

## **PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE**

### **Meeting Minutes, August 18, 2009**

*Members & Alternates in Attendance:* Thomas Bledsoe, MD, PCPAC Chair; David Ashley, MD; Michael Felder, DO, MA; David Gifford, MD, MPH; Christopher Koller; Kathryn Koncsol, MD; Al Kurose, MD; Elizabeth Lange, MD; Meg Lekander, MD; Anne Neuville, RNP; Richard Wagner, MD. *Guests:* Kim Barravecchia; Paul Block, PhD; Alison Buckser, MPH; Anton Dodek, MD; Neal Galinko, MD, MS; Gus Manocchia, MD; Jeff Migneault, PhD; Mike Ryan. *HEALTH:* Carrie Bridges, MPH; Dona Goldman, RN, MPH; Carla Lundquist.

*Member/Alternates Unable to Attend:* Gregory Allen, DO; Munawar Azam, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Mark Braun, MD; Matthew Burke, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Patricia Flanagan, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Raymond Maxim, MD; Lauren Meisel, MD; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH; Newell Warde, PhD.

**Open Meeting/Old Business** - PCPAC Chair Dr. Bledsoe called the meeting to order at 7:35 AM, and asked the Committee members present to review the minutes of the June 17, 2009 meeting. There were no comments and the minutes were approved as written (motion by Dr. Wagner, second by Dr. Lange, all in favor).

Dr. Bledsoe reviewed the PCPAC Priorities for Change in Primary Care that were developed at the September 2008 meeting. He allowed that the changing environment for primary care may have impacted the item ranking in the past year, but asked members to consider these priorities as a starting point when advising the Office of the Health Insurance Commissioner (OHIC) and the health insurers on additional investments in primary care.

**Increases in Primary Care Funding per OHIC Affordability Principles** - Chris Koller, Health Insurance Commissioner, briefly reviewed the System Affordability Priorities and Standards for Health Insurers in RI. Per the Standards, each health plan must increase the proportion of its spending on primary care by 1% each year over the next 5 years. In developing the Standards, the Health Advisory Council wanted the additional health insurer investments in primary care to promote payment reform and simply be poured into fee schedules, to improve the primary care system in RI. Long-term performance measures/goals for primary care system improvement include:

- Lower rates of Emergency Room (ER) visits for Ambulatory Care Sensitive Conditions (ACSC)
- Lower rates of hospital admissions (or re-admissions within a specified period) for ACSC
- Increased number of primary care providers per capita
- Improved trends for insurance premiums

HEALTH is developing baseline measures that will be presented to PCPAC in the next few months for review and feedback; periodic updates will be reported as data is collected. The measures were chosen for their sentinel value as indicators of the functioning of the primary care system, not for specific cost factors. Dr. Manocchia (BCBSRI) commented that estimates of ER over-use are about 25-30% of visits, and avoidable re-admissions about 5-10%, due to poor post-discharge care coordination. Dr. Galinko (UHC) noted that about 1/3 of spending is for inpatient costs and re-admissions range from 5-30% between hospitals. Dr. Gifford recommended caution in defining re-admissions as “inappropriate” as the re-admission may be medically necessary due to the patient’s condition, but possibly could have been avoided. It would not be reasonable or appropriate to try to eliminate all ACSC ER visits/hospitalizations/re-admissions; the goal is to bring the rates down in accordance with other primary care systems.

Mr. Koller reviewed a pie chart of health insurer spending and the methodology for determining the additional primary care spending required based on commercial spending only; this amounts to ~\$10M for BCBSRI and ~\$1.8M for UHC in 2010. Tufts also will be subject to the Standards, but has very small RI enrollment at present. Mr. Koller presented a grid of example primary care investment strategies stratified by the target practice types for each category of incentive, in order to achieve primary care system improvement (see below). The grid is not based on specific proposals – the health insurers will submit those for review at a later meeting. The target practice pool widens from left to right on the grid, based on the current level of engagement in practice improvement efforts. Promotion of the Patient-Centered Medical Home (PCMH) is key to improving the primary care system, and practices involved with initiatives such as the CSI-RI all payor PCMH pilot project are categorized as “high-performing.” Incentives listed in the right-hand column would be applicable to all primary care practices, including those not motivated to acquire/use EMR or arrange after-hours access, but overall fee schedule enhancements are not considered to be payment reform. However, fee schedule improvements may be needed in order to achieve

regional parity. Other categories, such as Practice Assistance and Loan Forgiveness, would not involve direct payment to practices but would focus on capacity building projects and primary care physician pipeline support.

