

Working Group to Reinvent Medicaid
Thursday April 30, 2015
Department of Administration Conference Rooms A & B
2:00pm – 4:00pm
Meeting Minutes

I. Welcome

- a. Dennis Keefe, Co-Chair: Welcomes everyone, thanks the Governor for attending, asks her to speak.

- b. Governor Raimondo: I am here to briefly thank you all. Dennis, and Ira you have been amazing with your leadership. Everyone in this room- I realize that I may have picked the busiest people in RI and put a lot of work on your plate. Grateful that you rose to the challenge and you all stepped up. I could not be more pleased. I gave you guidelines and you made it better, instead of just cuts, you provided an idea to move away from just cuts to also incentivizing better care and earning back money. Behavioral health care ideas, key, high utilizer ideas, great thank you. I said from the beginning the state wants to pay for value not volume and moving us towards ACOs, and moving Medicaid away from Fee for Service, and the path you are presenting me today makes that a possibility. I gave you guidelines, you worked hard, and what you are presenting today is much better than where we started. Only bad news is the reward for hard work is more hard work: next phase of your work is due July 1, getting into real delivery system reform. I am very excited. I know this is hard, any cuts are hard. We are taking care of the most vulnerable, budgets are already strapped. Health care industry is changing –that’s a fact . We had a choice here in RI, we could stand still and not embrace the change and move forward, but we did not do that, we are going to cut costs and make way for the future. As the Governor, I don’t want to face a \$200m deficit every year. I hear from businesses that we want predictability, so everyone here in the health care industry, thank you for stepping up. I will put my budget amendment in next week, based upon brave work here. I am grateful, RI is grateful, this sets the foundation for more vibrant, more stable RI. Thank you.

- c. Dennis Keefe: Thank you, Governor, you are the inspiration for this effort, certainly a challenge in RI, but I appreciate coming from out of state that this is going on around the country. A lot of impact with the ACA, insurance contracts, how those are being paid, This is a unique effort to RI, underscore that this is happening around the country. The magnitude of challenges may be different state to state, but it’s a central issue. Other states that have done a great job in this area always have an engaged governor leading the process. Someone needs

to lead the process, and in my experience when the Governor does that you bring many important players to the table and end up with a good outcome. To fame what is happening today, report. We know that not every member of this group agrees with every initiative. But we have heard you and will continue to note your concerns and use it to lay a strong foundation for this reform. After this presentation we will invite the working group members to send any final comments to the staff tonight, to be included as an appendix to the report and noted in public record. In my experience there are always things to learn: here I learned that people working, particularly with Medicaid population, are advocates for their populations and I value that immensely. In some cases we learned that services are as fragmented as we thought. Once people set forth their position, I did see a willingness to work towards new options and a new vision. Another obvious point is incremental change is difficult, transformative change is incredibly challenging. All the change we talk about here is transformative. Really have to meet people where they are in order to truly move forward. Have to continually bring people back to the vision to achieve these goals. These are take aways I wanted to share today, very rewarding and I really do look forward this next phase.

- d. Ira Wilson: Not only interesting but very inspiring. The governor had the foresight to put together a group that was very diverse. Lots of people in the state very knowledgeable about these issues, a group that represented well, and grateful for the fact that everyone was generous enough to represent the people they always do, but then also step above that and step beyond that to think about how to change. This is a public process that I have not seen before, quite like this in RI, and one reason this can happen is that we build on a lot of existing strength, strong providers strong healthcare system. In the intermediate term we have to think about how to build the infrastructure, a bridge towards a different health care system. The governor has a lot of difficult choices to make and I hope we are contributing to that. The short-term cuts coupled with the long-term discussions we will have are smart, doable, sustainable things that can make a big difference.

II. **Presentation of the Preliminary Report: Secretary Roberts**

- Reiterate what Dennis Keefe said was that in addition to keeping notes and hearing what you have to say, if you as working group members have formal concerns or comments that you want to feel has been heard, you may submit in writing to be added as an appendix to the report.
- Secretary gave initial presentation on the process; Co-Chairs presented the slides on the recommendations.
- Presentation available on reinventingmedicaid.ri.gov

Comments from the Working Group on the recommendations:

- Regarding Recommendation #1

Maureen Maigret: On number one, we've seen targets related to Medicare, but does the Office of the Health Insurance Commissioner (OHIC) have input on the commercial targets?

