



Minutes

SIM Steering Committee Meeting **Thursday, May 12, 2016 – 5:30 p.m. to 7:00 p.m.** **Hewlett Packard Offices, Conference Room 203** **301 Metro Center Blvd, Warwick, RI 02886**

SIM Steering Committee Attendees:

BHDDH: Maria Montanaro
Care New England: Alex Speredelozzi
CharterCARE: Lester Schindel
Coastal Medical: Al Kurose, MD
RIDOH: Ana Novais
EOHHS: Secretary Elizabeth H. Roberts
Gateway: Rich Leclerc
Greater Providence YMCA: Jim Berson, Vice-Chair
HealthSource RI: Zach Sherman
Leadership Council: Susan Storti
Lifespan: Mark Adelman
Neighborhood Health Plan of Rhode Island: Beth Marootian
OHIC: Kathleen C Hittner, MD
Rhode Island Business Group on Health: Al Charbonneau
Rhode Island Kids Count: Elizabeth Burke Bryant
The Rhode Island Foundation: Neil Steinberg
Rhode Island Medical Society: Peter Hollman, MD
Rhode Island Primary Care Physicians Corporation: Andrea Galgay
Rhode Island Health Center Association: Charles Hewitt
South County Hospital: Lou Giancola, Chair
Tufts Health Plan: David Brumley, MD
United Healthcare of New England: Neal Galinko

State Agency Staff:

Executive Office of Health and Human Services: Amy Zimmerman, Kim Paull; Melissa Lauer; Hannah Hakim, Cheryl Wojciechowski, Rick Brooks

Department of Health: Sandra Powell, Ailis Clyne, MD; Samara Viner-Brown, James Rajotte

Office of the Health Insurance Commissioner: Cory King; Sarah Nguyen

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals: Ann Detrick

HealthSource RI: John Cucco, Betsy Kerr

SIM: Marti Rosenberg

Site Visit Guests: Dr. Stephen Cha (CMMI); Emily Zylla (State Health Access Data Assistance Center); Kate Kiefert, Office of the National Coordinator; Rob Houston, Caitlin Thomas (Center for Health Care Strategies)

Other Attendees:

Rele Abiade (Office of Senator Whitehouse); Laura Adams, Elaine Fontaine, Alok Gupta, Scott Young (Rhode Island Quality Institute); Deb Hurwitz, Susanne Campbell, Pano Yeracaris, MD (CTC); Lisa Tomasso (TPC); Larry Warner (Rhode Island Foundation); Dean Briggs, Joanne Kalp (UMass); Sherry Lerch (TAC); Megan Hall, and Libby Bunzli (ProvPlan); Robert Cole (Horizon Healthcare Partners); Tara Townsend (RIPIN), Elliott Liebling (Care New England); Kara Butler (Healthcentric Advisors); Gary Bliss (Integra); Lynn Blanchette (Rhode Island College);; Maureen Glynn (Improving End of Life Care Coalition); Matt Collins (Blue Cross & Blue Shield of Rhode Island); William Hollinshead, MD (American Academy of Pediatrics, RI); Nelly Burdette (Providence Center); Catherine Taylor (University of Rhode Island); Beth Lange, MD (Coastal Medical); Jim McNulty (Mental Health Consumer Advocates); Richard Asinoff (Convergence RI).

1. Introductions

The meeting was convened at 5:30 p.m. by Chair Lou Giancola. He welcomed and introduced the guests visiting from Center for Medicare and Medicaid Innovation: Dr. Stephen Cha from CMMI (below), and the technical assistance consultant team: Emily Zylla, Rob Houston, Caitlyn Thomas, and Kate Kiefert.

2. Review Prior Meeting Minutes

Meeting minutes from April 14 were reviewed.

Mr. Giancola then handed off the meeting to Marti Rosenberg, SIM Project Director.

3. Presentation and Discussion:

Stephen Cha, MD; Director, State Innovations Group,
Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services

Ms. Rosenberg spoke about the federal site visit yesterday, then provided an introduction to Dr. Cha's remarks about State Innovations in Delivery and Payment Reform, and the Medicare Access and CHIP Reauthorization Act (MACRA) and the Quality Payment Program (QPP).



Dr. Cha offered to provide a picture of the national framework for where CMS is headed in terms of promoting state health system integration through SIM. He acknowledged all the great work that Rhode Island has done to prepare for system transformation, and to provide a look ahead at what is next from the federal government. For example, it is a federal goal to have 30% of Medicare payments in Alternative Payment Models (APMs) by the end of 2016. He noted that Medicare has exceeded this already. Their goal is to reach 85% tied to quality or value by the end of 2016.