**PCPAC Recommendations for Prioritization of Strategies and Allocation of Funds** – PCPAC member questions/comments and guest responses included:

- Whether the focus should be for long-term or short-term improvement should factor into PCPAC's prioritization; in general the health insurers are thinking long-term.
- Senator Whitehouse has asked the RIMS Executive Board for a plan to write regional parity into health care reform, but this could raise issues of total health care costs if parity is applied to sub-specialties as well as to primary care. Dr. Manocchia noted that the Standards require the additional primary care spend be implemented without premium increases, which may not be possible if sub-specialty parity is included.
- The mal-distribution of health care providers for specific population groups is well known but difficult to address; the best way to cut medical costs may be to target high users and include funding for patient self-management support in the primary care investments.
- Consideration should be made of the breadth and depth of funding to practices necessary to effect change; how much impact would the primary care investment have if spread across all practices? How much system-wide change could be achieved if the funds are concentrated in the top 20% or 50% of practices? Would \$30K or \$60K per practice (via various incentives) be sufficient to improve practice functioning and patient care? What is the return on investment for each type of incentive?
- Quantification of primary care practices and providers in RI (with a high level of confidence) is needed.
- It will be important to have some level of alignment/coordination between the health plans; could some incentives (such as EMR) have a common application/certification process, perhaps by an outside entity? Dr. Manocchia replied that the health insurers operate in a competitive market in which differentiation is necessary, and too much standardization would undermine their ability to compete for business. He and Dr. Galinko agreed that some uniformity could be implemented to assist providers, as was done for CSI-RI.
- From a practice perspective, services should be delivered in the same fashion to all patients who need them; avoid creating different levels of care for differently insured patients.
- The more that the investments are concentrated on the "high-performing" practices, the bigger the gaps will be between the high-performing, motivated, and not engaged practices, creating a system of haves and have-nots. This would lead to silos and feelings of disenfranchisement. There is risk in concentrating funds on a small number of providers; more movement toward the system goals might be achieved if everybody has a stake in most people succeeding.
- The CSI-RI PCMH pilot project included "pay for participation" aspects (vs. pay for performance), such as data collection/tracking incentives vs. patient outcome incentives, to build infrastructure for future improvements. The Chronic Care Collaboratives have demonstrated that outcome measurement with feedback to the provider creates competition within and between practices, leading to performance improvement. Incentives should be structured to enable providers to incorporate the next level practice improvement of which they are capable.
- The degree to which a practice can achieve the performance goals for the primary care system is highly dependent upon the community it serves, the risk factors experienced by the population, and the resources available to the community, particularly for patient self-management support.
- Part of the definition of "high performing" should include those practices that create better access to care, particularly for medically underserved populations, and those demonstrating cultural competence.

PCPAC members were asked to vote on the relative importance of general categories of investment and target practice sites. The distribution of votes (10 per member present, not including Dr. Gifford and Mr. Koller) is reflected in bold/italics below:

## Sample Strategies Stratified by PCP Groups Targeted

*[With PCPAC Recommendations for Investment Allocation]*

Categories	"Set the Bar very high": rewards go to high performing sites = 20% of all sites	"Set the Bar high": rewards go to high performing sites (20%) + motivated sites (30%) = 50% of all sites	"Get money in the system": high performing sites (20%) + motivated sites (30%) + not engaged sites (50%) = 100% of all sites
<b>Structure and Process Incentives</b>	- Enhanced case management programs (all payor or plan specific) <i>PCPAC - 21%</i>	- After hours incentives - EMR adoption incentives - Meet accreditation standards <i>PCPAC - 29%</i>	- Pay for training <i>PCPAC - 0%</i>
<b>Outcome Incentives</b>	- Enhanced fees or bonus payments to sites that score well on performance measures <i>PCPAC - 18%</i>	- Lump sum payments for performance on collection of measures (HEDIS, etc) <i>PCPAC - 3%</i>	
<b>Fee Schedule and Volume Enhancements</b>			- Regional and inter-plan parity <i>PCPAC - 7%</i>
<b>Other Categories:</b> <b>Practice Assistance:</b> <i>PCPAC - 15%</i> <b>Loan Forgiveness:</b> <i>PCPAC - 7%</i>			

### Other Business/Announcements

- Dr. Gifford announced that the PCPAC meeting scheduled for Wednesday, August 26, 2009 would focus on H1N1 planning in RI, including vaccine distribution plans, Health Service Regions & overflow plans, the most effective ways to communicate with the primary care community, management of the ill, deferring non-critical functions (e.g. school physicals), and appropriate use of antivirals.
- PCPAC will hear the health insurers' proposals for additional investments in primary care per the Office of the Health Insurance Commissioner (OHIC) Affordability Standards at the Wednesday, September 16<sup>th</sup> meeting.



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