Sam Salganik: Would like to piggy back on top of Maureen's comment that I believe there is a lot to learn and work to be done in collaboration with OHIC and other groups.

Linda Katz: From a process perspective, this is the first time we have seen these targets, haven't vetted these numbers, and may be better to discuss in our longer term discussion, just as Sam [Salganik] and OHIC say, that is something that we should all agree upon together.

Peter Andruszkiewicz: I agree, tremendous opportunity, not that different between how we pay for Medicaid, or commercial put all our efforts behind a single method for how we pay. BCBSRI is committed to essentially eliminating FFS by 2018.

Ira Wilson: In the high utilizer work stream we kept coming back to the idea of all payer models, and what we can do to coordinate in the state to be a role model for providers.

Regarding Recommendation #2

Peter Marino: Are payers at the table to talk about those metrics?

Dennis Keefe: I think so; we welcome the conversation – I think we are all beset by a myriad of metrics and indicators and any way we can be more transparent and work together we all would strongly support that.

John Simmons: How will the state handle FY17 year? Do you restore or give it back?

Dennis Keefe: Great question, one heard a few times, I think everything gets reset at the end of the fiscal year: see how hospitals did and open a whole new discussion when we see where we end in '16 and what the challenges are for '17. There is a leap of faith here, crossing budgetary years, and I get that.

Secretary Roberts: The plan is to drive the trend down, the metrics around appropriately lowering utilization. Actually we should meet that 5% target by managing utilization as well, and look at the coming year with an entirely different Medicaid number if what we are planning here

is effective. I think we will be using some of those dollars to drive change and adjust hospital spend.

Dennis Keefe: Modeled after value based purchasing program in Medicare, and in Medicare it restarts every year, look back at how successful look forward to new targets and always seek to improve.

Peter Marino: I agree that having a good incentive helps to move us all towards good change. On the right path.

Regarding Recommendation #3

Maureen Maigret: Because this will be done by cuts in FY16 I would ask that quality checks be put in nursing homes to ensure that quality in these homes remains as good as it has been.

Regarding Recommendation #5

Sam Salganik: Interesting, yet concerning proposal as provider groups are taking on more and more risk: I just have a million questions about how this would work if now the providers are fully at risk. I have submitted a letter to the Secretary already and will happily send it around to all.

Linda Katz: On a process note, this proposal was not vetted at any work stream meeting, and I would encourage this comes out, strongly.

Secretary Roberts: It is correct this is a late coming recommendation – this general approach was talked about but not with this particular dollar attached to it. We have discussed accountable entities what is the approach. These are all recommendations for the consideration, not for sure included by the Governor. This implementation phase will be a collaborative process as well, and our Managed Care Organizations are still our primary partners in our systems of care. We have two ACOs here now and BCBSRI is participating in an accountable entity, there are in fact protections as part of our managed care structure. You are correct many unanswered questions on how this would be created and moved, here as a proposal with an approach to take. The concept and approach was talked about, but yes I respect that the specific recommendation was a later add.

Linda Katz: I appreciate that and agree that the approach was heard, but I am concerned that the specific proposal was not allowed to be vetted.

Secretary Roberts: Putting a proposal like this out as organizations in the state may choose to participate. Look at piloting an accountable entity

in the state. This will be appended for the Governor's awareness of concerns in the state.

Maureen Maigret: I share the concerns, and I also question the ability to do this in the short term, with RFPs etc. I question if it should be on the short term list – not adverse to the idea- but concerned about its placement on the short term list.

Senator Miller: I have been present while this and many similar ideas have been presented and I think it is appropriate that this is proposed, but a watchdog to ensure the coordination and not denial of care is what will save money. I think this has been done and it can be done. Quality coordination is key.

Patrice Cooper (United): I feel this aligns a lot with the first proposal.

Peter Marino: Concerns about timelines on this one, I have also seen some proposals around this, aggressive proposals. Accounting for it as part of FY16 menu may be premature.

