

Nursing Home Incentive Program  
Stakeholder Advisory Group  
Thursday August 27, 2015  
9:30am – West Wing Conference Room

Deidre Gifford, Hugh Hall, Joan Kwiatkowski, Matt Trimble, Rosa Baier, Jim Nyberg, Lonchaim, Akshay Talwar, Michael McMahon, Virginia Burke, Tanesha Richards, Darren McDonald, Emmanuel Falck, Lauren Lapolla, Matthew Harvey, J Richard

- I. Welcome – Deidre Gifford welcomed members to this open public meeting, and thanked everyone for their time. Introductions were made around the table (see attendees).
- II. Charge of the Nursing Facility Incentive Program Stakeholder Advisory Group

Background:

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

*40-8-19.2. Nursing Facility Incentive Program (NFIP). -- The secretary of the executive office of health and human services is authorized to seek the federal authority required to implement a nursing facility incentive program (NFIP). The NFIP shall provide the participating licensed nursing facilities the ability to obtain certain payments for achieving performance goals established by the secretary. NFIP payments shall commence no earlier than July 1, 2016*

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

Role of the Stakeholder Advisory Group:

The Nursing Facility Incentive Program (NFIP) 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 nursing facilities and their associations; 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.

Meetings: The Advisory Group will meet at least monthly from August through December, 2015. Meetings will be open to the public.

Deidre asked if everyone was comfortable with the group charge, and with no objection, the group moved forward.

- III. Nursing Facility Incentive Program – An Overview (Presentation slides reviewed. Slides available by request via email to [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov))

### **Discussion, Comments, Questions**

Deidre discusses CMS approval timeline, encourages quick movement to get information to CMS.

Hugh Hall: On slide 8, is 6-9 months a real number?

Deidre Gifford: We are planning to get this approved through the CMS rubric for DSRIP. DSRIP is a way other states have approved to make payments to providers to support their transformation to more value and integrated based delivery systems. CA, TX, NJ, MA, NY all have these programs in place, the state that comes the closest to what they are willing to approve is NY, and NY's waiver negotiation took two years. We think we can profit from that, as they have already broken the ground, and we can hopefully follow suit for a more expedient timeline. The 6-9 month timeline came from CMS, based on our generic proposal and following the NY model. That being said, negotiations with CMS can take odd twists and turns, but on the DSRIP at the highest levels in CMS they are aware this is a priority for RI and are looking for this so far. We have had three conversations with them about this already, they have seen one concept paper on this. We owe them a second concept paper, which will include more information about this incentive program. They have been clear they want to see incentive programs in DSRIP that lead to true delivery system transformation. In NY, in order to get DSRIP funding you need to apply as a PPS, and the PPS is aggregations of providers who provide Medicaid care to members. Those PPS in NY are all different, not all the same aggregations of provider types. They are provider systems that apply and that is the path that we also see RI having the best chance for approval for. We would envision some type of accountable entity, that those would be the entities that are eligible to receive DSRIP funds.

Virginia Burke: An individual facility would not be eligible for an incentive unless belong to one of these providers?

Deidre Gifford: Interesting question. We see this NFIP as a subset of the larger DSRIP concept. DSRIP does not equal this incentive program. How the incentive program would fit in with this concept we need to talk through, as a part of this group. We also have an RFI in purchasing now that talks about AE, and we invite you all to look at. A good point and we need to work that through.

Joan Kwiatkowski: Is acuity related to quality in some way? Are you adjusting for acuity, or is acuity part of the definition when you consider quality or values?

Deidre Gifford: There is a very rigorous debate in the quality measurement world about how to account for acuity social determinants. There are vigorous proponents of doing so and not doing so. This group may want to take up that question, or not.

Rosa Baier: I would agree with that, and it depends on the measures.

Joan Kwiatkowski: Many of the payment methodologies these days are based on risk scores to clients, so just going with that theme, is there a way that that fits into this profile as well? In addition, on slide 4, the alternative payment models, is there a requirement for risk erring in the regulations?

Deidre Gifford: Yes & no. We haven't yet made a decision for how to measure this. Need to see if meeting that 50% goal, but also may start at the other end of the spectrum.

