured residents, are participating. Purchasers in the initiative are the two largest private-sector employers (Care New England and Lifespan), Rhode Island Medicaid, the state employees' health benefits program, and the Rhode Island Business Group on Health. Providers are represented by the state's largest primary care group practices and specialty associations. The five practices chosen to participate were among those identified as "champions" in their local communities; they serve almost 35,000 patients. Quality Partners of Rhode Island, the state's quality improvement organization, is managing and overseeing the project.

"In every state, there is interest in these kinds of initiatives, but state efforts are not always well-coordinated with the private sector," explained Deidre Gifford, MD, a consultant with Quality Partners. "A fragmented approach to payment and quality by different payers in the market just adds to the administrative burden and inefficiency for struggling primary care doctors. By working with payers and providers to agree on a single approach to the medical home, our program maximizes the investment from the payers. In order to make real change, providers need the same support from everyone who is sending them patients and money."

Indeed, quality improvement programs, including pay-for-performance arrangements, often represent the interests of an individual payer. As a result, physicians must respond to multiple and fragmented quality improvement programs and requirements, each one applying to a different subset of the physician's patient panel. By involving all purchasers and payers — Medicaid and the commercial sector – CSI-RI provides practices with the same programmatic guidelines for all of their patients, making compliance much easier and more appealing.

Criteria for a Patient-Centered Medical Home

To be recognized as a PCMH, a practice must meet National Committee for Quality Assurance standards regarding:[5]

1. *Patient access and communication*;
2. *Patient tracking and registry functions*;
3. *Care management*;
4. *Patient self-management support*;
5. *Electronic prescribing*;
6. *Test tracking*;
7. *Referral tracking*;
8. *Performance reporting and improvement*; and
9. *Advanced electronic communications*.

See **www.ncqa.org** for specific content and scoring.

The CSI-RI team also determined early on that its efforts had to be directed to the practice level. "Looking to achieve fundamental changes in care delivery, we realized that we needed to change delivery systems at the practice level, where patients are seen," added Gifford. "To do that, we needed sufficient dollars to get the practices' attention. We also needed the practices to see that our quality measures, reporting requirements, and technical assistance were coordinated and consistent across payers. Engaging public and private payers in the initiative achieved both of these goals."

CSI-RI in Practice

In October 2008, the five practices began working toward PCMH recognition. Elements of the delivery model and support include:

Practice Supports

1. ***Financial Incentives*** – Participating health plans increased their rate of payment by $3 PMPM, translating to an annual increase ranging from $166,000 to $387,000 for each practice. These payments are not linked to changes in patient utilization or clinical quality measures, but to practice self-assessment and achievement of NCQA's PCMH standards (see sidebar) by specific program deadlines.

2. ***Nurse Care Managers*** – The plans pooled resources to give the practices funding to hire nurse care managers. Focusing on the care of patients with chronic conditions, the nurse care managers are helping practices meet the new demands of developing a sustainable PCMH.

Practice Requirements

1. ***Commitment to Staff Training*** – Each practice agreed to bring its entire staff — from the front-desk receptionist to the physician — to three training sessions. Through these, staff from all five practices come together to learn how to implement the PCMH model, discuss challenges, and share successful strategies.

2. ***Use of Evidence-Based Care*** – Providers are sharing evidence-based guidelines and information with patients to encourage compliance, and are working toward enhanced access to care through expanded hours, open-access scheduling, and e-mail consultations.

3. ***Adoption of Common Clinical Measures*** – Each site is collecting treatment and outcomes data on patients with any of the targeted conditions (see Table 1). Practices are using these data to assess program impact and identify remaining areas of need.

4. ***Implementation of Electronic Medical Records and a Chronic Disease Registry*** – These tools: a) provide prompts to providers on indicated care; b) identify relevant sub-populations for proactive care; c) generate follow-up patient reminders; d) monitor the practice's performance on clinical quality measures; and e) enable e-prescribing.

5. ***Submission of Data to Achieve PCMH recognition*** – NCQA recognizes three levels of achievement — reflecting progressive compliance with program standards — among practices it designates as medical homes. When seeking this recognition, practices use a web-based data collection tool and provide supporting documentation. CSI-RI practices are required to meet standards for Level 1 within six months of the program's start, and Level 2 recognition within 18 months.

Table 1: CSI-RI Clinical Measures[6]

Coronary Artery Disease (CAD)	
Beta-blocker therapy persistence/prior MI	Age > 35 with CAD who were prescribed beta-blocker therapy during measurement year
Depression	
Depression screening	Age > 18 who were screened annually for depression
Diabetes	
HbA1c control	Age 18-75 with most recent HbA1c < 7.0%
BP control	Age 18-75 with most recent BP < 130/80 during the measurement year
LDL control (optional)	Age 18-75 with most recent LDL < 100 during 12-month measurement period
Eye exam (optional)	Age 18-75 who received dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year
All Patients	
Advising smokers to quit	Tobacco users who received advice from a health care provider during the one-year measurement period

Results to Date

The interim success of CSI-RI is evident in the practices' progress toward PCMH recognition. By January 2009, the five practices had hired nurse care managers, began receiving the additional $3 PMPM health plan reimbursement, completed NCQA's required self-assessment, and achieved Level 1 PCMH recognition on self assessments. By April 1, 2009, all five sites had submitted applications to NCQA for formal PCMH recognition.