HHS commitment to value and quality

In January 2015, the Department of Health and Human Services announced new goals for value-based payments and APMs in Medicare

Medicare Fee-for-Service

GOAL 1: 30%
 Medicare payments are tied to quality or value through alternative payment models (categories 3-4) by the end of 2016, and 50% by the end of 2018

GOAL 2: 85%
 Medicare fee-for-service payments are tied to quality or value (categories 2-4) by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:
 Consumers | Businesses
 Payers | Providers
 State Partners

Set internal goals for HHS

Invite private sector payers to match or exceed HHS goals

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Dr. Cha noted that CMS is seeking to create a better, smarter Medicare. They want to offer two choices for providers – the Merit Based Incentive Payment system (MIPS) or the Advanced APM (AAPM). Under AAPM, providers would be exempt from the MIPS payment adjustments and would instead qualify for a 5% incentive payment from Medicare. To qualify for AAPM, providers need to have enough of their payment or see enough of their patients through these models, which are proposed to include Medicare’s Shared Savings Program (Tracks 2 and 3) and the Next Generation ACO Model, among other models.

This model requires that providers bear payment risk, as Congress has mandated in the MACRA legislation. For our purposes, the performance year begins 2017, so this gives us a short window of time to help prepare Rhode Island providers. Dr. Cha also referenced the Quality Payment Program (QPP) Notice of Proposed Rulemaking (NPRM) released 2 weeks ago, which outlines the framework.



As Dr. Cha stated, “Medicare is evolving from fee-for-service and has set a goal of 50% of payments in alternative payment models by 2018. As part of this process, CMS is improving and streamlining its existing quality programs (PQRS, VBP, EHR incentives) into a single one that will reward clinicians for delivering coordinated care with better outcomes with the support of health information technology. These changes are reflective of and in response to the concerns that too many quality programs, technology requirements, and measures get between the clinician and the patient. That is why we are taking a hard look at what is working, what is not working, what is duplicative, and what is missing. We intend to continue to work hard at listening and improving based upon what we hear.”

He noted that they want providers to be engaged, since the program will be truly transformative. CMMI is not sure that providers really understand where this is going, and that they have growing unease about the technical details of these programs. In fact, what we have been doing through SIM is preparing them for these next changes. He emphasized that SIM is an opportunity to build partnerships with providers, that there is a place for providers to jump in and provide their input. He again noted the 5% incentive that CMS is putting on the table, noted that this transformation was a priority for federal departments, the President, and the Congress.

Quality Payment Program

- ✓ First step to a fresh start
- ✓ We're listening and help is available
- ✓ A better, smarter Medicare for healthier people
- ✓ Pay for what works to create a Medicare that is enduring
- ✓ Health information needs to be open, flexible, and user-centric

The Merit-based
Incentive Payment
System (MIPS)

or

Advanced
Alternative
Payment Models
(APMs)

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Dr. Cha continued: “The proposed rule is the next step in actually putting the new system envisioned by MACRA into place, in the form of the new Quality Payment Program. I want to thank you for all that you did to make this happen. It was thanks to strong support from medical associations and other stakeholders, that MACRA was signed into law last year. I also want to ask for your continued help, support, and input as we move forward with implementation.

“MACRA replaced a patchwork collection of quality programs with a single system where every Medicare physician and clinician has the opportunity to be paid more for better care. Doctors will be able to practice as they always have, but will also have the chance to get paid more for high quality care and investments that support patients. There are two paths to quality in this program:

- The Merit-based Incentive Payment
- The Advanced Alternative Payment Models

“In developing the rule, we were guided by the core goals of the legislation –streamlining and strengthening quality-based payments for all physicians; rewarding participation in Advanced Alternative Payment Models that create the strongest incentives for quality and coordinated care; and giving clinicians flexibility to choose how to participate in the new system.

“We will be providing tools and education to help you get ready for performance year 2017. Clinicians can visit go.cms.gov/QualityPaymentProgram for more information. In addition, we’re organizing groups across the country, so you can have local help as you get ready.”

Dr. Cha noted that we need to build incentives and reimburse providers for quality.

Advanced APMs meet certain criteria.

As defined by MACRA, advanced APMs **must meet the following criteria:**

- ✓ The APM requires participants to use **certified EHR technology.**
- ✓ The APM **bases payment on quality measures** comparable to those in the MIPS quality performance category.
- ✓ The APM either: (1) requires APM Entities to bear more than nominal **financial risk** for monetary losses; OR (2) is a **Medical Home Model** expanded under CMMI authority.

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“Now we want to talk about **advanced APMs**. According to MACRA, advanced APMs have to meet **certain criteria** which include: basing payment on quality measures comparable to those in MIPS, requiring use of EHR, and either bearing **more than nominal** financial risk OR being a medical home model expanded under CMMI authority.

“That all might sound pretty technical – the main takeaway point here is that **advanced APMs are the most advanced APMs and must meet these specific criteria**. It is a very high bar to be an “advanced APM.””

Dr. Cha sees SIM as a lead partner around the country to align incentives: benchmarks, quality measures and so on. He provided a brief history of SIM and its several rounds of stages: there are six Round 1 test states, and

eleven in Round 2, including Rhode Island. These 17 states have been awarded between \$15M and \$80M for their initiatives. He stressed that there is not a CMS or CMMI path. That the states need to define, and gave some examples.