Elizabeth Burke Bryant: I wanted to say that there has been a lot of agreement that coordinated care at the provider level is very important to reform efforts. I circulated a memo on successful efforts to build up on, including the success of the RIte Care program and the work of the state to build up a Medicaid managed care program to build up quality and care for children and families. We need to have the time to really look at what is working well, build upon that for mechanics. Some of the language in here brings questions to my mind that Medicaid managed care role has played to sort it out and really embrace reform. I agree the timing is early.

Senator DiPalma: For each of these I know will come before Senate finance I will ask what are the assumptions for each of them. For example: timeline, do we need CMS approval, is there government agency involvement, etc. What kinds of investments need to be made? Corollary: what are the risks? Invest in community based services to keep people at home, if that investment isn't made it is a risk. The assumption is bolster community health. If that's not done it's a risk. Not for today, but when in hearings these will need to be asked. I want to help and support and answer what these are to claim success. What are the three to five key assumptions and key risks that have to be addresses to ensure achieving the savings there?

John Simmons: Does the office have the capacity to do the thirty some odd items here? Concern is if you put \$80m of recommendations all hinged on execution, you need the timelines, the estimates, the capacity.

One way or another we will need to answer these soon.

Secretary Roberts: In our work we have attempted to do this, though with this we may have been rosier than perhaps you all think we should have been. We are doing a work plan over the next 30 days to deliver on the items you touched upon.

Peter Andruszkiewicz: Another lens to place on this maybe what could be or should be piloted or tested, and then asses if the pilots are successful – for if we wait a whole year and then review for ‘16, and then start new ideas in ‘17 that could be wasteful – let’s try to phase in or feather in recommendations.

Dennis Keefe: All points very well taken.

Regarding Recommendation #6

Dale Klatzker: It’s nice to have a behavioral health in the top ten list, helpful to improve the care for this population, meet the various organizations in the state where they are for their current level of operation. I certainly support this.

Linda Katz: Nice to see some proposals developed when the waiver was renewed come to fruition here, the SOBRA proposals and health at homes, those were both initiatives that many people had worked on, and it is great to see them come up now and come to fruition.

Regarding Recommendation #9

John Kelley: On Recommendation #9, I want to ask if we are moving to getting out of CEDARRs? If we are, why not just do it all and be done with it? I am concerned about leaving a system that barely exists and creates more issues?

Secretary Roberts: You are correct that this is a sizeable cut, it is not as much in the spend for the services that they order; the intent is to get interested participants to specify how that would work, get that fully resolved.

Tom Kane: I agree with John [Kelly’s] statement on CEDARRs, and also it is very different for patients to get into PASS and I think that should be looked at as well. I think getting rid of that duplication can save money.

Regarding Recommendation #11

Chuck Jones: The incentive program represents revenue coming to

health centers, strict targets for quality, so going back to the conversation from the beginning of the meeting, tools or infrastructure sound like they are going back to the hospitals, has the potential to impact infrastructure that we could expand on. No problem with incentive programs, careful that a 5% cut for Medicaid revenue for orgs helping those will help

Regarding Recommendation #12

Dale Klatzker: On Recommendation #12, I think this is a great initiative, long overdue. My other comment is on #14, as senator miller knows we have been working on this for a while, I think this is a grand slam for the system, a difficult population, do a better job engaging and working with. One where we truly can save money.

Dennis Keefe: On Recommendation #12, I applaud the state for looking at this, and specifically Director Montanaro for taking this on. We have a number of patients at Butler who have been in their beds for over a year, and that is just one example. It is a significant problem; want to call that one out as an example of how working together we can fix things that affect member organizations in an effective way.

Regarding Recommendation #14

Senator Miller: Also on Recommendation #14, and including Recommendation #2, the hospitals may look at this as a point of investment to use as a structure, to help manage the readmissions of addictive populations.

Regarding Recommendation #15

Tom Kane: I know that needs more assessment, but incorporate telehealth and meeting people where they are, getting health to people are.

Elizabeth Lange: Building on the telehealth part and the fact that we have a strong PCMH movement in this state, I think somewhere it should be stated that incorporating telehealth into that would be very helpful

Linda Katz: I wanted to note that all have done a tremendous amount of work in a short time. We did acknowledge that both the system of care for kids in DCYF custody and the care for those with Developmental Disabilities have not been drawn into this whole process. Want to be sure we are doing the same data dives and thoughtful approaches to think about doing care there.

