

Hospital Incentive Program
Stakeholder Advisory Group
Friday August 14, 2015
9:00am – 10:00am
Meeting Notes

Attendees: Deidre Gifford, Bill McQuade EOHHS, Larry Ross EOHHS, Dr. Ted Long, DOH, Craig O'Connor NHP, Rich Glucksman, BCBSRI, Christina Grande, Housing Works, Laretta Converse Senate Finance, Mike Souza, Mark Adelman Lifespan, Rosa Baier, Brown, Dave Ragosta Charter Care, Debbie Morales EOHHS, Kathy Calandra Healthcentric Advisors, Dominic Delmonico Care NE, Matthew Harvey EOHHS, Raymond Powrie, Care NE, David Dillon Care NE

- I. Call to order – Deidre Gifford calls the meeting to order, welcomes members, explains the charge of this stakeholder group

Background:

The Reinventing Medicaid Act of 2015 authorizes the Secretary of the Executive Office of Health & Human Services to develop a hospital incentive program. As per Article 5 of the FY2016 Budget,

40-8-13.5. Hospital Incentive Program (HIP). – The secretary of the executive office of health and human services is authorized to seek the federal authorities required to implement a hospital incentive program (HIP). The HIP shall provide the participating licensed hospitals the ability to obtain certain payments for achieving performance goals established by the secretary. HIP payments shall commence no earlier than July 1, 2016.

<http://webserver.rilin.state.ri.us/PublicLaws/law15/law15141-05.htm>

Role of the Stakeholder Advisory Group:

The Hospital Incentive Program (HIP) Stakeholder Advisory Group will be convened by EOHHS to provide input and feedback to the Secretary on the development and implementation of the program. Members will be asked to provide comment on:

Which measures to be included in the program

The baseline and performance thresholds for the measures

The methods for calculating how incentives would be earned

Membership:

The Advisory Group will include representatives from hospitals and the hospital association; consumer representative(s); technical experts, and the State. Other stakeholders, such as health plans and other provider groups, will be invited as appropriate. Membership is not by formal appointment, and all meetings are open to the public.

Introductions are made around the table.

II. Charge Questions:

Rich Glucksman: I wanted to see if there was any insight or thoughts you can share on how this group is aligning its measures and goals with all the other activities the state is doing, OHIC, SIM etc.?

Deidre Gifford: Yes, and you will see discussion of that in the slide deck here.

Craig O'Connor: CMS has come out with new Medicaid managed care regulations, a lot in there around quality measures, also keeping that in mind in terms of alignment might be helpful.

Deidre Gifford: Yes, and Debbie is our quality person for the Medicaid program and our font of knowledge of what we are measuring for HEDIS etc. and will help to remind us all of that.

III. Presentation on origin of group, explanation, and initial potential measures for consideration. (Slides available upon request via email to lauren.lapolla@ohhs.ri.gov)

Discussion

Craig O'Connor: Using the phrase alternative payment model, how broadly is that defined?

Deidre Gifford: One of our early jobs in this group is to give definition to some of these terms, we know that other's besides us will be doing that, particularly CMS, and OHIC has done work around this as well, so want to align those definitions

Mark Adelman: Backing up, it seems as though we have jumped into DSRIP, and I know that originally the state was looking to do "DSRIP-lite," now seems this needs to be developed by CMS. Other states have done lists of other projects in order to meet the metrics of other projects – are we doing something along the lines of what is happening in NY & NJ? Are we starting with goals and measures and then backing into projects? I want to understand.

Deidre Gifford: DSRIP is delivery system reform incentive program, a type of 1115 Waiver that certain states have gotten from the feds to do some innovative payment strategies. It is our intention that RI will apply for a DSRIP waiver and we have been in conversations w CMS about that. We envision that the Hospital Incentive Program (HIP) and the Nursing

Facility Incentive Program (NFIP) would be a part of the DSRIP request. We are in measurement right now because we will need to measure achievement and distribute current incentives at the beginning of next fiscal year assuming that we have an appropriation to do so. We have been told by CMS that optimistically to have a DSRIP waiver approved takes 6-9 months, assuming that they like the concept and there is not a lot of back and forth about the content. We are optimistic about that, several conversations about that in CMS with higher up folks, and they have given an initial nod to the approach that we are taking. But, we have to think about this in the larger context of a DSRIP, which wouldn't just be these two incentive programs, and they have been clear about that.

Mark Adelman: NY's DSRIP is funded by the reforms of Medicaid and their system, are you saying the potential for our DSRIP is larger than \$30million?

