

Working Group to Reinvent Medicaid
Optional Working Session
Wednesday June 10, 2015
Meeting Notes

Attendees: Ira Wilson, Dennis Keefe, Kathleen Kelly, Matt Trimble, Rebecca Boss, John Andrews, Michael Varadian, Lenore Heeney, Nicholas Oliver, Matt Harvey, Linda Katz, Ian Noles for Holly Cekala, Mat Roland, Chuck Jones, Mark Proto, Rebecca Plonksy, Nancy Hermes, Sarah, Sam Marullo, Dale Klatzker, Secretary Roberts, Kathleen Patty, Garry Bliss, Diane Giarusso, Maria Montanaro.

- I. Welcome & Introductions. Dennis asked if Secretary Roberts could give any update on the general assembly budget process from the prior evening. Secretary noted that with the budget process last night, the bed tax for the nursing homes was removed, the hospital proposal remained, the rate adjustment is there with the incentive proposal. We have not had the chance to actually compare it yet. Children's health account was removed, the GME payment went back in; the estate recovery making sure that sheltering assets, most of that was removed from the proposal, somewhere there is language that we need to really dig into; otherwise looks much like we submitted. Additional language came out after 11pm last night. Budget likely go to the floor of the house next Tuesday, legislative pieces to move as well that impact our worlds. Dennis thanked her, and he and Ira turned to Director Montanaro to present on Behavioral Health.
- II. Integrating behavioral health initiatives - Director Montanaro
 - a. First will talk about work we have done in a behavioral health work group. They have focused on the seriously mentally ill folks. Folks who have a diagnosis of one of six conditions. They use the programs quite regularly; have chronic conditions that have them in and out of the hospital regularly, recovery dependent on how stable they can remain for a period of time. We are working on adjusting the health home initiatives aimed at this population, that provision was weak in certain areas, particularly primary care, and medical care. It did not provide integration with a model that would invest and reward those programs within the system that had produced them. Those were good enough reasons to try to reinvent the health home initiative. In addition, we weren't involving the managed care organizations, missing an aspect of data management, care management, where patients were, looking to use some of those management tools to provide better care. Community mental health centers have a long history treating the population, but have not been using the data to inform their models, and how their delivery system was delivering results. The idea was to bring them through the transformation experience. I use the analogy of a monopoly board: some are at "Go,"

others are rounding Pacific Avenue. CMHCs need an approach that meets them where they are and advances them forward according to the concepts of population based management. CMHCs are the correct source of primary care for this population. Normative PCPs are not the right place for them – for those who have lived or have experience with serious mental illness, who have stayed exclusively with that population, are still dying 25 years before their peers, are still over utilizing the system. In Iowa, overall in that population those using a PCP as their primary care, had not seen that person in over two years – a system full of fragmentation, quixotic eligibility rules, a gap environment. Most primary care docs are not trained in this, yet the CMHCs are designed for this but they need the right door. The program design has the right elements for that. What is the design?

The design, while still working on financial details, is on a deadline of September 1, 2015 come hell or high-water. We can do that, we have assignments, attribution, algorithms, a lot of this already done, and the population has been served for two years. Not going to have a lot of trouble with assignment, etc, they are known to us through their relationship with the health homes. We will start Sept 1. We are assessing our CMHC participants already known as health homes, and assess them at two levels: providers, level one; more integrated, mastered the functioning roles of a patient centered medical home, they are level two. They understand the vertical integration that will be required and the financial incentives that more forward. Right now we have identified one at level two, and that is the Providence Center. The goal is to build the others to get them to level two, and I would say within a year or two many will be moved from level one to level two. I.e. Gateway has integration functions but is not a vertical integration system, need programmatic development. Payment structures will be different between level one and level two. What these centers do well 10,000 adults not all at the same level of severity. They are the most complex, they are the most ill, and for most evidenced based models put into use in RI that we want to retain – ACT model for example. We built that into this model. In terms of payment at level one for ACT members, they will receive an ACT bundled rate. This allows CMHCs to do the right thing for those folks and not worry about encounters as much. For the remaining of the population in level one, we will go FFS for a lot of the other codes. We are always in FFS, for institutional care and that will remain. We do need to correct the FFS rates, we need to pay for what we should be valuing and those FFS interventions have a value and our pricing has not affected that.

