



Minutes

SIM Steering Committee Meeting **Thursday, April 14, 2016 – 5:30 p.m. to 7:30 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
CareLink RI: Joan Kwiatkowski
CharterCARE: Lester Schindel
RIDOH: Nicole Alexander-Scott, MD
EOHHS: Secretary Elizabeth H. Roberts
Greater Providence YMCA: Jim Berson, Vice-Chair
HealthSource RI: Zach Sherman
Leadership Council: Susan Storti
Lifespan: Rich Leclerc
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
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: Kim Paull; Melissa Lauer; Hannah Hakim, Cheryl Wojciechowski

Department of Health: Ted Long, MD; Ailis Clyne, MD; James Rajotte

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

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

HealthSourceRI: John Cucco

SIM: Marti Rosenberg

Other Attendees:

Laura Adams, Alok Gupta (Rhode Island Quality Institute); Deb Hurwitz, Susanne Campbell, Pano Yeracaris, MD (CTC); Lisa Tomasso (TPC); Larry Warner (RI Foundation); Dean Briggs, Joanne Kalp (UMass); Sherry Lerch (TAC); Megan Hall, and Libby Bunzli (ProvPlan); Rick Brooks (Governor's Workforce Board); Robert Cole (Horizon Healthcare Partners); Tara Townsend, Tammy Russo (RIPIN); Carrie Bridges Feliz (Lifespan); Gail Costa (CareNE); John Keimig (Healthcentric Advisors); Gary Bliss, Integra; Mary Broe.

1. Welcome and Introductions

The meeting was convened at 5:30 p.m. by Health Insurance Commissioner Kathleen Hittner, MD.

Dr. Hittner shared that the SIM staff and consultants have been doing a significant amount of work to prepare the Operational Plan and the Integrated Population Health Plan. She framed the meeting by saying that this work would be reviewed during the meeting. She also requested input from the Steering Committee be given over the next couple of weeks on a number of topics. Finally, she noted that after some administrative updates, these elements of the plan will be reviewed:

- Mission
- System Transformation
- Data Analytics
- Community Health Teams (CHT)
- Integrated Population Health Plan (IPH)

2. Review Prior Meeting Minutes

Meeting minutes from March 10 were reviewed.

Dr. Hittner then handed off the meeting to Marti Rosenberg, SIM Project Director.

3. Administrative Updates

Ms. Rosenberg gave a brief update on the workgroup meetings that had taken place since the last Steering Committee meeting. The first meeting of the Patient Engagement workgroup took place on April 4, with attendance by 30 people. The Technical Reporting workgroup met on March 30 and created very helpful guidance for procurement. There was a meeting on Community Health Teams (CHT) with Hannah Hakim and representation from CTC. At the meeting, 25 people working on CHTs shared their insights. Finally, the SIM team held a third meeting of the Integrated Population Health workgroup on April 7. The team will be sharing the current version of the IPH plan and wants review and input from the Steering Committee members.

Ms. Rosenberg also noted the initiation of an allied effort – the pursuit of an Application Grant for Certified Community Behavioral Health Clinics (CCBHC). This is a joint effort between SIM and Behavioral Health Developmental Disabilities and Hospitals (BHDDH) to develop Centers of Excellence with a value based payment structure.

4. Presentation and Discussion: SIM Operational Plan Components

a. Operational Plan Overview

Ms. Rosenberg presented an overview of the Operational Plan, noting that the plan provides direction from Year 1 to Year 2; any funds not expended in Year 1 will be carried over to be spent in Year 2. She also reviewed the deadlines:

- We will have a very good first version to the Center for Medicare & Medicaid Innovation (CMMI) by April 30 and we will go through an iterative review process with them. During this time, we will also be adding content to the plan.
- June 30 is the final deadline.

For content to be reviewed tonight, she asked for input by April 25.

b. SIM Mission

Ms. Rosenberg reviewed the SIM Vision/Mission/Theory of Change and Guiding Principles. These were

distributed to Steering Committee members and interested parties in advance of the meeting. Steering Committee members had no edits during the meeting, and were asked to provide input by email.

c. System Transformation

Cory King, Principle Policy Associate – Delivery Systems Analyst, OHIC, presented an overview of the Delivery System Transformation portion of the SIM Operational Plan. He noted the shift from volume to value, and the role of payment incentives to encourage alignment among the system participants. He reviewed the 4 Transformation Elements of the plan:

Transformation Elements

Rhode Island's Delivery System Transformation Plan comprises four elements:

1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers. Rhode Island has adopted to goal of having 50% of commercial and Medicaid payments under an APM by 2018, and 80% of payments linked to value.
2. Support for multipayer payment reform and delivery system transformation with investments in workforce and health information technology.
3. Significant stakeholder engagement in policy development and SIM investment decisions through the SIM Steering Committee, SIM Workgroups and agency specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.
4. Fidelity to our Integrated Population Health Plan to ensure that transformation is consonant with our vision of improved physical and behavioral health for the state's residents.