Keys to Success

Members of the CSI-RI team point to a number of factors driving the program's preliminary and expected success:

- ***Leadership from the top*** – As initiator, champion and leader of CSI-RI, Koller leveraged the authority of his office to bring all parties to the table and keep them engaged in the program. He has been lauded for listening to the often disparate concerns and priorities of various plans and practices, and negotiating agreeable compromises.

  "It was very important to our program that the health insurance commissioner be involved. Collaboration, particularly among competitors, is always harder than doing something on your own," added Quality Partners' Gifford. "Having the state involved was very helpful in keeping people at the table and working together."

> Doctors will have more time to spend with patients and will get paid more appropriately for the services they provide. They won't have to churn through 30 or 40 patients a day. Patients will be more satisfied, as well, because other clinicians, including the nurse care managers, are involved with their care and can answer questions that the doctor does not have time for personally.
>
> *– Gus Manocchia, MD, Chief Medical Officer, Blue Cross & Blue Shield of Rhode Island*

- ***Leveraged Medicaid resources*** – Although Medicaid serves only 15% to 20% of the Rhode Island insurance marketplace, it is by far the largest purchaser in the state, and its ability to fuel a program that benefits two-thirds of insured residents is noteworthy. Representing a large proportion of patients with the most chronic needs, Medicaid has demonstrated that it is well-positioned to encourage multi-stakeholder involvement in quality improvement.

- ***Upfront investment from health plans*** – Participating plans increased their PMPM rate and funded nurse care managers for the practices at the start of the program – independent of subsequent utilization and clinical measures. This "gamble" reflects the plans' awareness of the upfront investment needed to effect fundamental change in chronic care delivery, particularly through funding of an "extra set of hands" onsite.

- ***Transparency*** – The state is committed to remaining transparent about financing issues. Sharing this information openly with purchasers, payers, and practices has been a key to building and maintaining trust among them.

Next Steps

As the five Rhode Island practices continue PCMH implementation, an assessment of the model's long-term feasibility and sustainable impact, as well as plans to expand the program, are underway. Throughout the two-year program, researchers from the Harvard School of Public Health are evaluating the pilot efforts through a grant from The Commonwealth Fund. They are assessing whether the program is effective in transforming the five practices into medical homes, and whether this transformation improves the quality of care and patients' experience of care, and reduces costs.

Hopeful about what those results will show is Gus Manocchia, MD, chief medical officer for Blue Cross & Blue Shield of Rhode Island. He believes that the program will significantly improve the patients' experience of care. "Doctors will have more time to spend with patients and will get paid more appropriately for the services they provide," he added. "They won't have to churn through 30 or 40 patients a day. Patients will be more satisfied, as well, because other clinicians, including the nurse care managers, are involved with their care and can answer questions that the doctor does not have time for personally."

> The people who put [CSI-RI] together understood that the impending collapse of the field of primary care is a community problem and that cost-shifting is not the answer...[F]or this project to work, we needed physicians, insurance plans, patients, and purchasers to work together — and they are.
> *—Thomas Bledsoe, MD, Governor Street Primary Care Center*

Echoing that optimism is Thomas Bledsoe, MD, a physician in the Governor Street Primary Care Center, one of the five CSI-RI practices. "The patient-centered medical home has given us a registered nurse in my office — something that I have never been able to afford in 15 years of practicing primary care medicine," he commented. "The people who put this project together understood that the impending collapse of the field of primary care is a community problem and that cost-shifting is not the answer. It's easy to say that insurance plans are the bad guys. But for this project to work, we needed physicians, insurance plans, patients, and purchasers to work together — and they are. This shows that the purchasers are starting to understand that primary care is important both in terms of the quality and cost-effectiveness of care."

---

[1] American College of Physicians (2008). "How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care? A Comprehensive Evidence Review," **http://www.acponline.org/advocacy/where_we_stand/policy/primary_shortage.pdf**.

[2] K.E. Hauer, S.J. Durning, W.N. Kernan, M. J. Fagan, M. Mintz, et al. "Factors Associated With Medical Students' Career Choices Regarding Internal Medicine," *JAMA*, 300, no. 10 (2008): 1154-1164.

[3] National Committee for Quality Assurance (2009). "Physician practice connections®– patient-centered medical home (PPC-PCMH™), "**http://www.ncqa.org/tabid/631/Default.aspx**.

[4] American College of Physicians, (2009). "What is the patient-centered medical home?" **http://www.acponline.org/running_practice/pcmh/understanding/what.htm**.

[5] National Committee for Quality Assurance, op cit.

[6] Quality Partners of Rhode Island, 2008.