

## C.4 Healthcare Delivery System Transformation Plan

Traditional state functions for advancing policy consist of the state as convener, purchaser, regulator, infrastructure funder, and evaluator.<sup>1</sup> Rhode Island's State Innovation Model (SIM) project is structured such that its footprint marks each of these domains of state action and, at a high level, SIM acts as a collaborative space, or hub, for interagency policy alignment and coordination as well as a public/private partnership with its Steering Committee and other stakeholders. Rhode Island is committed to transform the local healthcare system through the coordinated use of regulatory and purchasing levers, direct investment in workforce and health information technology infrastructure, and public-private collaboration.

### Baseline and Vision

Rhode Island's current healthcare system is not built to achieve the socially desirable ends of improved physical and behavioral health for the state's residents, nor is the system financially sustainable. Rhode Island's current healthcare system relies on fee-for-service reimbursement, which rewards volume generation and promotes fragmentation of care, resulting in duplication of lab and imaging services, unnecessary hospitalizations and emergency department visits, and unmet patient needs. There remain important gaps in health information technology, data infrastructure, and support for Rhode Island's healthcare workforce as well.

Through the assistance of a State Innovation Model Design grant in 2013, and the development of a State Innovation Model Test grant proposal in 2014, Rhode Island's healthcare stakeholders, public and private, have asked what resources, policy initiatives, and market rules are necessary to transform the local healthcare system to meet the goals of the Triple Aim.

Rhode Island's Model Test is built on the premise that transitioning to healthcare payment models that reward value, as opposed to volume, and incentivize providers to work together, is a necessary step toward building a sustainable healthcare delivery system that:

- Promotes high quality, patient-centered care that is organized around the needs and goals of each patient,
- Drives the efficient use of resources by providing coordinated and appropriate care in the right setting, and
- Supports a vibrant economy and healthy local communities by addressing the physical and behavioral health needs of residents, including an awareness of the social determinants of health.

Changing financial incentives is necessary, but not sufficient, for building a healthcare system that meets our vision. Rhode Island's SIM project coordinates state agency purchasing and regulatory initiatives along with private sector efforts to promote value-based payment and delivery system structures that support population health management, and are enabled by value-based payment. At the same time, SIM deploys direct investments in system transformation, encompassing support for Rhode Island's healthcare workforce and health information technology infrastructure.

**Commented [RM(1):** We will add in some specific behavioral health shortfalls here too.

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<sup>1</sup> Cite ACO Report

## The Rhode Island Approach to Transformation

The Rhode Island approach to healthcare system transformation is statewide and comprises the following 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 the 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.

The transformation activities executed and planned within each of these four elements are discussed below.

### **1. Coordinated and aligned approaches to expanding value-based payment models in Medicaid and commercial insurance through state purchasing and regulatory levers.**

Current initiatives through the Centers for Medicare and Medicaid Services (CMS) and the Health care Payment Learning and Action Network (LAN) emphasize the importance of reaching a “critical mass” of payers engaged in payment reform to ensure that the attendant financial incentives of value-based payments are strong enough to support system transformation.<sup>2</sup>

Rhode Island has derived great benefit from the Alternative Payment Model Framework developed by the LAN and published in January 2016. In what follows, the terms *value-based payment* (VBP) and *alternative payment models* (APM) are consistent with APM Framework categories 2 – 4 (VBP broadly) and 3 – 4 (APM), respectively.

At the outset of the SIM project, uptake of VBP and APMs was uneven across the local healthcare market. Commercial insurers and their provider networks had the longest experience contracting under VBP and APMs. In 2014, 24% of commercial insured medical payments were made under an APM, largely comprised of fee for service payments made under population-based APMs with shared savings. These contracts were generally no more than two years old. VBP models and APMs were in an early stage of development in the Medicaid market. Quality measures used for value-based contracting were not aligned major payers.