We need outcome data, and are going to create incentives in the payment structure, a total amount not going up, perhaps a bit of a

withhold but an opportunity to earn beyond it. National core measures treating folks living with a mental illness, process measures, ensure that we are advancing the model. Once that model processes to level two, then there are bundles: not just ACT, but other bundles as well. To get the pay for performance incentive around shared savings, still have to get the outcome measures to qualify, then will receive a shared savings arrangement, a trend line, a bottom line, if can get over it, can share that savings with the plan. The state will take its savings upfront – reflected in the Reinventing Medicaid report; should be an opportunity for the plans. What I want you to remember is that it is not all about savings, but about wellness and allowing these folks to spend more time in productive, meaningful lives in the community. That is the mission of all – give better tools to get there in the community, and pair it with better medical care as well. That’s the long and short of the program. The work group will continue to meet, staff meets every week, starting to finalize rates, will kick off September 1.

b. Questions:

- i. Matt Trimble: On the bundle approach who would be the downward partners?

Director Montanaro: Anyone rendering behavioral health services. Substance abuse providers, Housing supports, peer support networks.

- ii. Matt Roland: Are there draft written guidelines?

Director Montanaro: Yes, we are using guidelines that mimic, but are a bit ahead, of guidelines for SAMSA. We can send them around, tweaking them, but can share them.

- iii. Ira Wilson: What is the geographic coverage of level one and level two around the state?

Director Montanaro: We have coverage statewide, so everyone is already assigned. Whether they are assigned to level one or level two, right now just the Providence Center at level two, so perhaps extended. The Providence Center has populations in the urban core but also throughout the state – it is not location based. What will happen is as CMHCs perform in this state perhaps as some do well patients may migrate toward those systems. You will see FQHCs getting involved that might change the topography and success also. There are health centers that are outperforming others who may

- iv. Ira Wilson: Do the payment bundles that you talk about are those the whole medical spend?

Director Montanaro: On shared savings it’s the whole spend. That is the entire spend. The ACT bundle follows the traditional ACT services which is behavioral health. The

bundled PMPM should be behavioral health, so this is what we can control. If we start beyond the span of what CMHCs can control they are easily frustrated. We may go beyond that some day, yet across the country we have not seen that yet. In Florida, Magellan has progressed a bit, but we need to start where we are and get going.

- v. Ira Wilson: Is there a glide-path towards more of an all payer approach?

Director Montanaro: They could do that tomorrow, but because we have NHPRI and United participating they may see the logic of the adoption on the commercial side. The reality is that if you are severely mentally ill, nine times out of ten you are on Medicaid.

Dennis Keefe: Sometimes I get held up on the terminology: seriously mentally ill and SPMI?

Director Montanaro: Yes they are two separate populations, qualified with different characteristics. I would argue it may serve them better to consider them as one population – talk about people living with an illness not “THE” illness. The labeling belies the principles of recovery in many cases – these are diagnoses easy to measure, cull from the claims data, it’s a broader group. ACT would never be appropriate as a model for all – ACT is really for the sickest of the sick. That is where the distinction should lie and what we are basing on.

- vi. Secretary Roberts: Where are we with data infrastructure?

1. Director Montanaro: Plans can really help here – what we found in Iowa with Magellan – as a managed care provider filled the gap. You need three basic things at point of care data that everywhere the person you are serving in the system is going. Without claims data you cannot get there. You need a portal; ask the plans to solve that process with us – can have a lot of tools and aggregation data, but need to be able to translate it to the front offices. Those are relatively new, some medical records can get us there, but I am talking about powerful data management. Need to be able to run reports on demand, see real time data, and be able to flag diabetics. All of our CMHCs have some kind of EMR, they have mostly bought EMRs designed for mental health practices and overall they are not very good for doing the things that we are talking about. If you try to evaluate them as meaningful use not very good. In practice transformation, we are hiring coaches. One of the biggest things that medical homes have to do is look at their data, it is important that they have the tools

they need and can solve that problem on their own and the coaching can help with that so they can all be able to manage the reports. Eventually they invest in better data tools, they partner for better data tools.

- vii. Mark Proto: What level of info are we providing to providers on level one to level two categorization?

Director Montanaro: We will be hiring the coaches, monitoring their progress, and information them where they are.

- viii. Chuck Jones: We are working on a pilot to put data management in front of care managers the next morning and happy to share that you, and talk about successes. The initial twist is that per consent rules, RIQI can act as middleman on coordination of care enrollment.

