CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

October 13, 2020

Jennifer Marsocci
Project Manager – HSTP, State of Rhode Island
Executive Office of Health & Human Services
3 West Road, Virks Building
Cranston, RI 02920

Dear Jennifer,

RE: CTC-RI Response on Accountable Entity Roadmap & Sustainability Plan

On behalf of the Care Transformation Collaborative of Rhode Island (CTC-RI), I want to congratulate you and your team on the work accomplished to date to implement the strategic goals in the accountable entity roadmap as well as the development of a sustainability plan to ensure this work continues in the future. CTC-RI appreciates the opportunity to review these documents and respectfully submits the following input per your request for public comment.

We wholeheartedly agree with the overall premise that "effective transformations must build partnerships across payment, delivery and social support systems…" (p. 4). We would recommend adding some additional key concepts based on the recent work we have done with the Health Equity Challenge and using concepts from the Pathway to Population Health framework:

- We recommend including a central role incorporating the person with lived experience to better address underlying conditions and needs in the expectations, plan and metrics.
- People live in the community and the community can provide place-based solutions. We recommend including an emphasis on taking a place-based approach as a key principle. This input would be useful for the development of "in lieu of" and value-based service provisions.
- We need to not treat everyone the same and recommend incorporating risk stratification. Using the RIQI Care Management Dashboard is a helpful tool for identifying people in need of assistance and would recommend considering adding Social Vulnerability Index to better identify people in need based on potential disparity based on poverty, race and ethnicity.
- The Pathway to Population health framework includes 4 interconnected portfolios of work: the clinical side works on improving health and wellbeing of people and clinical—community linkages improve the health and wellbeing of places.

We recommend taking a multi-payer approach that is additionally aligned with OHIC for strengthening the "clinical side" and providing payment for comprehensive primary care (which

includes nursing, pharmacy, behavioral health (BH) care management, and community health teams (CHTs)). Value-based payments that are only based on total cost of care performance is inadequate to transform primary care. It is important for Medicaid and the MCOs to lay the groundwork and move quickly to pre-payment for primary care services (comprehensive primary care capitation) in concert with efforts from OHIC. This will help practices reach a desired threshold of 62% of attributed patients under capitation and maximize the care delivery workflows to support success.

- Presently MCOs are providing care management payment for pediatrics but not for the adult population. Payment for adult care management needs to be incorporated to provide care management across the age spectrum. Additionally, care management needs to be provided within the context of the patient-centered medical home, and cost savings and reduction in duplication of services can be better achieved by clarifying the role and responsibilities of the MCOs. It is not clear in the plan how the transition of MCO care management functions will be transitioned to the AE's.
- We fully support the role of the community health worker in assisting patients who are at high risk with a payment model that is not based on fee-for-service. For CHTs, we recommend a definition that includes provision of home-based BH services based on our findings that patients referred for community health team services have high incidence of depression, anxiety and substance use disorders.
- For strengthening clinical—community linkages, we support the inclusion of the MCOs for data management and potential use of MCO shared savings investment. We recommend including a role for the Health Equity Zone (HEZ) as a backbone for strengthening investment in building community solutions. We recommend outlining the key roles Accountable Entities have in building both community linkages and community solutions so their work on Rhode to Equity is not seen as "extra work".
- We understand the role of shared savings in terms of building ongoing sustainability and the need to concentrate on high-risk populations. The plan mentions prevention and children; however, the financial support for working on areas that may not reap immediate shared savings is of concern.
- For administrative simplification, we recommend including alignment strategies among the MCOs especially since MCOs certify that an AE has met the approved metrics.

We want to note 2 areas, in particular, where strong and effective partnerships and coordination between the health care system and community-based organizations are especially important:

- **Special attention needs to be paid to children and families** since health systems will naturally (and should) focus efforts on higher cost and rising risk patients. **Leveraging existing assets and natural connections of the 2 place-based CHTs – Family Services of RI (FSRI) and South County Health (SCH) – both connected to family home visiting services, will facilitate this child/family focus. Engaging schools is also very important in serving high-risk children and families.**

- Recognizing the interconnection between Medicaid and commercial coverage for the "working poor", as well as Medicare and dually-eligible members, requires a more comprehensive approach than a simple focus on the Accountable Entity (AE) structure. **A broader <u>multi-payer</u> and <u>multi-sector</u> programmatic and funding strategy will allow for greater long-term equity and sustainability.**

<u>Add Health Equity as part of Certification Process</u>

CTC-RI strongly supports the proposal included on page 10 to add an additional element to the certification process on health equity for the AEs. This addition would:

- Provide needed spotlight on the critical work that must be done to address existing inequities.
- Add weight and priority to initiatives outlined in the sustainability plan and the previously released SDOH strategy document, including the Health Equity Challenge and CHTs, that we believe are central to

our state's efforts to eliminate systemic racism and inequities.
- Ensure that resources – time, funding and attention – are dedicated to this work.