### **Year 1: Pre-Implementation**

To accelerate payment reform, and coordinate action across all payers, the Office of the Health Insurance Commissioner (OHIC) and Medicaid stewarded two closely aligned processes to advance VBP

<sup>2</sup> Rajkumar R, Conway P, Tavenner M. CMS – Engaging Multiple Payers in Payment Reform. JAMA. 2014; 311(19): 1967-1968.

and APMs in their respective market jurisdictions. OHIC and Medicaid have explicitly aligned payment reform targets with those announced in January 2015 by Secretary of Health and Human Services Sylvia Mathews Burwell.<sup>3</sup>

The SIM Project Director coordinated meetings between OHIC and Medicaid to ensure alignment of these initiatives. The SIM project has initiated an unprecedented level of interagency coordination and alignment in Rhode Island.

In February 2015, OHIC promulgated regulations that required commercial insurers to “significantly reduce the use of fee-for-service payment as a payment methodology, in order to mitigate fee-for-service volume incentives which unreasonably and unnecessarily increase the overall cost of care, and to replace fee-for-service payment with alternative payment methodologies that provide incentives for better quality and more efficient delivery of health services.”<sup>4</sup> To carry out this provision OHIC convened an Alternative Payment Methodology Advisory Committee, which held two rounds of meetings, in the spring and fall. The key objectives of the meetings were to define APMs, collect data from health plans to measure the baseline rate of APM uptake, and to develop binding annual regulatory targets for commercial insurer use of APMs through 2018. The outcome of the OHIC process was the promulgation of regulatory targets for commercial insurers based on percent of insured medical spending that is made under an APM according to the following schedule:

**Table: Rhode Island Commercial Payment Reform Targets**

Year	Target
2016	30%
2017	40%
2018	50%

Rhode Island’s Medicaid program contracts with two Managed Care Organizations (MCOs) for most beneficiaries and services. In 2015, Medicaid, as regulator and purchaser, embarked on a lengthy public process to transform the state’s Medicaid program and drive transformation of the healthcare system as a whole. This process resulted in several key reforms, including a Medicaid Accountable Entities (AE) Coordinated Care Pilot Program. Under the Coordinated Care Pilot Program, pilot AEs enter into contractual arrangements with Medicaid MCOs to manage a population of Medicaid members under a risk adjusted total cost of care arrangement. The Coordinated Care Pilot offered two tracks:

- **Type 1 Coordinated Care Pilot: Total Population, All Services:** This track offered an opportunity to contract for all Medicaid attributed populations, for all Medicaid services.
- **Type 2 Coordinated Care Pilot: Severely and Persistently Mentally Ill (SPMI)/Severely Mentally Ill (SMI) Population, All Services:** This track offered an opportunity to contract for a specialized Medicaid population, for all Medicaid services. Type 2 pilots were only established for persons with SPMI or SMI.

AEs are expected to develop and prove competency in two priority areas: 1. Integration and coordination of long-term services and supports; 2. Physical and behavioral health integration.

<sup>3</sup> Cite Press Release.

<sup>4</sup> OHIC Regulation 2 Section 10(d)(2)

Experience from the Coordinated Care Pilot Program will inform certification standards for Medicaid AEs. AE certification is discussed under Years 2-4: Implementation, below.

Medicaid also developed incentive payment programs for hospitals and nursing homes under the Rhode Island Health Transformation Program (RIHTP).

#### **Years 2-4: Implementation**

Rhode Island is poised to significantly advance the use of VBP and APMs through the implementation period of the SIM grant. In year two, Medicaid will develop certification standards for Medicaid AEs. Medicaid MCOs will be expected to contract with AEs on a total cost of care basis for attributed populations, according to specific annual targets specified in the MCO's contract with the state. AEs must demonstrate the capacity to integrate and manage the full continuum of physical and behavioral healthcare, from preventive services to hospital based and long-term services and supports. AEs must also focus on the social determinants of health among their attributed populations. The AE contracting mechanism will be one of the primary means for Medicaid to achieve 50% of payments under an APM by 2018.

OHIC will track commercial insurer compliance with their annual APM targets on a semi-annual basis. In addition to semi-annual reporting of APM use, OHIC will require each insurer to develop plans for engagement of specialists in VBP arrangements, including the development of APMs for high volume specialties and specialty care practices. These requirements build on extant rules that obligated insurers to have quality improvement programs with hospitals and tie hospital fee increases to quality performance.

