

RI Health System Transformation System  
Hospital & Nursing Facility  
March 16, 2016

Attendees:

Betsy Casey, Jennifer Fairbank, Hugh Hall, Rosa Baier, Kathy Calandra, Elaine Fontain, Mike Souza, Leslie Clark, Lauren Lapolla, Libby Sarro, Debbie Morales, Darren McDonald, Anya Wallack, Beth Marootian, Tricia Leddy

**I. Welcome and Introductions**

Director Wallack: Thought it was important to give you an update today to reassure that we are working hard on this but want to be clear this is a work in progress, particularly in terms of the long term process . The first year program is designed to make good on the promise of performance based payments. Rate cuts were enacted with eh promise that some of those would come back in the form of performance based payments. We are focused on being good on that, but a bit apart from the more thoughtful long term program, a program which will involve MCOs and providers. In some sense, we have put the long term program on hold, have some general language in front of the feds, but not a lot of detailed design work as working on making sure we're good on our one year promise.

**II. Funding Status**

Director Wallack: CNOMS, Darren can speak about the new items we are seeking to match.

Darren McDonald: At this time we are looking at elderly transportation, several new programs out of the health department not currently being matched, and our consumer assistance programs out of EOHHS like the Child Advocate, Commission on Disabilities etc., areas we are looking to generate new federal matching funds.

Director Wallack: All things we are spending money on in state funding that have proposed to the feds we match for the one year expenditure then the benefits would accrue to the programs we are matching. Depending on if they say yes to all of our request or not will determine if we can meet all of that statement.

Tricia Leddy: A DSHP is limited usually to five years and have a further limitation of any state matched that is saved by replacement of federal funds, the sue of the state funds is restricted to certain activities related to health care reform, but the DSHP does not need to look like a service.

Director Wallack: Right, main category there is workforce development that we are researching. We are making a case to the feds that certain amount of workforce training that is currently happening for people who graduate and are serving populations that are Medicaid or underserved populations;

California has made a match on this type of program. In RI we say they stay in RI, work in RI, working in any normal health care setting in RI they will be serving the underserved. We are waiting to hear back –CMS is working on being cooperative with us in our weekly discussions. Hope within the next couple of weeks to have a clear signal on how many we can look at.

Mike Souza: On the DOH programs you are seeking CNOM funding on can you be more specific?

Darren McDonald: Looking to match work by the state epidemiologists – right now they operate in state only funding, but we are making the argument to CMS that the services they provide are state wide including to the Medicaid population so it should be matchable.

Director Wallack: Another element of this, in addition to saying this workforce stuff has links to Medicaid and underserved populations now, as a part of the long term program plan we want to have a strong linkage between workforce needs and development around that concept. It is both an exciting idea that we would work with all three schools to do more deliberate planning around workforce and it means we have a lot of work to do.

Mike Souza: How does what we just talked about related to the Governor's proposed budget? Many of us will be in hearings next week – for example on Hospitals, we will have to talk about UPLs, etc.

Director Wallack: My charge has been to find something we can use to replace that in the budget – so I have been in a mad dash to do so and try to replace that as a funding source. There may be a piece of it that remains, but my charge and my goal is to get rid of as much as possible.

### **III. Proposed Program Eligibility Criteria**

Debbie Morales: EOHHS has been looking at what other states have done in DSRIP like programs. They had included in their incentive plans some sort of eligibility criteria, and we followed suite with states nearby. Thus we are proposing that: A provider is eligible to participate in this incentive program if: At least 30% of all patient volume in outpatient and inpatient lines of business are Medicaid, dual eligible, and/or uninsured; and the facility is currently contracted as a Medicaid managed care provider, inclusive of Rhody Health Options.

Mike Souza: Did you say that all hospitals would be eligible? Even like South County and Westerly would have 30% Medicaid populations? When they do the low income utilization rates only a few succeed – so I fear that it would only be.

Debbie Morales: If you are including all Medicare and Medicaid duals I think

we hit that, but we will review.

Director Wallack: Our intent was to focus this on providers who serve Medicaid, but may I ask that you two work on that after this meeting to review and make sure we aren't being exclusionary, but are working towards that topic.

#### **IV. Proposed Payout Mechanism and Process**

Director Wallack: This is for illustrative purposes. I will go through high level first. Part of the reason we are not calling it DSRIP anymore is that in conversations with CMS we have heard that we have authority to do our work through managed care organizations (MCOs) – if we went through DSRIP would need new authority, which would not come in time. We have had conversations with the MCOs to begin to discuss how we make the payments through them – still discussing, but that is our plan. Looking at quality metrics see how facilities score, send the money to the MCOs and they allocate it based on the distribution methodology that we give them. They do not have a lot of responsibility but also not a lot of input as to how they distribute it. In the long run a lot would go to AEs, but for year one – we send a check with a distribution methodology and facilities get what we say they get outside of MCO rates. The numbers on slide five are illustrative of what we would get on year one.