Matt Harvey: What we are talking about here will be one component of a larger program that we will need to come up with a way to fund in total. We have a way to fund this program thanks to General Assembly, but will need federal match etc. We know we have a fairly direct charge from the Governor and Secretary to get this project off the ground, we have a funding path, and we have buy in from stakeholders. The overall DSRIP strategy will include this.

Deidre Gifford: DSRIP is not synonymous with the HIP, rather HIP is a subpart of DSRIP. CMS has been very clear that they want to see the measures and the incentives in our DSRIP waiver be tied to true delivery system reform and the way care is delivered. That is our challenge.

Craig O'Connor: My understanding of DSRIP is essentially the state proposes a way to have savings in Medicaid program to find the money to fund the DSRIP activities...

Deidre Gifford: No. To the extent the 1115 waiver has to be budget neutral yes, but not an invisible source of federal dollars, we need to have funding in state. To the extent that there are new federal investments it has to be budget neutral.

Mark Adelman: Have we given CMS an idea of the size of our DSRIP?

Matt Harvey: We haven't talked about that yet; the clear direction we have gotten is not so much about the amount of money, but rather the size of it; likely as the scale of RI will not be a back breaker for CMS. They want to be sure they can do it to sustain the transformative change of these programs.

Deidre Gifford: As we think about how to advise the Secretary on this process, we need to really think about metrics in this process, to result in measurable outcomes for our members. The challenge for us is the timeframe to put this HIP together.

Domenic Delmonico: Given the public health aspect of this, it would be

good if there was a goal that was tied back to that. Started to do a community health needs assessment, which makes sense. Are there boundaries to using that? Also, in thinking about Department of Health goals, are there particular pockets of public health concerns that should also be factored into these measures so that it doesn't drive it the wrong way. Do you have a sense from the leadership about particular health pockets of high priority to look to?

Deidre Gifford: Yes, the second slide that discusses the goals, high cost high need members, often called super utilizers, etc., that is a focus in that goal. That is the 7% of the Medicaid pop driving the cost. Also for behavioral health & substance abuse disorders is a focus, and aligning with our dual SIM work, hospital care, specialty and primary care, long term care also.

Domenic Delmonico: If you talk to public health folks, you hear calls to help the public through things like smoking cessation programs and pediatric care. Is that too broad?

Deidre Gifford: Not at all but more within DSRIP writ large. It may not be to scale in this particular subpart of DSRIP.

Domenic Delmonico: The HIP sets an artificial boundary of how far those goals can go if it is just a hospital program.

Matt Harvey: Yes in this room, but not overall. And you can make recommendations to include hospital based public health goals.

Mike Souza: This is just the HIP, but we are also aware that NFIP is underway, will there be an alignment between those two?

Matt Harvey: We are convening a similar advisory group for the NFIP, and I am not sure whether we have intentionally cross-pollinated membership of those two groups, but both membership is open, and members should be pushed in both direction.

Deidre Gifford: And if it seems like that would be a good idea to have a joint meeting, we are open to any and all ideas about process. The most chance of getting real movement is through alignment, and thus we count on you to share with us.

Rich Glucksman: On that point of alignment I am here to think about how commercial payers align with this work so that providers aren't being so different. A question, as you seem to focus a lot of FY17, what is the year in concern here?

Deidre Gifford: 1115 are typically five-year programs. There is a SIM measure alignment work group, I think the numbers to establish and track our progress will be a part of SIM alignment, and I would imagine that some of that will be relevant to DSRIP. To the extent what other states have done is establish structural milestones, those would not be part of the same type of things we are used to, rather unique to our DSRIP.

Mark Adelman: Is the timeline budget focused?

Deidre Gifford: We look at that 6-9 month approval process with CMS, and our goal is to have our DSRIP waiver approved by the end of our fiscal year, and this is marching back from that goal.

Matt Harvey: And this program envisions that the first payment would be made first quarter fiscal year '17 - that is a consideration.

Mark Adelman: Do you view the process as requiring organizations and entities to partner up?

Deidre Gifford: Yes, in service to those goals in the final Reinventing Medicaid report, that is a vision. We released yesterday an RFI on Accountable Entities for DOA, but if you didn't see it we can get you the link, and invite all of you to send us comments or questions. It can be found on the RI purchasing website.

Domenic Delmonico: We all have heard that 5% use 50% adage, etc. From a longer term view that may not have the return we are looking for initially, such as pediatric care and engagement, will help significantly in the long term.