Adding this domain to the certification process can also help spur small but important changes in how we frame and think about the work ahead required to ensure that all Rhode Islanders receive equitable access and care. For example, we would suggest a reframe of the terminology on page 22, where you describe some outstanding examples of community—clinical partnerships that support sustainability. Instead of referring to these partnerships as "External Partnership", we suggest changing this to say "Community—Clinical Partnerships" to better reflect and be more aligned with the approach and intent behind the SDOH Strategies document.

Paying for Staff Providing High-Value Services

We agree that figuring out how to support staffing needs over the longer term is a priority and needs more examination. We suggest adding Peer Recovery Specialists (PRS), especially PRS roles that are cross-trained to serve as Community Health Workers (CHWs) to the plan's comprehensive list (p. 23).

And, as is pointed out in the Sustainability Plan, it is important to explore sustainable avenues to pay for these high-value services. As you note in the discussion of high-value services, there are barriers to billing, especially BH services delivered outside the health care setting, such as care provided in the community by the CHTs. From our experience supporting the CHTs, services provided in these crucial roles are often not fully reimbursable (i.e. BH Clinicians) or are not billable at all (i.e. CHWs). We look forward to working with our state partners to investigate forward-looking and creative ways to pay for these high-value services long-term, including alternative payment methodologies that support comprehensive primary care. Incorporating CHTs as part a comprehensive payment for primary care will help mitigate the challenges associated with billing for BH services, as many of the services provided by the BH Clinician on the CHT are not reimbursable (i.e. case conferencing, travel, warm handoffs).

Key Role for Practice Facilitation

We agree with the emphasis on best practice sharing and strongly support the comments noting the cost effectiveness of practice facilitation support for providers as a way to share best practices and support change efforts at the practice level. Having led the way in this practice over 10 years, we want to add that this approach is not only cost-effective but also highly effective.

Invest in Centralized HIT, including a Community Referral Platform

We want to strongly suggest that the Community Referral Platform be included as a main component of a centralized IT plan along with the other components already included in the document. Toward this end, as outlined in comments recently submitted for the HSTP SDOH strategy document, we share the following suggestions to further improve the outcome of the effort to standup an e-referral system as an integrated part of the HIT landscape:

- Maximize connectivity with other systems to the extent possible, including to the HIE.
- Promote the use of one e-referral platform statewide, to the extent possible. With multiple platforms currently being promoted, we recommend EOHHS take leadership on the use of a **single statewide system** to ensure widespread use. Our concern is that with multiple e-referral systems in use in RI, providers will not use them.
- Ensure that the e-referral system is also available to health plans. This is an important way to improve

coordination and reduce duplication of services.

- Address concerns around patient consent, stigma and privacy while maximizing care coordination and avoiding duplication of services.
- This system needs to be able to easily and effectively identify a "primary care manager/ quarterback".
- This is a complex undertaking; recommend including strategy of using a peer learning community approach that includes goals, deliverables, infrastructure and incentive payment, and peer learning community approach.

Health Equity Challenge (HEC)

CTC-RI strongly supports expansion of the HEC as a component of the effort to provide more centralized infrastructure and more effectively address social determinants of health. Even in just the few months since CTC-RI has worked with RIDOH to launch the HEC, this approach has already proven effective. Here is just one example:

> East Bay Community Action Program, Inc. (EBCAP) is one of the HEC teams which includes a representation from: 1) HEZ, 2) CHTs, 3) clinical practice site (AE), and 4) a person with lived experience. The team completed the Pathway to Population Health Compass tool and identified 7 people with diabetes to interview about their experiences and needs. Team partners additionally identified assets and needs and developed an AIM statement to provide healthy food to people with diabetes. Resources were identified within the HEZ Community and within the EBCAP social services program. They were able to access gift cards and clinical advice from a dietician. Additionally, they identified people who needed healthy foods by looking at people who were seen at COVID-19 testing sites, clinical sites, CHTs, and BH sites. The team has started matching the needs with the resources as a first step in building community solutions.

This example illustrates, by focusing on a shared challenge, that clinical and community partners have been able to successfully work together to identify and implement solutions with and for the people living and working in each of the communities in the project.