During year two of the grant, the SIM team will convene a learning collaborative comprised of providers and payers who are engaged in VBP and APMs, to discuss best practices around VBP contracting methodologies and implementation. With an eye toward process and program evaluation, the learning collaborative will shed light on what works, and discuss potential alignment of VBP contracting strategies. The collaborative will provide a valuable forum for providers and payers to learn from one another, to ensure that we maximize the potential of payment reform to support delivery system transformation and meet our cost, quality, and population health goals.

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.

#### **2. Support for multipayer payment reform and delivery system transformation with investments in workforce and health information technology.**

Despite significant investments in healthcare system transformation from payers, providers, community non-profits, and the state, as well as preliminary steps to transition toward value-base payment models that support that transformation, there still exist gaps in health information technology, data analytics, and workforce supports to achieve the Rhode Island vision outlined above.

## Year 1: Pre-Implementation

During year one of the grant, the SIM Project Director met with each member of the SIM Steering Committee. The purpose of these meetings was to ascertain where the greatest needs were, and how SIM investments could best address those needs. The question of how Rhode Island should allocate SIM funds presented a choice between going “narrow and deep” or “wide and thin.” Through a lengthy and iterative process of consensus building, the SIM Steering Committee endorsed three interconnected buckets of SIM program investment:

- Investment in Rhode Island’s Healthcare Workforce – Practice Transformation
- Investment in Patient Empowerment
- Investment in Increasing Data Capability and Expertise

The investments within each of these buckets address a critical need, which will facilitate payment reform and delivery system transformation. The figure below, known among SIM stakeholders as “The Transformation Wheel” illustrates the portfolio of SIM investments authorized by the SIM Steering Committee.

Supporting healthcare providers at all levels with practice transformation activities is critical to building a sustainable healthcare system that meets patient needs and pursues improved population health as its outcome. Rhode Island has a mature multipayer patient-centered medical home (PCMH) program and a strong commitment to support primary care. Given that primary care providers have assumed greater accountability for improving system performance and population health, the investments in the practice transformation bucket are intended to provide support for drawing linkages between patient care and community resources (Community Health Teams), access to expertise outside of the primary care office (through the Child Psychiatry Access Program), transformation assistance for behavioral health providers, and a technology platform for collecting clinical data and reporting measures to payers. All of these activities are meant to ensure that providers can work to the top of their licenses and experience more job satisfaction. SIM has convened several workgroups in this area in order to further define these areas of practice transformation and to ensure that SIM-funded resources are coordinated and not duplicative of private sector resources.

There was broad agreement among the SIM Steering Committee that patient behavior was a critical piece of the overall project. In discussions about our Driver Diagram, certain assumptions about patient behavior undergirded the causal pathways from interventions and drivers to program aims. Patients must become active agents in their health and healthcare. To support patient agency, the SIM Patient Engagement Workgroup began holding meetings in year one to determine the tools and information necessary to meet this goal.

Data analytic capacity and expertise is absolutely critical to improving and evaluating healthcare system performance. The SIM Steering Committee authorized investments in HealthFacts RI (Rhode Island’s all payer claims database), a statewide Common Provider Directory, and infrastructure enhancements to Rhode Island’s Data Warehouse.

Pre-implementation activities for the above areas of practice transformation, patient engagement, and data analytic capacity and expertise include convening workgroups and stakeholder meetings to ensure proper allocation of resources and community buy-in, working through the state procurement system to buy services as appropriate, and developing metrics to measure success for each of these investments.

The procurement of funds for HealthFacts RI and the Common Provider Directory has happened, and the funds began flowing to these projects in year one.

#### Years 2-4: Implementation

In year two, Rhode Island will procure the services and structures necessary to carry out the remaining activities enumerated in the Wheel.

Rhode Island plans to apply the following principles to the implementation of these activities:

- Ongoing evaluation, including mid-course adjustments as necessary,
- Flexibility in the design and implementation of these activities to account for potential changes to the health care environment, and
- Continued stakeholder engagement among governmental agencies and private sector participants, including providers, payers, and community organizations.

#### Practice Transformation:

During Years 2-4, Rhode Island will continue to strengthen its health care workforce and the connection of that workforce to the community through the practice transformation initiatives outlined in the Wheel. The workgroups mentioned in the Year 1 Pre-Implementation phase will continue and be used for community feedback.