Tricia Leddy: The first chunk here would be that 90% of the funds would go to providers and accountable entities. You can see that the first year, year one would be provider payments and according to the criteria that Debbie discussed here today. However a small amount of the funds would be maybe used for administration at EOHHS or to prepare for workforce development, preparation for administering both programs. These are just estimates, based on broad percentages. In the following years, there would be planning grants to new accountable entities being certified and those would help the accountable entities to prepare for a more robust application for infrastructure funds over the next several years which would be the biggest chunk of what would be paid out by the state through the HMOs. Planning grants would be certain amounts (which would kick in year 2), there are also infrastructure payments that same year, and those paid over, say 3.5 years, and would be issued through an RFP or RFI where the state would provide certain categories of projects used for infrastructure, such as a more robust computer systems to get providers together to manage care through one entity. This would be so they can make improvements to their infrastructure which over the five year period would be able to go towards a contracted increasing risk basis to manage care, quality, access and cost for the population they are responsible for. CMS does not usually approve these beyond the five year period, as hopefully by year five you have achieved the goals. Some of this money CMS would put at risk based, sometimes 5-10% based on performance. That is a part of the CMS structure of allowing us to

use these kinds of DSHP payments to help create accountable entities. The way that this money is divided is according to the money available, or that we predict available requested from CMS each year; really want to underscore that this is for illustration purposes.

Director Wallack: As you can see we have the 5% for workforce development, and then 5% for program administration.

Tricia Leddy: Assuming the state would pay the MCOs out of the 5% to administer as they have some of that infrastructure in place.

Director Wallack: This is the really high level that we have discussed with the feds, and they will probably nail down some of these things in a hard and fast way, but there is a lot we cannot nail down – discussions about how we evolve the metrics, how much money we should allocate by year.

Hugh Hall: Who are the certified AEs at this point?

Director Wallack: We have five total – Integra, Prospect/CharterCare, PCHC, Blackstone Valley and Eastbay. We have one more that I think has come in wanting to be certified.

Hugh Hall: In year one the hospitals and nursing facilities share in this money if achieved; in year two the money gets funneled through an AE?

Director Wallack: Yes that is what we are proposing.

Tricia Leddy: And more than those types of providers – providers that would be more than just hospitals and nursing homes – could be physicians etc.

Jenifer Fairbank: So the money goes out of a provider pocket and into an AE?

Director Wallack: No; in all years we are proposing that those funding sources would be the source of funds for the out years. Year one is separate.

Hugh Hall: Are there providers who are not members/participating in one of those five AEs?

Beth Marootian: Yes –there is a part of the provider population not participating.

Director Wallack: That is part of the point on the state and federal level – to encourage providers to move towards more organizations like that, which again is clearly part of our state policy, but consistent with Medicaid policy.

Debbie Morales: ACO has historically been hospital and PCP focused, but in the future it could be focused around other types.

Director Wallack: Right and we hope there will be new ones in the future.

Rich Glucksman: To the extent there are not a lot in AEs now, and the planning is now on year two, providers who are not in AEs yet should really aim to do that so they can get the planning grant in year two?

Director Wallack: Yes.

Mike Souza: Is the intent to have everyone in an AE?

Director Wallack: The intent is to encourage that...

Mike Souza: If not how do we still have some performance based measures, so that those not focused on AEs don't look performance based work?

Director Wallack: Two things – we will talk about the metrics in a minute, there should be some connection between the year one metrics, and the AEs in the out year. So join an AE and expect to perform on the same types of things. On the policy, yes we want to encourage providers to join these types of organizations, but you could make a case as providers you should retain some part of this to go directly to providers – and that can be a basis for future discussion – but we think it may be a way of transforming the system.

Jenifer Fairbank: But they are exclusionary – multiple providers out there who are being excluded from these AEs and they are providing the best case – we need to take a look at it.

Director Wallack: We can – on the other hand it's not just about are you providing good care – but it is a part of a large effort on the large spectrum of health care delivery – how we get care. Not about the stand alone quality, but are you involved in a quality improvement effort in a way that transforms care.

Jenifer Fairbank: I would argue they do, but they are being excluded.

Director Wallack: Sure – and I would encourage you all to come forward with ideas for how to reward that if you are not in an AE structure but still doing the work we discuss.

Virginia Burke: At the moment if you provided incentive through the AEs, and at the moment there is only one nursing facility asked to join an AE. They are not ready for long term care, if that continues into year two I think we should have a quality incentive program for our facilities.

Director Wallack: Ok. Again if you can come forward with ideas for how to do that, it would be helpful. We don't want to leave long term care out, but need new ideas. We need to be sure we capture that provider community but do not capture it with a wall built between the two systems.

Beth Marootian: Tricia, what is your best guess for year one?

Director Wallack: Our intent is to make the first hospital payments before the end of their current fiscal year.

Tricia Leddy: Requested authority for July of this year for year one.

Beth Marootian: So then you would have the authority to continue forward?

