RI SIM Sustainability Submission
Part 1 – End State Vision
October 26, 2018

1) RI SIM End State Vision

RI SIM began our project with the Triple Aim as our vision and through all we have learned over the last three years of the SIM process, the central tenets of our vision based on the Triple Aim of healthcare remain intact.

The following descriptive language reflects the ways that RI SIM now understands the Triple Aim more completely, and clarifies what we it means to us and RI SIM's vision for the future of Rhode Island's health system:

1) Better health
    - We look at population health outcomes and disparities across the life course, focusing on equity and the integration of behavioral health (including mental health and substance use) with physical health (including oral health), while also identifying and addressing the social determinants of health.
    - Better health includes promoting social cohesion and connectedness to achieve active patient engagement and support recovery from addiction
2) Better healthcare
    - This includes a foundation of longer-term planning for an effective health system that melds payment and delivery reforms with investments in healthcare quality improvement and the health workforce (such as Rhode Island's inter-professional training initiatives), and in building the capacity to identify and address social determinants of health.
    - Better healthcare includes a focus on provider satisfaction and avoiding burn-out.
3) Smarter spending
    - This includes ongoing implementation of OHIC's Affordability Standards with a continued emphasis on cost management strategies that use practice-based performance improvement strategies.
    - We understand the differences between short-term and long-term cost savings. We also understand that long-term savings require investments (especially in our children) that are often reflected in different areas than the initial expense. For instance, investments in children's behavioral health in one year can reduce costs in DCYF in future years. Additionally, addressing social determinants of health will require building a system that supports strategic investments outside of healthcare including one where financial risk and reward are shared across sectors.
    - For significant long-term savings, we aim to retain investments that improve social services and support place-based community infrastructure to address socio-economic and environmental determinants of health.

2) RI SIM Goals for Payment and Delivery Reform

When RI SIM began our project, we made it clear that in Rhode Island, the state and private entities were already moving from volume to value. The Office of the Health Insurance Commissioner (OHIC) and Medicaid were taking the lead on the state side to increase their pursuit of value-based strategies through OHIC's Affordability Standards (Section 10, Page 16) and other regulatory actions. Medicaid was creating Accountable Entities through their relationships with Managed Care Organizations. Private organizations such as Blue Cross & Blue Shield of Rhode Island, Coastal Medical, and the Integra ACO were providing more and more care through value-based arrangements.

Our theory of change stated that since Rhode Island was already pursuing this course of action, our top priority was to support the people and institutions that were making these changes. Thus, our funding focused on practice and workforce transformation, patient engagement, and improving our state infrastructure, with a focus on Health Information Technology (HIT) improvements.

Rhode Island's unique regulatory advantage, then, is that our goals for payment and delivery reform are built into our existing structure. OHIC's ongoing activities to support their Affordability Standards are the way that Rhode Island is sustaining our payment and delivery reforms, setting annual targets, and evaluating how we are doing in meeting those goals. The process is entirely transparent, with significant stakeholder participation.

In fact, the annual process has just begun this October 2018. OHIC's two primary stakeholder committees – the Alternative Payment Model Workgroup and the Care Transformation Workgroup – have just started to meet to carry out their regulatorily-required activities. These documents lay out all the goals and activities still to be undertaken by the state — and this process continues seamlessly through our regulatory structure.

The other annual process carried out by OHIC is the Measure Alignment review. The state's Measure Alignment work started within SIM, creating an aligned set of measures and a menu set. We have added on to that measure work, and OHIC has inserted the requirements to use the measure sets into its state regulations as well. See page 20 of the linked OHIC regulations above.

OHIC and Medicaid work together as much as possible, to align their regulatory actions. Medicaid's Accountable Entity program uses the same measures and aligns their system transformation efforts wherever possible.

The best way to see Rhode Island's ongoing payment and delivery system reform is to explore these documents. We are happy to share the results of this year's work when the conclusory documents are finalized with the Commissioner's signature this winter. We have also included the Final Alternative Payment Model Report from winter 2018, to demonstrate how the committee work turns into annual state policy.