- 1. Director Montanaro: To be in this population and be served by this health home, you have to enroll in CurrentCare, thus consent to share all data. Everyone will be in, turn on capabilities.

Chuck Jones: Is it correct to assume level one is not eligible for shared savings?

Director Montanaro: Yes, will get data about populations cost of care, can go for incentives. Have to hold out a carrot; can you show performance measures, outcome measures. As soon as you start to bundle payments and put the theory in front of the practice, you can actually lock people out of care. Within a savings cycle you can do a lot of things. By level two they are so entrenched in doing the right thing that the bundle is just laid on top.

Chuck Jones: What is the intersection with the duals program?

Director Montanaro: They are in it – there are about four products that come through Medicaid and we have to stage their entry into this program. This will be part of the duals demonstration, because of the freedom of choice that we need to obtain, they will be in the last wave, likely spring of 2016. Along the way, people can opt in from any product.

- ix. Sam Salganik: You mentioned that providers can achieve savings in a payment cycle, what is the process for patients who suspect that?

Director Montanaro: They can be reported to BHDDH, and I believe the plans have that in as well. We will be working in partner with the plans, give providers a grade etc.

Dennis Keefe: I would recommend an IT and data work group for Behavioral Health. There is a proliferation of

portals out there, we get it. It is about coordination care management, but we want to ensure not working across goals.

Director Montanaro: Good idea, perhaps Chuck and Dale could help me get that group together.

- x. Secretary Roberts: Initially there were some policies in place in CurrentCare around the behavioral health population. Is that still the case? I think segregating a bunch of their information would be problematic as we move this forward.

Director Montanaro: Certainly worth exploring and delving into.

Dale Klatzker: As described to me, if we load our attributed client base into the system they can ping for us every hour if one of our patients shows up in an ER or hospital.

Director Montanaro: Don't underestimate the need for the basic data as well: Medical reconciliation, colonoscopy and mammography rates, etc. Much of the savings is on the medical side. What you really need to know at the CMHC is who is missing what in primary care.

III. Data and High Utilizers - Rick Jacobsen

Rick passed out documents on the medical cost structure and behavioral health data. (available on website)

- a. Ira Wilson: Doesn't mean that 82% of the cost are because of mental health disorders, just means that many high utilizers do have a mental health diagnosis.

Rick Jacobsen: Correct.

- b. Secretary Roberts: How many will fall into the population Director Montanaro talks about, and how many fall into where will we find them?

Rebecca Plonksy: We are not touching anyone with primary substance use, as involved in Opioid health homes and receiving other services.

Director Montanaro: There are a lot of other high utilizers, we have an approach for that group of high utilizers, what we need to do now is understand what are the multifocal interventions on the rest of the populations for whom health homes impact in the high utilizer populations. The engagement of primary care in the population for screening, diagnosing and following is the next evolution of PCMH activity. If not SPMI, if not going through the right door, then Primary care has to figure out how they are screening and assessing behavioral health conditions and then managing them.

- c. Looking at the numbers, ABD adults, is the 64.6% BH costs, and 225 total spend?

Rick Jacobsen: Not entirely, many other services are not in plan. It is a coincidence of the 64.6% but not entirely.

- d. Secretary Roberts: I am interested in our institutional settings how much behavioral health drives hospitalizations, unmet needs, how behavioral health impacts nursing homes etc.
Rick Jacobsen: We will come to that on a second handout (available on website)
- e. Dennis Keefe: Is this information on the handout current?
Rick Jacobsen: This is 2013 data.
Dennis Keefe: On the ACA, on inpatient side, huge changes, huge increases.
Rick Jacobsen: This doesn't touch expansion population.
- f. Ira Wilson: I also see the pharmacy numbers and am surprised at how low they are. Need better treatment for their medical problems – not only the medications these folks are on, and they are expensive. That number should go up not go down, if they obtain good, quality care.
Matthew Harvey: Net of rebates will also bring that number down.
Rick Jacobsen: The rebates on the FFS side have pushed down cost, on the managed care side rebate around 40.
Dennis Keefe: I have always assumed that pharmacy-spend on inpatient is difficult to pull out and segregate. These numbers are dispensed in a pharmacy.
- g. Ira Wilson: When looking at non-institutionalized population, a lot to be gained. What are thoughts in savings on that side?
- i. Director Montanaro: Yes, I think that's a good comment and leads to other reductions in BHDDH. Moving folks in institutional based settings to community based settings. We have folks that are sitting in institutional care, some in critical care, waiting to step down to Eleanor Slater (ESH), who cannot do so do to a hold not to hit the IMD trip wire that we hope would be struck but won't for a while. We can only have less than 50% of our population in psych beds. CMS Proposed regulations yesterday came out nationally around managed care and IMD specific, needs to be analyzed. The point is we cannot take them at ESH due to limited psych beds. Even more importantly on any given day we have 15-20 folks moved out of ESH, but there are no group home beds. We do not need more group home beds we need more supportive residential services. We do not have halfway houses, recovery houses; we don't have rehabilitation services in home based services. Instead we have a critical hospital; we need to also get supportive housing. Not primarily looking at Medicaid money, RI had a failed policy over the past decade of reducing state spend, keeping safe in the community, focusing on everything being a Medicaid match. We need to look at the state – where do we save money when we invest in housing and homelessness reduction. Need a visionary strategy to do that.