- Community Health Teams
- Child Psychiatry Access Program
- Behavioral Health Transformation
- Health Care Quality, Measurement Reporting and Feedback System

#### Patient Engagement:

#### Data Analytic Capacity and Expertise:

### 3. Significant stakeholder engagement in policy development and SIM investments through the SIM Steering Committee, SIM Workgroups and agency-specific advisory groups. In Rhode Island, healthcare delivery system transformation is a public-private partnership.

Rhode Island has a long tradition of stakeholder engagement in policy development. The state's small size enables key stakeholders to physically convene on a regular basis and with relatively little cost. Healthcare reform in Rhode Island has benefitted greatly from this tradition. Under the leadership of then-Lieutenant Governor Elizabeth Roberts (who now serves as Secretary of the Executive Office of Health and Human Services) the Rhode Island Healthcare Reform Commission stewarded a process of lengthy public engagement around Affordable Care Act implementation. The Healthcare Reform Commission infrastructure was leveraged during Rhode Island's State Innovation Model Design phase, and supplemented by topic-specific workgroups, developed the State Health Innovation Plan (SHIP) which served as the basis of Rhode Island's State Innovation Model Test Proposal.

**Commented [RM(2)]:** As we continue writing, we will include more specifics around the specific interventions here, including milestones for the interventions and metrics from the driver diagram.

**Commented [RM(3)]:** To be completed.

**Commented [RM(4)]:** We have a lot of information on our stakeholder work in the specific stakeholder section of the Operational Plan that we can reference. We will also use the chart of related groups that Jenn Wood created for SIM in the document.

## **Year 1: Pre-Implementation**

Rhode Island's SIM project relies on significant stakeholder engagement to achieve consensus on where our healthcare system's needs are, and how we can best address those needs. During year one of the grant, the SIM Steering Committee met seven times and reached consensus on a portfolio of SIM funded investments for the life of the grant. The Steering Committee also endorsed several workgroups to advise or develop specific products within the grant. These workgroups include:

- Integrated Population Health Plan
- Measure Alignment
- Technology Reporting
- Patient Engagement

In addition, SIM is working with two community groups that have brought stakeholders together to focus on Community Health Teams and Provider Practice Transformation. Rather than form our own competing workgroups that would bring people to duplicative meetings, we have asked these community organizations to allow Healthy Rhode Island to put topics on these workgroups' agendas and have them serve as our touchpoints on these issues.

Workgroups have been an effective mechanism for processing the needs and goals of the larger community and achieving buy-in for specific investments and initiatives.

## **Years 2-4: Implementation**

All of these workgroups will continue through year two of the grant.

The Integrated Population Health Workgroup will continue to meet on a quarterly basis, to check in on the progress toward population health improvement goals. The Technology Reporting Workgroup will continue to refine the scope of the Quality Measurement, Reporting and Feedback System for procurement by the state. The Patient Engagement Workgroup will continue to meet to assess the tools necessary to equip consumers with information to become effective consumers of health care. The Measure Alignment Work Group is discussed at length in Section C.7.

We may create additional workgroups in year two, including a group on Workforce Development.

### **4. Fidelity to our Integrated Population Health Plan to ensure that transformation is consonant with our vision of improved physical and behavioral health.**

Rhode Island has committed to improving the physical and behavioral health of its residents. The Integrated Population Health Plan provides a philosophy and a set of recommendations for stakeholders, including state agencies, to ensure that policymaking and delivery system transformation are consonant with our vision for improved population health. Rhode Island understands that much of what determines health is contingent on factors outside of medical care delivery. However, as payment models change to enable and incent system transformation, stakeholders should interrogate whether these models and structures are supporting improvements in the health of the population and communities served by the system.

**Year 1: Pre-Implementation**

In year one Rhode Island developed the Integrated Population Health Plan, included in Section C3 of this Operational Plan. The Integrated Population Health Plan was completed with considerable guidance from the Rhode Island Department of Health and the Department of Behavioral Health, Developmental Disabilities and Hospitals.

**Years 2-4: Implementation**

In development.