APM Advisory Committee meeting p

Care Transformation Advisory Committee r

2018 Alternative Payment Methodolog

2018-Care-Transformation-Plan-Final-Adop

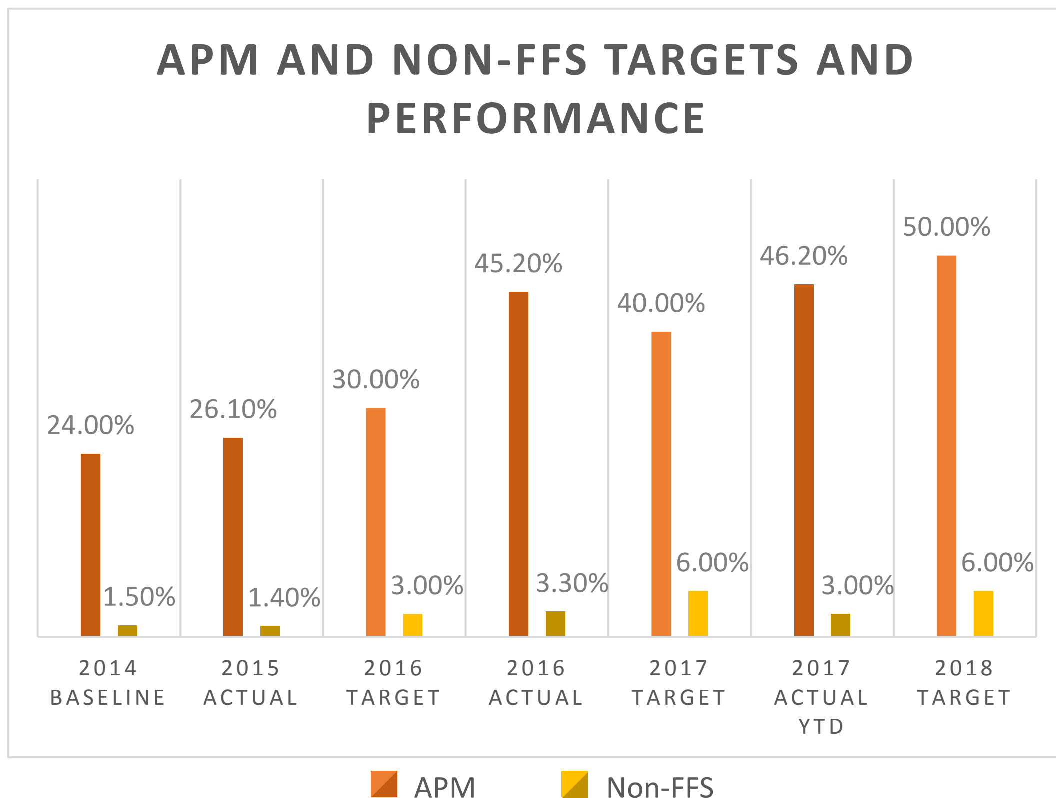
Finally, OHIC has been overseeing the drive to our APM targets. We have excerpted the following from our AY4 Operational Plan (taken from between Pages 98 and 108 and updated in October 2018

Award Years 3-4 (Implementation)

Year 3 Implementation: In the early months of 2018, OHIC evaluated commercial insurer performance relative to the 2017 APM and Care Transformation targets. When payments under APMs relative to total medical spend was aggregated across insurers, OHIC found that insurers surpassed the 2017 target, achieving 46.20% of payments in an APM, as shown in Figure 12 below. No insurer met the Non-Fee-For-Service target, however. OHIC has found that there is a lack of payment arrangements in the Rhode Island market that could be classified as stage 4 APMs according to the LAN Framework, such as capitation or bundled payments. To support insurers and providers in moving toward these types of arrangements, OHIC has taken a number of actions, including the development of a primary care capitation model by a work group in 2017, the planned implementation of said capitation model in a small cohort of practices in a multi-payer fashion and the analysis of commonly defined episodes of care that will inform the development of bundled payment arrangements that can be adopted in a multi-payer manner. These activities are further articulated in the 2018 APM Plan, which was signed into effect by Commissioner Marie Ganim on January 24th, 2018.

In addition to these activities, OHIC will also be leading a work group to explore pediatric APMs, to promote continued engagement of our pediatric provider community in healthcare reform and to ensure that pediatrics is not neglected as an unintended consequence of pursuing savings through common means such as chronic care management. OHIC will also be exploring regulatory authority and potential methodology for assessing provider financial capacity for risk bearing.