Virginia Burke: I hate to be the skunk at the picnic, but this is a quality incentive being funded by rate cuts across the industry. There will be savings from the 2% this year, and some or all will be used to fund quality incentives next year, but then there will be cuts the following year to fund the future and so on. I have many who are financially tight already in my group and there will be push back from the industry. I don't want to fight another battle at the State House to protect existing facilities. That impact needs to be a factor.

Deidre Gifford: I would ask if there are ways to construct performance incentives to address those concerns? How would members see structuring the incentive program to both meet the goals that we have just reviewed and also to address concerns?

Virginia Burke: If we had a number of ways to get there – like the Georgia model or the Illinois model with an overall report card, then everyone has a shot at it. That is my overall notion.

Deidre Gifford: That makes sense, maybe you could share those two state models as things to look at in a future meeting.

Matthew Harvey: It is fair to say that our goal is also to come up with incentives that are achievable, and that drive the program in the direction we want it to go. We don't want to set the bar so high that all shrug shoulders at it. Also may look at measures that ramp up over time, and

build on progressive successes.

Deidre Gifford: Should be a variety of measures in different categories so that the strength of facilities can be demonstrated if they perform well in one place instead of another.

Akshay Talwar: You utilize the term “value based care.” Since we have not made the full transition in facilities as they exist right now, there is a value based system that low reimbursed systems are providing higher value to the state as a starting point. The state should not put those homes at peril or jeopardy.

Deidre Gifford: I think what we are missing in our payment methodology right now is a quality piece. Typically when you talk about a value based purchasing scheme it has both cost, quality and member satisfaction, and that is what we are talking about adding in.

Akshay Talwar: Right but somehow in that calculation consider what those facilities are being reimbursed right now as you are getting value for your money.

Virginia Burke: It would also be well received if we make a point that the 2% cut year after year would only go to this incentive program again, and not to general revenue.

Matthew Harvey: That is how it is designed - of course dependent upon the General Assembly not adjusting in future years. The size of the pool is about \$16-17 million to be eligible to be earned by facilities by the metrics designed here.

Deidre Gifford: There is an assumption that the measures will be tied in some way to achieving those savings.

Virginia Burke: We may not capture it all in the first year, and so what we don't capture, I feel should go towards the next year's incentive pool rather than general revenue.

Matthew Harvey: That is hard to do in state budgeting.

Deidre Gifford: I hear you asking for not making this a one-off program, but rather to establish a more sustained and predictable program. I think the DSRIP is the strategy that we can think about to do that. The opportunity to have a more defined structure for earning these types of incentives over a five year period of the DSRIP. We may want to think about a two phase recommendation. Immediate term recommendation we need to jump start and get in place, but must be aligned with this overall incentive program. Those metrics need to be a combo of population health goals, regular delivery system performance, and milestones in achieving delivery system transformation that are measurable and able to be evaluated.

Joan Kwiatkowski: Within the DSRIP program, some of the \$2million could go towards population specific models?

Deidre Gifford: Not only does it allow for it, it somewhat insists on it. If

we align incentives between Nursing Facilities & hospitals that is a huge win.

Matthew Harvey: Want to be sure NFIP stakeholders & HIP Stakeholders align. Further down the road we will reach out and schedule that joint meeting.

Draft document from Leading Age to get thoughts and ideas of Measures to consider was discussed with the group. To request a copy of this document, please email [lauren.lapolla@ohhs.ri.gov](mailto:lauren.lapolla@ohhs.ri.gov)

Akshay Talwar: Already taken into account hours thus far. Increasing staffing hours for a low cost home may be not possible – a high cost home could do that. I don't think you can say a measure of RN hours will be a metric.

Virginia Burke: Or pay everyone the same rate, or not increased staffing but rather staffing stability.

Joan Kwiatkowski: Is your hope that we raise potential indicators and then throw them out as determined as too hard. What's the process?

Deidre Gifford: We thought that for September we would come up with a candidate list of measures. Get comments on a draft set of measures, get a baseline performance.

Matt Trimble: I think the industry is familiar with quality measures out there, but I am curious from the states perspective - are there quality measures you can derive from the Medicaid claims?

Deidre Gifford: Yes. We have a mixture of Medicare and Medicaid members, and so what we get from Medicare is not as great as we would like it to be, and just embarking on this duals demonstration. Early in that process of getting a richer Medicare data set with our Medicaid data set. If it is a Medicaid-only benefit, then yes can calculate the data. But for the members you serve, the Medicaid only data is the Nursing Facility payment, but not the value components. We would need to use an MDS measure to provide a report on say readmissions, where as there are others that you are more used to seeing. On the quality and clinical side, rely more on the quality.