Director Montanaro: Not just looking at it, already working on it – part of a robust transformation in that system.

Linda Katz: Just think we should acknowledge in the report that is happening.

Secretary Roberts: And DCYF is engaged, not as ready yet as this. We are in active conversation with them around.

On Recommendation #16

Tom Kane: On Recommendation #16, is there any impact on timeliness of payments? And on Recommendation #16, where does that information go? It seems troubling if it goes to state and not to providers.

Bruce McIntyre: Sitting down tomorrow, actually, to really talk through how to best track the information. Want people to know that they won't be subject to post payment audits and move forward with a system to allow them to proceed with business.

Tom Kane: Also when show up at a home and no one there, how is that documented?

Bruce McIntyre: discussed having it through geo-tracking on a cell phone, one is voice recognition, others use geo-tracking, others use a transponder. We need to sit down with all those options and chose the route that makes the most sense.

Regarding Waste, Fraud and Abuse Generally

Senator DiPalma: Based on what other states have done, how might these in waste, fraud and abuse compare in savings? Have we looked at what other states have invested?

Bruce McIntyre: I am happy to respond, as head of Program Integrity for EOHHS. What we have attempted to do is conservatively estimate based on the experience of other states and there is a bit of a wild card and that is that we are on the forefront of doing the computer based analytics in this particular space. We have limited experience to draw data, close to Massachusetts and we are basing it on MA a bit.

Senator DiPalma: The AG's office has expanded its investigative ability within other states; maybe work with the AG's office to see what else could be done.

Bruce McIntyre: The AG has civil investigative authority so what we

wanted to do was move quickly to see where things stand and then turn that over to the AG.

On Recommendation #18

Linda Katz: Quick comment on Recommendation #18, I am glad to see this, yet want to comment the state should explore the feasibility. I think we should step back and say there are problems in terms of verification; not at provider fraud it is directed at consumers. WE have just built a system for HealthSourceRI to verify info – I don't think we should look to spend money where we do not know there is a problem.

Secretary Roberts : We as moved out the eligibility for the other services and programs we want to see if we want a service like what UHIP is doing now for other services.

Linda Katz: My point is let's figure out if it is needed, before we decide to just do it.

Hugh Hall: Regarding Recommendation #18 combined with Recommendation #26, I was pleased to hear that community eligibility is being looked at. In our world an application process can be four months to a year, I am happy to hear this would be 47 days. I would love to see some attention to the other side of that.

On Recommendation #20

Peter Marino: Regarding Recommendation #20, we look forward to having many conversations on this, and I would argue that NHP is a very strong organization on this and I think it will be a good discussion.

Patrice Cooper: I would just echo Peter's comment, we understand that all of us were asked to take cuts and we appreciate that, but we look forward to conversations.

On Recommendation #21

Peter Andruszkiewicz: On Recommendation #21, there is an implication that there is a savings, and I feel it is a misnomer: not a savings but rather an incremental fee paid by privately insured people in the state. Not coming out of anything it is being added to. Also on Recommendation #21 the legislature changed the way this was paid, one of the things that was criticized by the opponents of last year's legislation was that this might become a tree to put things on, and I feel it has become just that. We would suggest this comes off the list

Secretary Roberts: I was not here last year for the conversation on children's savings account, looking at children with unique health care needs which Medicaid ends up becoming the payer from. These are privately insured people that we are paying for their services, a means of moving it back. The balance is types of services not offered in the community.

On Recommendation #23

Tome Kane: Concern on Recommendation #23, eligibility, last paragraph on criteria in other New England states – other states not with the consent decree and I think there can be a problem with covering people in a federal lawsuit. When looking to other states realize some are still living in institutions whereas that may not be the case in RI. When doing a comparison, do so for the whole picture, not just the savings pieces.