Figure 12: Rhode Island Commercial Payment Reform Performance and Targets, 2018

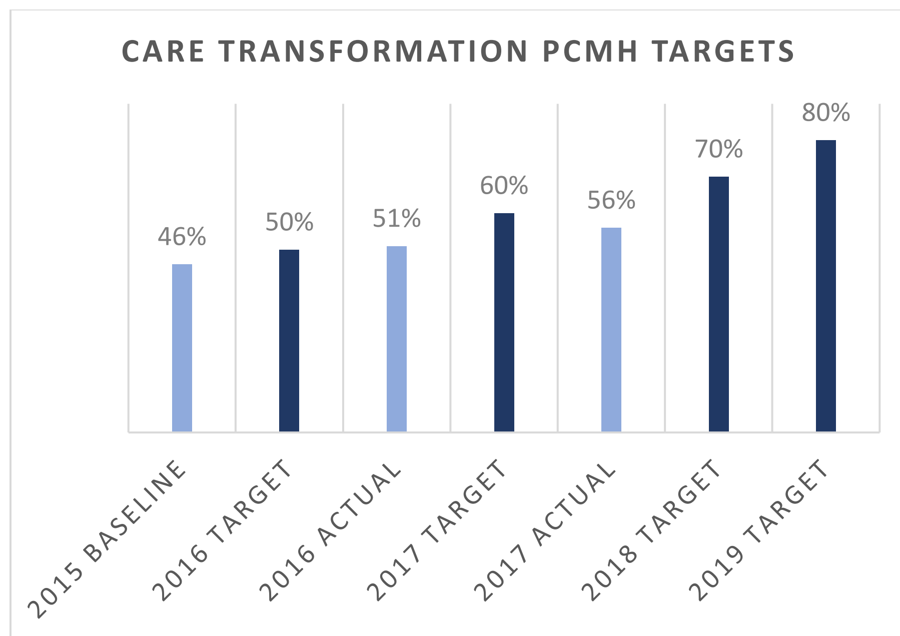


The state's 2017 care transformation target was to achieve 60% of primary care providers operating within a PCMH (insurers had unique targets based on baseline performance). While insurers missed this target by about 4%, as shown in Figure 139 below, upon review of practice performance relative to OHIC's three-part PCMH definition, 39 practices submitted data to OHIC and failed to achieve PCMH status. OHIC has noted that a significant number of clinicians are affiliated with a Federally Qualified Health Center that either failed to meet the Cost Management Strategies, or did not report to OHIC at all, despite participating in a transformation initiative or achieving PCMH status last year. OHIC has been coordinating with the insurers and CTC-RI to encourage these practices through practice facilitation and contracting mechanisms to achieve all OHIC PCMH requirements in 2018.

Recognizing the growing presence of ACOs in Rhode Island's care delivery landscape, OHIC is directing insurers to focus on practices that have not yet achieved PCMH status but are affiliated with an ACO or system of care. OHIC is also recognizing the ACO role in transformation and has developed a set of criteria against which to evaluate the supports and programming offered by ACOs to gear their practices up to be operating as a PCMH (as defined by OHIC). This will enable an ACO's practices that are participating in their transformation program to be entitled to infrastructure payments from insurers.

As articulated in the 2018 Care Transformation Plan, signed into effect by Commissioner Marie Ganim on January 24th, 2018, OHIC will support continued transformation of primary care by revising the cost management requirements of OHIC's PCMH definition, investigating and addressing administrative challenges associated with behavioral health integration, and working with other state agencies to improve data sharing and communication between providers when patients cross organizational lines or clinical settings.

Figure 13: Rhode Island Commercial PCMH Performance and Targets, 2018



Year 4 Implementation: Moving forward, Rhode Island is poised to continue to significantly advance the use of multi-payer VBP and APMs through the implementation period of the SIM grant and beyond.

OHIC will continue to track commercial insurer compliance with their annual APM targets on a semi-annual basis.

In September of each year, OHIC will administer a survey to primary care practices to assess achievement of the PCMH cost containment strategies. OHIC will also collect data on clinical quality performance measures. These elements will be combined to produce a list of practices sites and associated clinician rosters who have met the OHIC definition of PCMH.

OHIC will assess compliance with commercial insurer payment reform targets, care transformation requirements, and hospital contracting requirements in the context of the annual rate review process in 2018 and 2019. The Commissioner may consider each insurer's efforts to meet the delivery system and payment reform targets as a factor in her decision to approve, modify, or reject any regulatory filing. OHIC will publish public reports on insurer compliance with the annual APM and PCMH targets.