Matt Trimble: Thinking in terms of claims system can you tell when a Medicaid beneficiary gets hospitalized?

Rosa Baier: What about APCD?

Deidre Gifford: Right now, in this moment, in the next six months, we don't have that ability to put the data into action.

Matt Trimble: Need to consider measures that are self-reported and unaudited.

Deidre Gifford: That might want to be a recommendation from this group

or to have an audit function on these measures. But the NY application as it was, was 300 pages. I think CMS is focused that these measures need to increase delivery system transformation and how we document is key.

Deidre Gifford: Back in 1998 we talked about a continuity of care document at Healthcentric. Talked about everyone going back and forth, having issues etc. Twenty years later, here we are and still working on that. Everyone knows that communication around nursing facility & hospital transitions is critical to a safe and effective transition. If what we need is to put incentive dollars on the table to fix that problem, then let's work with this group and the hospitals to try to fix this. Just an example of something we can measure, and incentivize.

Matthew Harvey: If going after DSRIP we need to hook these to the delivery system transformation.

Deidre Gifford: Right, but think of this as an opportunity. Think about things that drive you nuts about the delivery system that are barriers to your delivery of care across the system the way you would like to. Another thing we have discussed is broadening the spectrum of things available to our members, interim levels of care, how might we incentivize that, is it home care agencies, is it primary care provider groups, etc. and how to build that.

Matthew Harvey: The DSRIP opportunity is that we can pay you to make structural changes. We have all these parts of the system that we need to operate, so from the nursing facility perspective, what do we need them to do different, what do you need to do differently?

Hugh Hall: On a personal level, the outliers – i.e. the re-hospitalization. Recently presented with a person ready to be discharged from a hospital, looking for a transition, and was terminal. The patient had four different palliative care discussions, but continued to want everything done. How do we reach them, how does that effect an individual home's performance if that person is in and out, being re-hospitalized. May not be a big percentage but one I believe we need to consider.

Joan Kwiatkowski: Indicators, and what are the unintended consequences that the indicator may create, the whole infrastructure that this model presents. Is it audit by on demand, is it periodic, can you lose an incentive if numbers to match. Does DSRIP provide that structure?

Deidre Gifford: DSRIP is a concept, but not a structure. In quality measurement writ large, always an exception that doesn't quite fit. The measures are never perfect, but designed globally. The cherry picking or withholding of care issue is the reason managed care of the 80s faded. The going theory on why this is different is now we are better at measuring. Have this concept of the triple aim, so we have progressed in

theory. Making it real and making sure not rewarding that type of behavior is a challenge.

Matt Trimble: You are talking about systems that have been developed around managed care. A piece lost is the Medicaid systems haven't really progressed in measuring. An ACO for a Medicare population is different from an ACO for a Medicaid population. That is a challenge.

Deidre Gifford: I agree we are behind in Medicaid, CMS is pushing the states to change that, we now know the quality of care in managed care. Medicaid nursing home quality measurement is well behind the rest of the industry. Not saying you are under-measured, but there are few Medicaid programs that have focused on that.

Matt Trimble: Some organizations measure based on full time employees, some include per diem staff, and it is not standardized.

J Richard: On the spirit of it, our facility is large enough to use a pool or not, and op not to. We have a bevy of folks that we pick up for a few days, but that staff is high turnover because we cannot offer them consistent employment, so that impacts that.

Deidre Gifford: What about consistent assignment?

Jim Nyberg: It is a complicated calculation.

Akshay Talwar: Everyone does consistent assignments, but the problem is that people who did not use pool, we tried to use self-employment, etc. Those who did not have temp employees were penalized in the calculation. A better measure may be not just the line staff, but supervisor staff as well. There is talk in literature now of trying to measure a couple of things, but including a measure for key supervisory folks also.

Rosa Baier: For anti-psychotics, is this something you are seeing as an issue with folks returning from hospitals?

Hugh Hall: Short term.

Matt Trimble: At times when we readmit from the community they can be loaded with anti-psychotics.

Rosa Baier: I have heard much about folks with traumatic brain injury, and RI Hospital has issues with that because the patients are then loaded with anti-psychotic medications.