As part of the HEC, teams were eligible for $20,000 to cover the costs associated with participating in the 5-month learning collaborative (including payment for the person with lived experience). Teams were expected to meet weekly and devote additional time to develop and implement action plans. Team members represented different aspects of the Pathway to Population Health portfolio and each voice was needed to establish stronger clinical and community linkages that improve health and wellbeing of people and places. **The proposed HSTP investment in the expansion of the HEC needs to include funding to support team participation and team coaching support**. It is additionally recommended that the work plan include a focus on obtaining "lessons learned" from the 2 existing teams and identify what is needed to successfully implement action plans during Phase 2 action labs. **Most communities have practices from more than one AE. The HEC should recognize this and encourage coordination between the multiple AE practices along with the CHT/HEZ and MCOs**.

From our experience in PCMH transformation, we recommend establishing common standards, goals, metrics across all CHTs; having infrastructure payment and incentive payments for meeting goals, together with a learning community and data management system for reporting metrics. We advocate for a strategy to address a mechanism whereby all Medicaid patients have access to CHTs and strategy for ensuring that children, families are included in having access to CHTs.

We envision the HEC as a vehicle to foster meaningful, long-term collaborative relationships between the HEZ, AEs/CHTs and MCOs by providing a model for transformation and cross-sector collaboration. Ultimately, we hope this effort lives up to its name and spurs an even larger effort to achieve equity in our health care systems and communities.

Sustain Community Health Teams (CHTs)

We were gratified to see the value and importance placed on CHWs and CHTs is included in the Sustainability Plan and included as one of the 5 key investments in the previously released HSTP Social Determinants of Health Investment Strategy.

Under CTC-RI's multi-payer CHT pilot, over $5M has been invested over 5 years in the development and evaluation of the CHTs. CTC-RI's CHT model utilizes CHWs and BH Clinicians as a critical extension of primary care, especially for individuals and families who have a high level of chronic care, BH and/or social needs. Outside evaluation findings as well as our own internal data collection demonstrated the value of this intervention. A Brown University study shows reduction in total cost of care for CHT members when compared to a matched comparison group (over $6,000 less annually with an estimated annual return on investment of $2.85 for every $1 invested). Additionally, the University of RI has reported improvements in clinical scores and improvements in social needs for CHT members served after only 5 months.

As referenced above, CTC-RI has invested in formalizing partnerships between RIDOH family home visiting programs and CHTs. The result has increased cross-agency, multi-disciplinary, team-based approaches to serving families with complex needs. This is particularly true for our 2 CHT teams (FSRI and SCH). We see value in expanding this approach to serve more families with continued CHT support.

We want to recognize the 2 CHT models that CTC-RI supports and the value for continued support for both models. The teams that are based in a Federally Qualified Health Center (FQHC) are clearly part of their AE's care management functions and have enough volume to be internally focused. **The place-based teams have found success in serving multiple AEs and providers with a multi-payer approach.** It is evident that CTC-RI's CHTs provide more intensive community-based and BH supports to the clients they serve and can serve as an adjunct to existing care management services.

We want to suggest that sustaining the CHTs be called out more specifically in the Sustainability Plan, similar to the manner with which the Community Referral platform and Health Equity Challenge are noted in the document. As was shared in previous public comment, in order to fully achieve their potential, these CHTs, and the organizations that employ them, need a sustainable, multi-year stream of funding aligned closely with the AEs, HEZ and other efforts to address SDOH and provide care coordination for families with complex, high levels of need. Without a reliable, multi-year funding stream, it will continue to be challenging to make the longer-term investments needed for this program to reach its full potential. Here are some of the benefits that we believe will be realized once a sustainable funding source is in place:

- Ability to invest in more robust data collection, including using the state's QRS system to measure quality and to tailor agencies' EHRs to expand patient data capture.

- Ability to set performance standards and identify metrics that can be measured over a timeframe longer than 12 months. Ability to expand more multi-disciplinary teams to serve high-risk families. Increased coordination with RIPIN can also strengthen a coordinated approach for children and families.
- Ongoing collaboration with Medical-Legal Partnership Boston (MLPB).
- A multi-sector funding/investment approach including hospitals can help provide significant resources to the community-based teams for relatively small investments from the different sectors.

Further, our experience on the ground confirms that the development of a sustainable funding stream will be most impactful if it is firmly placed within a service delivery framework that is multi-payer and multi-sector. This will ensure that we support full access for all individuals and families in need of services with no financial, insurance or geographic barriers to service.

Sincerely,

Debra Hurwitz, MBA, BSN, RN
Executive Director
dhurwitz@ctc-ri.org
978-502-9811