Continued Engagement of Payers and Providers

Rhode Island is advancing the work of payment reform in a coordinated way. The goal of achieving critical mass for payment reform across Medicare, Medicaid, and commercial insurance is a necessary condition for transforming the healthcare system as a whole. As noted above, Rhode Island has adopted the goal of having 50% of commercial and Medicaid payments under an APM by 2018, and 80% of payments linked to value.

While we had planned to carry out a Learning Collaborative on VBP implementation, we determined that it would be duplicative of the significant stakeholder engagement that OHIC organizes throughout its workgroup processes. SIM is available to help OHIC with its stakeholder work, and OHIC reports that many SIM participants have begun to attend OHIC meetings.

Additionally, the Rhode Island State Employees Health Plan, which covers about 44,000 members, is an important lever toward our APM goals. The state health plan is currently administered by UnitedHealthcare and it participates in UnitedHealthcare's ACO shared savings program. To the extent a state employee is cared for by a practice in one of our three ACOs (Coastal Medicine, Lifespan, or the Rhode Island Primary Care Physicians Corporation), they are considered to be participating in the corresponding ACO program. As of March 31, 2016, 76% of State of Rhode Island members are attributed to an ACO or another population-based program (such as the PCMHs through CTC). As Rhode Island prepares to reprocure the State Employee Health Plan, OHIC has engaged with the Department of Administration to encourage the state to include requirements to align with SIM initiatives. Proposed contractual requirements included the adoption of the SIM Aligned Measures, the continued submission of claims data to the APCD, and the support of PCMH transformation. It is not yet clear whether the state will agree to include these requirements.

3) RI SIM Healthcare Spending or Savings Goal

Over the years, various Rhode Island government and healthcare leaders have discussed setting healthcare spending goals. Through the advocacy of the Raimondo administration and a $550,000 grant from the Peterson Center on Healthcare, the SIM Steering Committee and other stakeholders have begun to lay the groundwork for a formal and serious look at developing a state cost growth target for healthcare, through the RI Healthcare Cost Trends Collaborative Project.

This project is guided by a Steering Committee comprised of government, business and community leaders, and will leverage the state's existing APCD to identify cost drivers, develop an annual health care cost growth target, and inform system performance improvements. The Steering Committee was convened in August 2018 by EOHHS and OHIC, in partnership with Brown University and the Peterson Center on Healthcare. Rhode Island joins only a handful of U.S. states to launch a comprehensive effort to measure health care expenditures, examine how dollars are spent, and set a spending target. The group will also draw upon work done by the Massachusetts' Health Policy Commission, which has set annual health care cost growth targets since 2013.

At the first meeting, the Committee reviewed their charge. The Steering Committee will specifically advise the State on:

1. The methodology to measure and report on the total cost of health care in Rhode Island;
2. The methodology to establish an annual health care cost growth target to first employ in 2019;
3. How to analyze and report publicly on state, insurer, and provider performance relative to the target;
4. A data analysis plan designed to measure health system cost performance on a pilot basis during 2018-19, and
5. A data analysis and use plan to guide future, ongoing analysis of cost growth drivers and sources of cost growth variation.

The group has discussed the analytic methodology for the study population, patient attribution, data sources, and outcome definitions. The initial phase of work will analyze claims data to identify cost trends and drivers of cost in the state. The specific short-term aims of this work are threefold: (1) to assess cost trends in Rhode Island, (2) to assess select cost drivers in the state, and (3) to deconstruct total medical expenditures by volume and price.

4) RI SIM Population Health Goals

From our AY4 Operational Plan (Page 88), here are RI SIM's Population Health Goals:

Figure 6: Integrated Population Health Goals

Also from our AY4 Operational Plan (Page 91), here are Rhode Island population health targets:

Table 5: Original RIDOH Key Metrics by Health Focus Area

Health Focus Area	Integrated Population Health Goal	Original Key Metrics (Revisions Underway)
Obesity	Reduce obesity in children, adolescents, and adults	Decrease the proportion of Rhode Island adults who are obese from 27% to 24% by 2020.
		Decrease the proportion of Rhode Island high school students who are obese from 12% to 10.8% by 2020.
		Increase the proportion of Rhode Island adults participating in physical activities during the past month from 77.5% to 86.5% by 2020.
Chronic Disease	Reduce chronic illnesses, such as diabetes, heart disease, asthma, and cancer	Increase the proportion of the diabetic population with an A1c value less than 8% from 68.2% to 73.8% by 2020.
		Increase the average percentage of weight-loss among participants who complete the diabetes prevention program from 5.7% to 7% by 2020.
	Improve emergency response and prevention in communities	Decrease stroke deaths from 33.4/100,000 to 38/100,000 by 2020.
		Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911 or other emergency number from 37% to 40.9% by 2020.
Maternal and Child Health	Promote the health of mothers and their children	Decrease the proportion of children ages 3-5 with dental caries experience in their primary teeth from 29.4% to 26.5% by 2020.
		Maintain the proportion of screen-positive children who receive follow up testing with in the recommended time period at 100% through 2020.
		Increase the proportion of children in participating primary care practices who receive regular standardized developmental screening to from 54% to 75% by 2020.
		Increase the proportion of children aged 6 to 9 years with dental sealants from 11 % to 20 % by 2020.
		Increase the number of women with Medicaid insurance who visit the dentist during pregnancy from 28% to 32 % by 2020.
		Increase the percentage of adolescents (ages 12-17) with a preventive medical visit in the past year 68.3% to 74.5% by 2020.
	Reduce environmental toxic substances, such as tobacco and lead	Decrease the statewide incidence rate of Rhode Island children aged 1-5 years with blood lead levels >=5 ug/dL from 4.1% to less than 2% by 2020.
	Improve access to care include physical health, oral health,	Increase the proportion of children, adolescents and adults who used the oral health care system in the past year from 42.1 % to 40 % by 2020.

	and behavioral health systems	Increase the number of RI children with special needs (birth to 18) who participate in enhanced medical home practices to double the number 1495 Number to 2990 Number by 2020.
	Improve emergency response and prevention in communities	Increase RI's Hospital Pediatric Emergency Readiness score from 61.2 to above national median (69.1) by 2020.
	Ensure that quality public health data are collected consistently using current technology	Increase the number of immunization data submitters who submit data at least once annually, using HL7 standards from 122 to 200 by 2020.
		Increase the number of annual hits on KIDSNET by all healthcare providers from 1,124,177 to 1,600,000 by 2020.
Tobacco Use	Reduce environmental toxic substances, such as tobacco and lead	Decrease cigarette smoking by Rhode Island adults from 16.3% to 12 % by 2020.
		Decrease the proportion of Rhode Island adults exposed to secondhand smoke in the home 7.8% to 4.8% by 2020.
Depression	Improve access to care include physical health, oral health, and behavioral health systems	Decrease the RI suicide rate from 12.6/100,000 to 10.2/100,000 by 2020.
Children with Social and Emotional Disturbance		Increase annually the number of Rhode Islanders who have access to primary care (medical, behavioral, and oral) services through implementation of primary care workforce programs from 85,500 to 90,000 by 2020.
Serious Mental Illness		
Opioid Use Disorder	Reduce substance use disorders	Decrease the proportion of adults reporting use of any illicit drug during the past 30 days from 14.75% to 7.1% by 2020.
		Decrease the proportion of high school students reporting use of marijuana during the past 30 days to from 23.6% to 21.2% by 2020.
		Decrease the proportion of high school students who report they ever used prescription drugs (e.g., OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription from 11.6% to 9 % by 2020.
		Decrease the number of overdose drug deaths annually from 257 to 160 by 2020.
	Analyze public health data to monitor trends, identify emerging problems, and determine populations at risk	Increase the monthly average of unique providers checking Prescription Drug Monitoring Program (PDMP) each month from 1,062 to 2,500 by 2020.

Conclusion

RI SIM understands that knowing where we are headed is the only way that we will know when we have achieved our goals. We have kept this End State Vision in mind as we have carried out our project—and we will keep it front and center in this final year.

When we think about sustaining SIM, we are focused on much more than simply sustaining our funded projects. We aim to sustain the drive toward health system transformation and improvements in population health; the awareness and prioritization of addressing the social and environmental determinants of health; and ensuring the continuance and deepening of our Culture of Collaboration that has allowed to achieve as many of our stated goals as we have.

Next, please see the Landscape of Healthcare in Rhode Island document, which is Part Two of our Sustainability submission.