

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, September 16, 2009

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; Gregory Allen, DO; David Ashley, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; Mark Braun, MD; Denise Coppa, PHD, RNP; Joanna D'Afflitti, MD; Michael Felder, DO, MA; Joseph Frank, MD; David Gifford, MD, MPH; Christopher Koller; Kathryn Koncsol, MD; Al Kurose, MD; Elizabeth Lange, MD. *Guests:* Kim Barravecchia; Paul Block, PhD; Alison Buckser, MPH; Leslie Carver; Deb Faulkner; Neal Galinko, MD, MS; Perri Levis; Jeff Migneault, PhD; Harold Picken, MD, MPH. *HEALTH:* Carrie Bridges, MPH; Robert Crausman, MD, MMS; Carla Lundquist; Ana Novais, MA; Mia Patriarca O'Flaherty, MA; Peter Simon, MD, MPH.

Members & Alternates Unable to Attend: Munawar Azam, MD; David Bourassa, 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; Meg Lekander, MD; Raymond Maxim, MD; Lauren Meisel, MD; Tom Murphy, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD; Newell Warde, PhD.

Open Meeting/Old Business - PCPAC Chair Dr. Bledsoe called the meeting to order at 7:37 AM, and asked the Committee members present to review the minutes of the August 18, 2009 meeting. There were no comments and the minutes were approved as written (motion by Dr. Kurose, second by Dr. Borkan, all in favor).

H1N1 Update – Dr. Gifford asked PCPAC to help get the message out that each practice must register on the HEALTH web site in order to receive H1N1 vaccine, similar to but separately from the registration for seasonal flu vaccine. Health insurers also were asked to spread the word. HEALTH will be conducting ~600 evening/weekend H1N1 vaccine clinics in schools and is seeking volunteers to assist. Any health professionals, medical office staff, residents, or health professions students willing to volunteer should register individually at www.riresponds.org.

Increases in Primary Care Funding per OHIC Affordability Principles - Chris Koller, RI Health Insurance Commissioner, reviewed the System Affordability priorities and goals, the requirement for increased spending on primary care, and the prioritization exercise done at the August 18th PCPAC meeting. Blue Cross Blue Shield of RI and United Healthcare have drafted plans for investment of the additional 1% of spending for primary care in 2010. Due to its recent entry and small market share, Tufts Health Plan will measure/report spending and will participate in the CSI-RI PCMH project in 2010. The BCBSRI and UHC rough draft investment details (attached) are categorized by the grid of strategy types and targeted practices used for the PCPAC prioritization exercise, although the plans were not bound by the PCPAC recommendations. The plans diverge on their investment allocations due to their specific needs and constraints; UHC is making a greater allocation to fee schedule adjustments in 2010 to address market discrepancies in physician and flu clinic administration fees. Also, UHC currently has less flexibility than BCBSRI to make lump sum payments to practices due to their national payment models. PCPAC members voiced a number of concerns regarding the draft plans, including:

- Many of these initiatives require PCP involvement, but PCPs can only respond to so many initiatives at a given time; PCPs need these efforts to be simple and unified across the health plans, and they need to be compensated for the care they are providing, particularly care coordination.
- Get motivated & not engaged practices moving toward high-performance to avoid a sense of disenfranchisement.
- Patient involvement is key to many of these initiatives; investment must be made in patient navigation and self-management support.
- Increasing after-hours access will greatly aid movement toward the system goals, but it is very expensive to provide and should receive greater funding.
- Greater funding for interdisciplinary primary care teams is needed, together with revision of health insurer policies that limit practices from hiring and maintaining interdisciplinary teams.
- The BCBSRI Delivery System Improvement initiatives focused on hospitals and specialists seem to fall outside the goal of supporting primary care and the purpose of the OHIC mandates.
- Payment for pediatric screenings needs to be addressed. Multiple screenings are very time consuming yet insurers do not permit separate payment for each screening. Pediatric practices lose money giving vaccines.
- PCPs are being encouraged to provide more phone and email consults, at higher liability risk without adequate payment. E-prescribing is not fully supported by the health plans.
- The UHC initiative to support primary care by increasing the volume of patient visits due to zero co-pays does not make sense as PCPs already are overtaxed – this is reinforcing the fee-for-service (FFS) treadmill.

PCPAC members and guests discussed the extent to which the draft plans represent systems-wide change vs. specific incentives/activities, and whether these efforts will create significant differences in primary care in the coming years. Dr. Picken (BCBSRI) commented that the FFS environment has created a focus on hospitals and specialists that has been toxic for primary care. BCBSRI is trying to recognize and compensate value added work via mechanisms outside the FFS system, instead of adding more items such as phone or email consults to the FFS schedule. These initiatives include higher management fees for complex patients (initially only complex patients as proof of concept & savings), leading to wider payment reform.