Director Wallack: I hope so. We know we need to make some payment before the end of the hospital and before the end of the nursing home fiscal year. Depending on what CMS approves would impact the cash flow into this program.

Beth Marootian: How much of the development we are looking for around accountability- it has to come from infrastructure and planning grant?

Director Wallack: Yes we are looking at other levers – we have our own idea

for example of how we use our MCO contract.

Beth Marootian: Because without doing a lot you have five or six AEs that you haven't promised money to, so...

Director Wallack: Right but I do not want to make the same mistake as Medicare that you encourage people to go into these AEs.

Beth Marootian: AEs as a vehicle for infrastructure change in addition to savings? If AEs means creating connection and accountability that is a different policy purpose.

Director Wallack: Right and that speaks to what are our long term policy decisions for AEs.

Beth Marootian: In the future I hope we can talk about accountability outside the AE structure. I think you can get there in this state with other arrangements.

Director Wallack: We can have those conversations once we get beyond year one, and that is the interesting conversations. We are making assumptions here and we need to talk about how we get the change we want to get.

## **V. Review of Final Measures Set**

Debbie Morales: Anya has indicated we use our infrastructure with the MCOS to pass through the funding on this. The final set of recommended measures will be equality weighted. The dollar allocation for each measure by provider will be determined by taking the total dollar value for each measure and multiplying by the % of total claims paid in the first three quarters of SFY 16 (July 2015-March 2016). The total amount to be paid for each provider will be equally distributed among each Health Plan, when applicable. However, EOHHS anticipates that only NHPRI will be providing the incentive payments to the nursing facilities. In terms of the measures, we have been meeting numerous times with you all, internally and with the pans to discuss the proposed measures. How can we accomplish this one year goal in as simple a way as possible and make it some kind of a launching pad for future years. You will see we did cut back – we have six for hospitals and three for nursing facility. On the hospital side we added a measure on encouraging the use of alt payment methodologies in your business. This is a baseline for years 2-6 and there wouldn't be a benchmark per say, but rather to have a sense of how hospitals are operating.

Director Wallack: You wouldn't get more funding as a result of your response, but we ask in good faith you report on this and help us get a sense now so we can build in the out years.

Darren McDonald: Right.

Mike Souza: I think alternative payment methodology (APM) means different things to different people – when it says Pay for Performance, is half quality, all commercial is basically an APM under this definition.

Director Wallack: We did try to use the OHIC definitions to make life easier

for all involved.

Mike Souza: Right, I wanted to be sure it was that and not just bundled payments. But it looks like this definition is more inclusive.

Debbie Morales: Increase in CurrentCare enrollment – we were thinking just an aggregate increase from eh baseline period to the measurement period in membership. We do think it will be feasible to say one place increased 3% and another 2% - if there is an increase across the board it benefits all.

Elaine Fountain: On this its percentage of all Medicaid enrollees for the denominator.

Libby Sarro: CurrentCare in nursing homes, when you come to live in a nursing home in Medicaid, you aren't going anywhere else and we aren't sending you anywhere else. It is relevant for post-acute short term stay, but for long term it means nothing. In the past we tried to sign them up for long term care residents CurrentCare. If we send them to Lifespan we are connected to their computers – I just don't see the value in long term care.

Director Wallack: Does that suggest that there is a category of patients.

Debbie Morales: If in this quarter of this year there was 34% of enrollees in CurrentCare, and then next quarter it is 36% then there is a community increase, and then you all reach the requirement for funding.

Elaine Fountain: We do have a nursing home project in place, we know that hospitals have different programs to enroll in CurrentCare program, and we hear many times for enrollment of Medicaid patients in skilled nursing facility or long term care. There is an effort for state wide Medicaid enrollment.

Virginia Burke: It is not necessarily for the benefit of your patients at that moment in time, it is rather the data mining benefits to Medicaid. It is less a quality measure than incentive, because if hopefully everyone is enrollees then the state can track lab tests etc. It may not have benefits to the facility and residents at that moment in time, but it does have benefit to the Medicaid system as a whole.

Beth Marootian: Have we ever considered CurrentCare to be eligibility based?

Director Wallack: We have considered that and we are looking to put it in the UHIP system so that they can affirm or dissent initially. I do not know if that will go in July or for a later release.

Debbie Morales: Yes it is a basic metric - I anticipate years 2-6 would show more robust efforts around analytic purposes.

Director Wallack: Do want to be sensitive to time, please send your comments on the measures directly to Debbie Morales so that we can have that information.

## **VI. Next Steps**

Director Wallack: I would ask that you understand this is all very much draft. We have asked for permission from CMS but we have not yet been granted permission for funding to go forward on all of this – so again it is draft. We will continue to work with the plans on the nitty gritty (for example taxes, etc.). We will bring the final design to this group once we have the direction from CMS, we will change the proposed budget language to reflect what we have approval for from CMS before the end of the leg session. We will regroup on measure baselines and improvement goals and Debbie will reconvene you all to talk about that. And obviously as I said earlier there will be many future discussions about the years 2-6 programs.