Part of what we can control is a reformation of ESH. Supportive housing is more difficulty. Issue of corrections also. When Dale mentions stability in the community, it is not just length of stays in the hospital, but also letting people fall through the cracks in the judicial system in the corrections system. Part of what we will need to focus on is a concerted approach to dealing with these issues. Things we can do within the construct of our Medicaid program, but a lot outside we need to do.

- h. Matt Trimble: Didn't mention nursing home, but with the population you speak of what percentage do you see in nursing homes?

Rick Jacobsen: See this distribution of duals doc (available on website). About 30K, 31K of these folks in long term care settings in the groups depicted here. Obviously a lot of people with a behavioral health co-morbidity, but smaller in the community. In the long term care group, that shifts, better than a 2:1 ratio in the LTC setting of people with behavioral health co-morbidity, dementia falls into that also. We do a better job of being able to support people with physical regressive ADL issues, until the behavioral health issue begins to appear.

Matt Trimble: When look at other population have 8K adults, how many would move into the hospice nursing home population. What can we do now to delay that?

Rick Jacobsen: One of the ways looked at ICI, what percent over the course of three years migrate to long term services and support, or into nursing homes. What percent receiving waiver services are in nursing homes, and what percent return to the community? We want to increase the number into the community and slow the progression into the nursing homes. The numbers of people returning to community from LTC is about 0.5%; when looking at ICI we want to slow progression in, and increase ability to move successfully out. Behavioral health supports are a big part of that.

- i. Ira Wilson: I think the same issues in institutional populations exist that perhaps medical issues are not being cared for, as we mentioned with the behavioral health population.

Director Montanaro: I cannot comment to what is outside what we are doing, keep a focus on that; as generalized population of folks living with a serious mental illness, but may move into an institution if, for example, their diabetes was not well managed and they had to amputate a foot. The one thing we haven't talk about today is the profound impact that substance use disorders pays on this whole discussion – really the lack of the key components in delivery in thee state. 80% of high utilizers have a behavioral health condition, it is important to tease out how

much is substance use disorder and what services are being used there.

Dale Klatzker: Also, why we shouldn't let substance use resources sit outside for too long. Clearly an adequacy of financing, separate from the CMHC.

Director Montanaro: For the really, seriously, chronically using folks, it is working. For the broader population, more concern. Need to cull out what is going on with substance use disorder – heroin addicts; if they are unable to function we tag them. We don't get to others with a substance use disorder, being managed as a population, the focus has to be in primary care; for those who have a co-occurring behavioral health condition, but primarily shows medical issues – we need to look at that.

Secretary Roberts: This is one area in which an all-payer approach could be really useful. We should also think about young adults on parents' insurance, number of issues in substance use and behavioral health that are inside coverage, but will pop out at age 26.

Dennis Keefe: The dollars are here for substance abuse, don't want to change the wrong priorities.

IV. Public Comment – No additional comment offered at this time.

V. Adjourn – Meeting concluded at 9am.

Dennis Keefe: In many ways these are old conversations, but also new conversations around old topics.

Secretary Roberts: Finally seeing discussion around the provider community. That there are categories of providers here that don't know one another and we need to break that down.

Director Montanaro: How do we get to those other issues is a real discussion. Principles are very important, primary care is the next transformational pathway, and pain management as well. At the mental health summit on Monday we really saw a large primary care practice serving 145K patients make a transformation in prescribing opioids for chronic pain. We need to get that transformation in our community. Incentives and protocols that drive PCMH adoption in those issues