Ted Long: I know one of the challenges with measure development is there are a lot of ways to put them together. On one side you have public health influences thinking of what to do, on others, what has been vigorously tested and proven. There are good lists out there on hospital quality measures that have been risk standardized by academic groups, and are helpful to think through. When we do measure development, we look at those at national organizations, we look at outcomes that are creative, but we know that we are not innovating. Keep in mind there are helpful brainstorming resources to think through possible measures that may not be innovative, but rather inspiring.

Mark Adelman: On the SIM alignment question, if their subcommittee on alignment measures is meeting, would we be branching out from those measures? Trying to figure out how this all fits.

Deidre Gifford: To an extent "we are they and they are we," as some of us cross pollinate all of those committees. I do not know if anyone here is on SIM alignment measurement group, (yes), I think we are covered in that way. I think given both the timeframe and the focus of the HIP, it merits a separate discussion outside of the SIM measure alignment, as they don't have the exact same focus and charge. You are right that we do not want to have, say, a 30 day readmission measure for SIM and a 70 day Readmission measure for HIP, but I do think that this group and these measures will have some weight in addition to those developed by the SIM group.

Raymond Prowie: I think it behooves us to not pick anything too radical,

predictable to see what is in the core of the SIM group; I am less worried about that. Just be conscious.

Craig O'Connor: I am thinking about things that Domenic Delmonico said, as related to public health outcomes, early interventions, rising risk patients that may not have an immediate financial impact, but are deeply valuable. Some of the potential performance measures are quantifiable, some less so, of the latter those can be among the most valuable. Want to think about how to put those into a plan to prove that we are improving the system.

Matt Harvey: Whatever measures we put forward as part of HIP and DSRIP in general, will be short term savings to fund it, and long term things to transform the system. We cannot let the need be the enemy of the good. Directionally correct is key, and the plan has to carry us through the length of the five year waiver, and always a chance to review and revise. Don't want to have a narrow 15 month cost return only thought, but cannot exclude those. Need to put measures across the spectrum.

Deidre Gifford: The conversations as this program is being developed that to a large extent would offset the reinvestment. Will need to be able to tell a story with the measures we select, to the extent it justifies the reinvestment of the \$31m back into the system.

Rich Glucksman: Is there risk or intent that things stack up to multiply the dollar effect, or risk that feds feel they are paying for the same thing in two separate buckets and they pull back? Are we positive it's synergistic and in a negative a legal risk.

Deidre Gifford: As you may know, the dollar allocation for the SIM has not yet been decided. A population health plan will be developed and the steering committee will be advising how the budget for SIM will be spent. And that won't happen until after this process is complete. That population health plan will be done this year and the budget will be established based on the results of that plan. Lots of opportunity to coordinate and not duplicate.

Domenic Delmonico: For a few years with insurers we have worked to negotiate what the measures are, a challenge is that Medicaid pays below cost for a lot of what we are doing. The fact is we want to make some money back here too. A challenge to meet is to scale targets between stretch and achievable. For us achieving back a fair amount of that reduction is key, and we can say changing how we deliver care we may get some back, but that tension between setting targets that are achievable and stretch targets that represent disruption, we will need to determine that balance. No one in this room as too much money, and we will need to figure that out. Want the targets to be aggressive, to push us, but want to be realistic in our needs.

Deidre Gifford: We hear you, and our challenge is to convince CMS that is

not what we are doing with this program, cannot be a complete restoration of funds.

Domenic Delmonico: Oh and I get that, and we wouldn't want that either. Just need to talk balance.

Matt Harvey: One of the opportunities of DSRIP is to pay out on milestones; we can set some aggressive metrics that are probably readily achievable and that we can for the first time attach a dollar amount to.

Ted Long: The NQF perspective is a representation of the quality, performance, and feasibility. If you have an idea that seems good you need to be sure it is feasible. May be useful to keep the criteria of NQF in mind when considering creation of metrics.

Raymond Prowrie: We are not interested only in things that are easy wins, but we do want to create change that is achievable. Things that we both have interest in making happen for the people we serve. Things like improvement and maintenance are different concepts. Emergency room visits, and healthcare acquired infections are major drivers and I would like to talk about those too.

Kathy Calandra: there is also potential that there are things in place that you haven't been awarded for – things you may want to highlight and include in this program for benefit.

- IV. Public Comment: No additional comment provided at this time.
- V. Adjourn – We would like to proceed by soliciting from you all in structured categories some measures, put together into a candidate list for review with some sort of scoring in terms of feasibility, and get it out prior to the next meeting in September, and use the next meeting to review those.