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Chairman Lou Giancola pointed out that nowhere in the SIM Operational Plan was there a discussion of planning or central decision making about resource distribution. There followed a discussion among the group about the best place for such a planning discussion/document, e.g. integrated into SIM or as a separate undertaking. It was suggested that there could be some reference to planning in the Operational Plan document. .

d. SIM Driver Diagram Metrics

Mr. King continued to his next presentation on metrics to be used to measure progress on interventions described in the Driver Diagram. (See presentation, below)

Background

CMMI requires Model Test states to develop a portfolio of SIM reporting metrics. These metrics will allow CMMI and the State to track the progress of the SIM grant.

Each metric should tie to an intervention of the SIM grant or track broader processes and outcomes pursued under the grant.

CMMI lumps metrics in the following categories:

- Model Participation (providers and beneficiaries – mostly relating to SIM interventions)
- Payer Participation (dollars allocated to VBP and APMs)
- Model Performance (impact on cost, utilization, quality, patient experience, etc.)

CMMI grants the states some flexibility within this framework to specify metrics that reflect the goals and activities of the grant.

Progress in Metric Specification

The SIM team is developing metrics around specific SIM funded interventions (like Community Health Teams) and metrics for tracking system transformation (like percent of medical payments tied to value).

See Handout

Metrics and data collection strategies related to specific SIM-funded interventions will be built in to procurements to the extent possible.

Metrics related to system transformation (such as payment reform and delivery system transformation) derive from existing initiatives at OHIC and EOHHS.

Example: Payer Participation Metrics

Payer Participation

Payer Participation: The focus of this tab is specific to payer participation in value-based purchasing and/or alternative payment models supported by SIM. Awardees must report information on payer participation and should align their reporting to the Payment Taxonomy Framework Categories to the best extent possible. Awardees should consider using this framework to establish principles for data-sharing and goal-setting among payers in the state.

Payer Participation in Value-based and Alternative Payment Model												
	Category 1 Payments: Fee-for-service with no link of payment to quality			Category 2 Payments: Payment Linked to Quality			Category 3 Payment: Alternative Payment Models			Category 4 Payment: Population-based Payment		
Payer Name	A. Total Number of Beneficiaries	B. Total % of Payments to Providers	C. Payment Model Name(s) and other Notes	A. Total Number of Beneficiaries	B. Total % of Payments to Providers	C. Payment Model Name(s) and other Notes	A. Total Number of Beneficiaries	B. Total % of Payments to Providers	C. Payment Model Name(s) and other Notes	A. Total Number of Beneficiaries	B. Total % of Payments to Providers	C. Payment Model Name(s) and other Notes
Example: Medicaid	200,000	10%	FFS Medicaid	1,000,000	50%	Primary Care Case Management	300,000	15%	Medicaid Health Homes	250,000	25%	Medicare-Medicaid (duals) plan

Model Performance

CMMI suggested metrics:

- ED visits
- All-Cause Readmissions
- Cost of care
- Patient experience
- Tobacco Use: Screening & Cessation Intervention
- Screening for Clinical Depression and Follow-up Plan
- Controlling High Blood Pressure
- BMI Screening and Follow-up

Rhode Island can adopt alternatives to these metrics where appropriate. We will leverage existing resources, like Health Facts RI, to compute these metrics.

Mr. King explained that CMMI requires SIM model participants to produce a metrics portfolio of model participation, payer participation and model performance. He noted, on slide 4, (Payer Participation) that there were four categories of payer participation models aligned with the recently released Whitepaper from the Healthcare Payment Learning and Action Network. The data on the Payer Participation slide is

just an example, but is in line with where CMS is encouraging states to move, toward Categories 3 and 4 on the right. CMS's actions are based on the notion that, as the payment model changes, the delivery system will also transform. OHIC has the ability to populate most of these cells based on currently available data. The SIM team will populate the table for CMMI, to the extent we can. Mr. King also noted that we will need to report on cost, quality, utilization and population health in the areas identified on slide 5, Model Performance. As no state agency owns system performance metrics, this might be an area that SIM should consolidate and own.

Steering Committee members discussed the suggested metrics, and expressed some concern about the metric limitations, especially in the realm of behavioral health. Mr. King responded that these were just the suggested metrics from CMMI and that we should take the opportunity to create additional and more meaningful metrics for Rhode Island.