PCPAC members expressed a strong desire to see the health plans work together and align their initiatives to enhance primary care. The health plans should review and revise their policies that restrict practice in primary care and do not correlate with practice law, in order to promote adoption of interdisciplinary teams and expand access to coordinated, comprehensive care. Practice restriction policies particularly limit efforts to expand evening and weekend hours. In addition, sharing of baseline financial utilization data from the health insurers is needed for PCPAC and other stakeholders to make informed decisions about these changes.

Mr. Koller summarized the comments as calls for coordination, boldness, and large, focused investment. He noted two major risks to this approach: (1) this is a step into the unknown - there are data gaps in cost-benefit analysis and elements of risk for all stakeholders; and (2) it is time-consuming and expensive and there must be sufficient motivation/incentive to make bold changes; focusing efforts on a limited number of practices means some practices may feel disenfranchised. It is important to keep in mind that the health insurers must deal with multiple constituencies in addition to primary care. Dr. Borkan offered to send out new data on cost-benefit of the PCMH model, and pointed out that this is a unique chance to enact big changes to the delivery of care statewide versus making small changes around the edges. Dr. Felder commented that the proposed changes must be translated into concrete terms for PCPs to capture their attention. The financial benefit and the ultimate goal of healthier patients must be defined in order for PCPs to understand that it will be worth the enormous effort of transforming.

Mr. Koller outlined the immediate work and challenges facing the health insurers in developing their final primary care spending plans for implementation in January 2010. Due to the changes requested and the health insurers' staffing constraints, the extra PCPAC meeting on September 30th will be canceled and the final spending plans will be presented at the October 21st meeting.

Other Business/Announcements

- Next Meeting Wednesday, October 21, 2009, 7:30 – 8:45 AM, Conf. Room B, Dept. of Administration
- Next PCPAC/H1N1 Conference Call Wednesday, September 23, 2009, 7:30 – 8:00 AM



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Possible 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% / all sites
Structure and Process Incentives	<ul style="list-style-type: none"> - CSR-RI all payor medical home pilot - Enhanced case management programs (all payor or plan specific) - Other ideas <p style="text-align: center;">BCBSRI – 75% UHC – 30% <i>PCPAC - 21%</i></p>	<ul style="list-style-type: none"> - After hours incentives - EMR adoption incentives - Meet accreditation standards - E-Rx incentives - Other ideas <p style="text-align: center;">BCBSRI – 10% UHC – 13-20% <i>PCPAC - 29%</i></p>	<ul style="list-style-type: none"> - Specific items to be determined - to be consistent across plans <p style="text-align: center;">BCBSRI – 10% UHC – 0-7% <i>PCPAC - 0%</i></p>
Outcome Incentives	<ul style="list-style-type: none"> - Enhanced fees or bonus payments to sites that score well on performance measures <p style="text-align: center;">BCBSRI – 0% UHC – 20% <i>PCPAC - 18%</i></p>	<p style="text-align: center;">BCBSRI – 0% UHC – 5% <i>PCPAC - 3%</i></p>	
Fee Schedule and Volume Enhancements			<p style="text-align: center;">BCBSRI – 0% UHC – 25% <i>PCPAC - 7%</i></p>
<p>Other Categories: <i>PCPAC - 22%</i> (Practice Assistance: <i>15%</i> & Loan Forgiveness: <i>7%</i>)</p> <p>(Total for Other Categories) BCBSRI – 5% UHC – 0-7%</p>			

Blue Cross Blue Shield of RI Investment Plan Detail (DRAFT)

NOTE: The programs listed here are subject to implementation. Actual spending may differ from projected because of change in program details, changes in implementation, or variation in number of providers who meet standards of program. Health plans will be held accountable for achieving overall primary care spend rate targets. [BCBSRI additional investment for 2010 is roughly estimated to be \$10 million.]