Deidre Gifford: To that point, do you have a group of providers in the community that refer to you?

Matt Trimble: On short term rehab there is a core group, not on long term.

Joan Kwiatkowski: The anti-psychotic will impact the setting and the treatment process.

Deidre Gifford: Since it's a long stay measure, they don't get into your denominator till 90 days?

Matt Trimble: We are all on the same measure on the same playing field

that is fair.

Akshay Talwar: I think a difference between short term rehab, and long term dementia units. I think it should be risk or acuity adjusted.

Rosa Baier: This may be more to the hospital group then.

J Richard: I want to return to Hugh's comment regarding acute case setting readmissions. My observation with short stay populations is that you will see this more often. These are families who are not emotionally ready, and thus may be a higher risk for re-hospitalization. Many things that can be provided in the setting to proactively manage in place, but risk is higher no matter how you slice it. I think that is getting to be three or four out of ten. Some hospitals are better at having the treatment conversation vs. end of life conversations, you inherit it, but whether you have a smaller short stay unit or larger skews that number.

Joan Kwiatkowski: That goes back to the outlier conversation: will the incentive program have some measure of opportunity for homes that have a higher degree of that indicator, whatever the indicator may be? Going back to structure, will there be opportunity to appeal?

Virginia Burke: I am wondering what home health agencies would ask of us, as we have things to say about hospitals.

Deidre Gifford: That is a good idea. Want to think on our end to put measures on a hospital incentive list that would facilitate doing a better job, and vice versa to them re: you all. We want to talk about delivery system performance, include talking about the docs that take care of members outside your facility. They need to be on the same page. That is where ACOs come in too. Not going to solve it in the next couple years, but need to begin down that path.

Matt Trimble: I keep going back to some of the infrastructure suggestions in the leading age doc – use of nurse practitioners and electronic health records. Perhaps give facilities that already have that some incentive funds for it, and give to those who want to increase use of those.

Akshay Talwar: Is it right that paying those who already have a system to give them money for it? For not doing anything?

Joan Kwiatkowski: If it's electronic health record tied to meaningful use designations, but value to care transitions, value to communications, then I think there should be an incentive payment for that.

Deidre Gifford: I think we can bridge that. Might be a way to incentivize the use of the tool rather than the existence of the tool itself.

Akshay Talwar: Exactly. The incentive program should incentivize what you are going to do, not what you have done.

Rosa Baier: The Department of Health RI Nursing Home Inventory survey has good data. Could be useful.

J Richard: Again though, self-reporting.

Hugh Hall: Home care does not get paid for coming in on day one, yet that day is critical. They cannot come in until the next day post nursing facility discharge, and I think that first day is critical to help stem readmissions.

Virginia Burke: I think this aspect of our work, identifying how others could help us, will be easier for us. We will listen to what they say about us too.

Hugh Hall: If the emphasis is on getting folks back in the community, we have trouble with finding enough home care, which is not the home care agencies fault. Somewhere in the background there may be some thought to that.

Deidre Gifford: A really great point. Trying to think about getting this work done in the time frame we need to with all the people we need. Perhaps think about proposed metrics around the collaboration that you talk about, and it may involve sharing the incentives outside the nursing facilities & hospitals, should talk about how to make that a win for those around the table. May find a way to frame up measures and incentives that don't have the details entirely fleshed out.

Hugh Hall: Any thought to pain –pain management as a quality measure?

Matt Trimble: Is there any indication of hospice usage in RI nursing homes? Bouncing back and forth, really utilizing the system. Also the nurse practitioner has more familiarity with the patient through those last few months.

J Richard: Enough stats in the state, show we are low on geriatric care.

Deidre Gifford: You could propose a way to get a part of DSRIP money is to develop an industry collaboration with URI for nurse practitioner program with geriatric focus or working in nursing facilities.

Rosa Baier: I have also heard of some states with nurses getting nursing home exposure, similar to a residency.

J Richard: What I have heard is that can get expensive to maintain with teaching. Though I do understand what you are saying if we can find a practical way of doing that.

Next steps – we will reach out with some sample measures for your input. We will do our best to have a doc to you in advance of our next meeting to advance the conversation. Think outside the box, think outside your building, and give us all your ideas.

- I. Public Comment – No additional comment offered at this time.
- II. Adjourn