Ms. Rosenberg asked Ms. Deb Hurwitz to share her conversations with CMS about the Medicare Access and CHIP Reauthorization Act (MACRA). Ms. Hurwitz told the group that Medicare is shifting from delivery model change to payment model change, because if they shift payments, the rest will follow, supporting Mr. King's earlier statement. MACRA is monitoring the portfolio of clinical business: the proportion in fee-for-service, vs. that in value based payments. In the early years, a delivery system will need to have at least 25% of its panel in a Medicare Alternate Payment Model (APM). If not, there will be a penalty. MACRA is expecting an increase in the portion of the panel in APM over time.

Dr. Hittner said that Rhode Island's model is very similar to what is being done by CMMI and will help us to manage what is coming. Ms. Rosenberg added that Merit Based Incentive Payment Systems (MIPS) is the wave of the future and so we should move ahead in concert with it.

Ms. Rosenberg asked if there were volunteers who would like to participate in a one time, interim meeting of the Measure Alignment Workgroup to address system performance metrics, to be held sometime in early May. The following Steering Committee members and community stakeholders volunteered: Larry Warner, Beth Marootian, Gary Bliss, Andrea Galgay, Joan Kwiatkowski, Al Charbonneau, Jim McNulty, Dr. Alexander-Scott, Elizabeth Burke Bryant, and Jim Beasley.

e. Community Health Teams

Ms. Rosenberg introduced the topic of Community Health Teams (CHT) and reviewed the CHTs in the context of the SIM wheel. She also reviewed the planning assumptions and the key roles of RIDOH and OHIC. She noted that we have a variety of models that are currently part of the CHT environment and that a workgroup composed of representatives from CTC and Hannah Hakim, PCMH Kids, has informed this process. Ms. Rosenberg reviewed the proposed core functions:

1. Improving population health by addressing social, behavioral, and environmental needs.

2. Supporting providers in making the transition to value-based systems of care;
3. Transforming primary care in a way that increases quality of care, improves coordination of care, and reduces/controls related costs and expenditures.

There was some discussion of primary care, as not all of the current CHTs have a focus on primary care. Chairman Giancola asked for an explanation about the difference between point #1 and #2. Ms. Rosenberg explained that the CHT members provide specific support to providers by the provision of care and the support for clinical compliance. As a result, they support providers in the transition to value based care.

Next Ms. Rosenberg reviewed SIM’s proposed CHT objectives:

- Help individuals engage consistently in primary care at times, in places, and for costs that are optimal;
- Promote more frequent or active engagement when necessary for the patient;
- Encourage increased use of electronic health records, patient portals, and other communication tools;
- Facilitate adoption of a patient-centric culture and assure continuity of care between providers;
- Access to appropriate community services and resources to address identified health needs;
- Help educate patients, families, or caregivers to improve health/healthcare literacy; and
- Empower patients and caregivers to be active voices who advocate for their needs.

Secretary Roberts commented that in prior objective lists, we had explicitly included the behavioral health connection, but we don’t here. Do we need to make that explicit? Ms. Rosenberg agreed that we did, and that the behavioral health connection would be returned.

Ms. Rosenberg then referenced the CHT handout, beginning with a revised budget proposal:

DESCRIPTION	TOTAL (3 YRS)	PROCUREMENT TIMELINE
CHT Initiative At-Large	\$2,000,000	---
Focus 1: New CHTs	\$1,500,000 to 1,750,000	June 2016 (Yrs. 1-3)
Focus 2: CHT Capacity - Infrastructure and enhancements - Provider Education	\$250,000 to \$500,000	June 2016 (Yrs. 1-3)

She noted that some Steering Committee members have been talking about the need for more CHTs, and so we were bringing forth this new budget proposal to allow more dollars for new teams (rather than splitting the dollars more evenly between new CHTs and infrastructure enhancements).

The Steering Committee approved this request for budget flexibility.

Next, Steering Committee members discussed the lack of explicit inclusion of children and adolescents in this model. An attendee suggested that perhaps the Cedar model could be expanded to include more children, including those not in Medicaid. Other points expressed covered funding for new vs. old teams, combining and leveraging administrative infrastructure to serve all teams, and the need to utilize the competitive RFP approach for this initiative.

Ms. Rosenberg led the Steering Committee in a discussion of additional proposal for SIM investments, based on the document handed out at the meeting (quoted language in italics):

Specific Proposal for SIM Investment

Enhancing Current Teams

SIM staff held a discussion with approximately 20 leaders of Rhode Island CHTs to determine what specific investments would work to build their capacity to serve more individuals and leverage additional care for Rhode Islanders at “highest-risk.” Resulting from these discussions were four areas for investment:

- *Centralized, statewide training and professional development—including promotion of community health worker (CHW) certification; platforms for information sharing (e.g., care management dashboards and shared plans of care);*
- *Development, collection, and sharing of screening/other clinical tools for inter-team implementation; and*
- *Development and evaluation of a financial model for long-term sustainability.*

SIM Steering Committee approval was requested to allow SIM to make funding decisions for current CHT activities that meet the spirit of these suggestions, and other related, creative ideas. The Steering Committee agreed with this request.