Category	Description	% of Total \$
1) Patient-Centered Medical Home (PCMH)	Funding to support adoption of PCMH. Includes: 1) BCBSRI-only program, focused on complex members, with funding for infrastructure (e.g. nurse case manager) and PMPM payments 2) expansion of CSI-RI program	50.0%
2) Electronic Health Record	Funding to support implementation and use of electronic health records. Includes: 1) funding for pre-implementation readiness assessment for new EHR users 2) funding for new EHR users (including training) 3) funding for existing EHR users 4) enhanced fee schedule for qualified providers	10.0%
3) Behavioral Health and Primary Care Integration	Funding to improve behavioral health access and communication between primary care and behavioral health providers. Includes support for co-location of behavioral health in primary care practices and for the development of collaborative agreements [at least 5 new co-located practices and several collaborative agreements]	5.0%
4) Value-based Benefits	Co-pay waivers to incent use of targeted PCPs	(TBD)
5) Delivery System Improvement (Specialist Focus)	Funding for specialist providers to improve coordination with primary care. Includes 1) Enhanced fee schedule for specialist EHR users who coordinate care/communicate with PCPs 2) bonus based on PCP satisfaction with specialist services / care coordination 3) funding to develop principal care centers (specialist "medical homes" - an example is end stage CHF/Cardiology) 4) lump sum funding for "urgent" access to specialists as alternative to ER/urgicenter	10.0%
6) Delivery System Improvement (Hospital Focus)	Funding to support the development of a patient-centered medical "neighborhood" - new contracts support care coordination among hospital, specialists, and PCPs [funding to hospital for NCM who provides care coordination services to multiple local PCP practices]	5.0%
7) Pay for Performance	Incentive to promote more cost effective drug utilization [i.e. therapeutic substitution for cholesterol lowering /PPI drugs] - gainsharing with "non-engaged" PCPs	7.5%
8) Accountable Care Organizations	Incentives [lump sum grants] to encourage the development of accountable care organizations. Examples include: 1) incentives for smaller practices to merge or join larger organizations 2) incentives for quality improvement activities [i.e. educational meetings] 3) incentives for practices to improve access by extending office hours	5.0%
9) Discharge Care Coordination	Fee for service payment to PCPs for coordination of care after a patient is discharged from a facility [hospital/SNF]	2.5%
10) Loan Repayment	Funding available in the Rhode Island Primary Care Educational Loan Repayment Program	5.0%

100.0%

United Healthcare Investment Plan Detail (DRAFT)

NOTE: The programs listed here are subject to implementation. Actual spending may differ from projected because of change in program details, changes in implementation, or variation in number of providers who meet standards of program. Health plans will be held accountable for achieving overall primary care spend rate targets. [UHC additional investment for 2010 is roughly estimated to be \$1.8 million.]

Investment Plan Detail	Description	%
Structure and Process Incentives:		50%
CSI All payer medical home	Health plans commit to establish a NCQA certified Medical Home and commit to supporting an expansion of either the Rhode Island Chronic Care Sustainability Initiative or an alternative all payer medical home model. The expansion shall entail an increase of at least 15 PCP FTEs from the current 28 FTEs level, including the addition of new practices beyond the initial 5 CSI-RI practice participants.	30%
EMR Incentive Programs	Health plans to commit to implementation of a certified electronic medical record (i.e. certification by the Commission for Healthcare Information Technology (CCHIT) physician primary care and/or specialty care EMR adoption incentive that pays: (i.e. United: \$2,500 or more, up to a practice maximum of \$7,500) in bonus in the form of pay-for-participation payments equal to \$.60 PMPM or in increased fees, totaling in value at least 3% great than the insurer's standard fee schedule.	13%
Primary Care QTIAC Requests	UHC Quality and Technology Investment Advisory Council (QTIAC) consists of constituents who guide and participate in the selection of community quality and technology health care initiatives based on projects' value to the health care community, including its value to providers, employer and consumers of the RI health care system. QTIAC will invest in certain primary care initiatives such as Loan Forgiveness, RICCC, and others.	7%
Outcomes Incentives:		25%
Pay for Performance	Practice Rewards - a United Healthcare National program that offers financial recognition program for physicians who have met the highest quality and cost efficiency criteria under the United Health Premium Designation program. A 5% fee schedule differential recognizes physicians and facilities who meet or exceed guidelines for quality and cost efficient care. A 3% fee schedule differential recognizes those physicians and facilities who have shown improvement from the previous year (this is new for 2010). United expects more paid under this program in 2010 - to more physicians who exceed guidelines and for the new improvement program.	20%
After hours Incentives	Additional payment to physicians who offer extended hours or provide services in office to their patients resulting in lower ER visits and other cost savings advantages. Although subject to further details the program would include: in 2010 there will be an additional payment for after hours care, regardless of the utilization results. Beginning in 2011, increased reimbursement will be tied to a change in ER utilization.	5%
Fee Schedule, bonus enhancements and volume enhancements:		25%
Shift of Services	Plan design changes currently under review expected to shift utilization to PCP offices	5%
Vaccine Administration	Increase in physician and flu clinic administration fees.	20%
		100%