- Almost all states are investing in their primary care infrastructures, including Patient-Centered Medical Homes (PCMH), Behavioral Health and Substance Use Disorder integration. He has advised states that unless they include these features, they will not be able to control their Medicaid costs.
- Building in risk to providers, both upside and downside. States have been challenged in implementing community-based goals; for example, it is difficult to hold hospitals at risk for patient smoking cessation.
- He noted that it is a leap for states to tie population health to clinical care, that there is a need to tie systems together to have everyone accountable. There are many pieces, and it's not just about big ACOs.
- A lot of states are building community care teams, and stressed the challenges with case coordination — what does it mean? How do we make it effective?
- He noted the experiment in Maryland, where they have established the first all-payer model with Medicare, structuring it so that it is more profitable for systems to keep patients out of the hospital rather than bringing them in.
- They are in conversations with 10-11 other states about adopting this model, including Vermont and Pennsylvania, but they haven't agreed to anything yet.
- What they are all struggling with is, what happens when the SIM money is gone? Will these innovations have become part of the fabric of the system so that they will continue?



A question and answer period, open to all, followed.

Dr. Cha explained, in response to questions, that:

- They don't need all stakeholders in a state to sign on to these system transformations all at once. They can do it in groups.
- The Delivery System Reform Incentive Payment (DSRIP) initiatives for states with 1115 waivers was entirely synergistic with these proposals.
- New York has developed a plan that looks much like LAN.
- To a question about whether the CPC+ approach versus ACO group constitutes contradictory approaches: need to look at program collision. To the extent the Medicaid ACOs happen – silent on that.

4. Update on Integrated Population Health Plan: Reggie Tucker-Seeley, ScD; Megan Hall, MPH; Sherry Lerch

Our ProvPlan and TAC consultants provided an overview of SIM's effort, and noted that they were providing an update. They enumerated the Plan's focus areas: tobacco, obesity, chronic illness (diabetes, heart disease and stroke), and behavioral health issues (depression, children with social and emotional disturbances, severe mental illness, and substance use disorder). They noted that population prevalence drove their focus. Next step is the planning part — what to do next? This is the work for Section 9 of the report. Their next task is to integrate the Integrated Population Health Plan (IPHP) with the SIM Operations Plan. They will leverage the Operations Plan measures, and also ensure that they have identified the areas where further data is needed. Their priority is also to benefit from data provided by initiatives that Rhode Island is already running.

One key strategy that has arisen is the power of aligning the variety of programs and services across the state, so that we can maximize their effectiveness, serve more people, avoid duplication and potentially save money. The presenters noted that since the SIM funds have largely been allocated for interventions on the Transformation Wheel, their goal was to make the most of funding already in place. They are suggesting that by being efficient, integrated, and facilitating program alignment, Rhode Island can reduce some of the social disparities in physical and behavioral health between groups.

In the discussion that followed, participants made the following point:

- One means of fostering alignment within SIM is to collect data on the interventions that we are funding. Our consultants noted that we have been discussing a data reporting requirement from potential SIM grantees that can reduce some of the data gaps. It was noted that if the state wants to impact Medicaid costs, they need to address behavioral health disorders. Also, patients with primary medical conditions may not comply well with treatment if they have a behavioral health disorder. In addition, a member noted that lack of psychiatric services limits pediatric primary care practitioners' ability to refer children. In the future, PCPs must have a place to refer children.

Our consultants shared that as they advance the work on the Integrated Population Health Plan (IPHP), they will expand outreach to the community to gain additional input. They plan to approach grassroots healthcare providers to get their perspectives on issues with linkages in care.

- Secretary Roberts noted that her office has a large contact list from their work on SHIP, and will provide it to the team.
- SIM Chair Giancola asked whether IPHP was aligned with Population Health 2020? Ms. Novais from DOH confirmed that it was.
- Ms. Bryant thanked DOH for their hard work providing aggregated data on race and ethnicity for their work. She validated with Dr. Tucker-Seeley that the IPHP team is using the available data.
- During further discussion on grassroots outreach, SIM staff agreed that it will work with the Health Equity Zones (HEZ).
- The presenters noted that this effort must align the healthcare system with epidemiology, in order to improve population health — and particularly to address social determinants of health. The Department of Health noted that this is their focus — addressing the social determinants of health.
- It was noted by an audience member that significant social determinants of health need to be increasingly within the sphere of influence of public health — such as housing.

5. Public Comment

There were public questions and comments throughout the presentations and discussion. Those remarks are captured above. In addition, Nelly Burdette, spoke to encourage the SIM team to describe how primary care transformation will occur, particularly training of medical practitioners in behavioral health care. She highlighted the lack of a trained healthcare workforce that can integrate with behavioral health. She noted the need to align funding streams to accomplish this.

Ms. Rosenberg thanked the attendees for their input.

6. Adjourn

Ms. Rosenberg noted that:

- the next IPHP meeting will be held June 1, at 9:15 AM, location TBD
- the next Steering Committee meeting will be held on June 9, from 5:30 PM to 7:00 PM at 301 Metro Center Blvd.

With no further business or discussion, the meeting adjourned at 7:00 PM.

Notes prepared and respectfully submitted by:

Dean Briggs
UMass Program Management
May 23, 2016