On Recommendation #33

Sen DiPalma: I recognize the work of DCYF. I see Recommendation #33 and I realize that for the long term perspective what are we looking at from a DCYF perspective is group homes. Kids are getting the wrong services at the wrong time, etc. and part of that is due to the structure of group homes. I will put these in a note to you all. But clearly future savings

III. Next Steps:

There will be a budget article with the report, comments, a budget amendment submitted next week. We would like to reconvene these dates: May 18, June 1, and June 22 all at 4:00 – 6:00pm. To remind you what we are working on now is the broader picture of where we want to go and the strategies to get us there. It is where you will start to see some of the areas there, range of programs from Behavioral programs, hospital structures working effectively etc. Really work to have a plan to carry forward throughout the Governor's administration. We hope that you will be engaged in this process fully – we welcome people's participation in the work streams which goes back, does work, and brings them back to the larger conversation. We really value your participation. Today we have a hearing on articles 3, 4 and 5 on the upper payment limit for hospitals and one on nursing homes proposed cut. Two weeks from yesterday will be the budget hearing on this work. We had a favorable Caseload estimating conference this week.

-Maureen Maigret: The budget amendment offering next week, will it include legislative changes?

-Secretary Roberts: Yes, there will be statutory changes, proposals to modify impediments etc. Those can be very technical in nature and thus not vetted entirely here, all will be legislative

IV. **Public Comment**

- Work for a small medical provider in North Kingstown. Concern about cuts that not made by this committee but from last term. We feel these cuts will impact the people we provide services to. I brought data on this for review. Concern in particular about cuts to incontinence products, have thus come up with solution based on Minnesota state plans. The reason I bring it here today is that this type of cut would undermine your hopes of quality vs. quantity, and also you all are quite good at transparency.

-Are these next three meetings open to the public? And will the list of the new [recommendations] be on the website?

-Recommendations on the website tomorrow.

-Jim McNulty from consumer health advocates of RI: "There was an article series this week in the ProJo about a young woman who has been unable to receive satisfactory treatment in the system. The challenge will be the devil in the details of design. What I heard today is that many of these things will be addressed. I want to be sure that you know it will be tough and I will be there as you do. For every Katie Hart who gets an article spread there are at least 200 out there that we don't know about. Keep those people in mind."

Mike Cansalary, CEO of one of the four CEDARR centers in RI: "The cuts being discussed for CEDARRs are for one of the most established centers in RI. Problems of many stem from being a child I families accessing services. Having a third of a cut while others move toward community care model is concerning to me. Talking about over 1200 treatment plans a year, that is concerning. Having the boots on the ground care coordination away from these families is a big worry. Please take this into consideration."

-Bob Hague, owner of healthcare services partner with capitol network. "We have grown over the years capitol provides Medicaid services and skilled services to the Medicaid population. For eight years now we have not received a raise in our reimbursement rate, understandable. But next January we will have the business change to the ACA, which will require more coverage to employees. Reward us for keeping people over 28 hours per week – allow us to provide the pay and the coverage needed. RI has a small percentage of its Medicaid dollars going to home care, and a huge percentage. Weeks' worth of service 21 hours per week. Cost of a day and half in a nursing home in a week of home care. Better bang for buck keeping people at home. "

- Brandi, a CNA & owner of home care agency: "I would like the group to consider stepping outside the box a bit to look at other pieces of the puzzle to help guide and fix the overall situation. Many of our workers are

not only providers but also partakers, come to our agencies looking for a better life a way out of the systems, but they still need support from the systems. For day care support they have to work 30 hours a week and I cannot guarantee that for any client as I cannot afford to pay for internal staff work that is not done in the field. We will lose employees, we will have dissatisfied clients, missing clients, now in a hospital. The reimbursement rate needs to be considered, we need to move with the minimum wage raise. In addition, please consider that I believe it is important for each agency to be accountable for hours providing services, but I do not think the way to do that is to have the state or big brother over our shoulder through geo-tracking. As a nurse I work full time I go out, I am responsible for my 137 clients. I do not get paid for extra care visits for clients. Sometimes I am in and out in half an hour, some I am there two hours or longer. Home care agencies have to provide 1% of care as charity care. Add onto that tracking the aides, using check in system. The Electronic Medical Records we use now offer that, 10 cents per call, and that is almost \$2K per month that we cannot afford. We do supervisory visits. I think the responsibility lies with the agency, not the state. Work hard and I would not expect them to account for every second of where they are.”

V. Adjourn – Thank you