Creating a New Team, or New Teams

Here are the general guidelines we are proposing as a strawman for Steering Committee approval. In order to receive funding, a new CHT should meet the following guidelines:

- *A new CHT should be multi-disciplinary and consist of both community health workers and health coaches;*
 - *CHWs are non-licensed generalists with a CHW certification (in the absence of certification, those currently acting as peer navigators/care coordinators/resource specialists are considered CHWs).*
 - *Health coaches are licensed healthcare professionals with community health focus and/or specialization who provide clinical education and input into clinical decisions related to care.*
- *The composition of the CHT and the disciplines participating in the teams should reflect the needs and diversity of the community being served;*
- *The CHT should be accessible to all individuals regardless of insurance (i.e., the CHT funded by SIM should not exclude anyone because of the insurance that they have or because they are uninsured); and*
- *The CHT should work directly in the home or the community to address factors that impact people’s health, including social, behavioral, and environmental determinants of health.*

SIM Steering Committee approval is requested to allow SIM to make funding decisions for new CHT activities that meet the spirit of these guidelines and other related principles.

Steering Committee members carried out a broad discussion. They questioned the potential geography of the new CHTs. (Ms. Rosenberg noted that while the proposal was silent on geography, primary providers do all exist in a particular geography.) Members talked about the importance of avoiding duplication by covering people not already covered by health homes model, how CHTs should serve those without insurance, undocumented or not, or covered by any carrier.

Ms. Rosenberg then moved to two additional specific requests for Steering Committee approval:

Proposed Model for How a New SIM-Funded CHT Will Connect with Clients

SIM has the money to fully fund one or two teams. We believe that funding a team that aligns with one of the current provider-based CHT models in the state allows us a better opportunity to evaluate the new team's effectiveness rather than trying to evaluate one team in a new model. The latter option's success might be replicable or it might be merely a fluke. Therefore, we are proposing that the new SIM-funded CHT be distinctly connected to a provider – either primary care or community mental healthcare for a population with SMI/SPMI.

Proposed Targets for New Funding

Again, because we are only funding one to two teams, we propose to spend these dollars on focused interventions on "highest-risk" individuals. "Highest-risk" can be defined in myriad ways, but at a minimum should consider the general criteria listed as part of our estimate of need. Particular focus could be placed on an individual's utilization of healthcare services, chronic, complex, and uncontrolled conditions, untreated behavioral health needs, and specific neighborhoods disparately affected by poor social or environmental determinants of health.

In response to a question about the moving forward to fund the CHTs, Ms. Rosenberg suggested that we could write a RFP that was sufficiently broad so that responders could make their best arguments for their model. She emphasized that the expenditure was to be for new services. An attendee noted that there should be an evaluation component and Ms. Rosenberg agreed that all RFPs will have a strong evaluative component. Jim Berson commented that he was there was risk associated with a broad RFP and that the RFP should outline principles and priorities.

Ms. Rosenberg then asked for consensus on these specific criteria – that SIM would fund CHTs tied to providers, flexible on funding, targeted to those at highest risk, and a more narrowly focused RFP, incorporating Mr. Berson's suggestions regarding principles and priorities. The Steering Committee came to unanimous consensus on this request.

f. Integrated Population Health Plan

With little time left, Sherry Lerch, from the Technical Assistance Collaborative (TAC) summarized the key areas of change in the updated IPH plan document sent to the Steering Committee for review:

- We have moved from a single behavioral health measurement area, Behavioral Health Morbidity, to four focus areas – Depression, Serious Mental Illness, Children with Social and Emotional Disturbance, and Opioid Use Disorder. She emphasized that while these are the areas around which data can be collected, they are not the only conditions that will be mentioned in the report.
- Regarding Sections 9 and 10 of the Operational Plan, discussing new innovations, for the April 30 draft submission we will be focused on those existing interventions and how they can be scaled

and/or integrated for more leverage. We will explore new interventions for the June 30 version of the Plan.

- We will shift the focus, post April 30, to a plan more focused on wellness and health. The requirements from CMS to measure several specific morbidities or illnesses have led to a plan that seems overly focused on disease – and we will work to change that frame in the second phase of the Integrated Population Health writing.

5. Public Comment

There were public questions and comments throughout the presentations and discussion. Those remarks are captured above. Ms. Rosenberg thanked the group and staff for their efforts. The attendees applauded.

6. Adjourn

The next meeting will be held on May 12, from 5:30 PM to 7:00 PM at 301 Metro Center Blvd.

With no further business or discussion, the meeting adjourned at 7:30 PM.

Notes prepared and respectfully submitted by:

Joanne Kalp
UMass Program Management
April 20, 2016