Project Narrative

Healthy Rhode Island: A Plan for Rhode Island's Health Care System of the Future

Overview. For decades, Rhode Island has been focused on strengthening and improving our community's health and our health care system. From the ground-breaking RIte Care managed care program for children and adults, to capitated, limited network health plans, to a nation-leading focus on patient-centered medical homes, our state has pressed forward on health care innovation. And yet, as the coverage expansions under the Affordable Care Act rapidly approach, the health care system in Rhode Island continues to struggle under the weight of unsustainable cost increases, poor coordination, and a lack of clarity surrounding the true health needs of the community in the future. Despite these challenges, Rhode Island's health care community, including payers, health care consumers, employers, providers and government, continue to work to reach a commonly held, but seldom explicated goal – to reshape the health care system into one that allows for the best treatment and services, in the right setting, at the proper time, and at a sustainable, affordable cost. In order to achieve this right time, right place future health care delivery system we will need to dramatically reorganize, creating a system that meets the triple aim of improving population health, improving the patient experience of care and doing so at an affordable, sustainable cost.

This health care system of the future cannot be segmented, but rather must be a coherent, coordinated and integrated system that cares for and supports a person from birth through death, regardless of health status, socio-economic status or payer. To accommodate this level of integration, the infrastructure to support care must always be at the forefront of technology. To ensure the quality of care and the accessibility of providers, health services must be provided and paid for with a minimum of administrative burden while maintaining the integrity of the health care financing system. To support the continued innovation of the health care system, payers and government regulators must be willing and able to adapt to the changing needs of providers and

patients. To support improved health in the community, state and local leaders must join with health industry leaders, working together toward the goal of strengthening population health.

Despite the progress that Rhode Island has made in building the foundation of its health care system of the future, and despite Rhode Island's demonstrated ability to meaningfully reshape its health care system, the needed change will not come easily, nor will it come without a facilitated planning process. In order to address that challenge, Rhode Island has made the decision to pursue the option for model design as offered by the Center for Medicare and Medicaid Innovation.

A. State Health Care Innovation Plan and Model Design Strategy. We envision a robust, high-intensity, multi-stakeholder process for the development of the Rhode Island Health Care Innovation Plan, including innovation models for intervention that will result in significant changes in the health delivery system. The ultimate goal for the plan, and the models envisioned under the plan, is to move Rhode Island's health care delivery system to a value-driven, community-based and patient centered system. It has been Rhode Island's experience that major planning processes are most successful with five essential components:

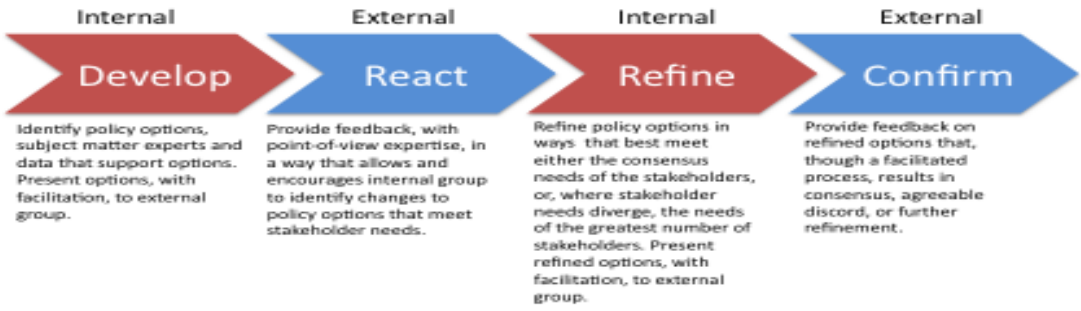
- State government leadership at the cabinet and sub-cabinet level that is coordinated and committed to both the planning process and to the end goal of the plan,
- Dedicated state staff, with deep subject matter expertise, who are representative of all program areas involved, and who are provided support and decisional discretion by their agency leadership,
- Robust stakeholder engagement that is open and inclusive of all stakeholders and in which the opinions and suggestions of stakeholders have a meaningful impact on policy and program development, and
- Expert technical assistance, provided through contracted services, which is trusted by leadership, that supports and complements staff and that is engaged with and responsive to stakeholders.

- Community leaders who are committed to the planning process and to the integration of improved population health into their own respective policy goals.

Rhode Island's successful Health Benefits Exchange planning, as well as the ongoing, first-in-the-nation implementation of a completely integrated technology system for Medicaid and human service program eligibility and the Health Benefits Exchange, have been successful because of the inclusion of all of these components. We are proposing that the process for the development of the state health care innovation plan and delivery system reform models uses this paradigm.

The creation of the innovation plan and models will be completed through an iterative policy development blueprint modeled on the process below, which is also being used in the Health Benefit Exchange development process. The four-step flow for policy development relies on heavy interaction between state staff and stakeholders in which staff, working with technical assistance and under the guidance of state leadership, develop specific policy recommendations. Stakeholders are invited and encouraged to react to the recommendations. Staff incorporates those reactions and refines the policy. Finally, the refined policy recommendations are brought back to stakeholders to confirm that the stakeholders affirm the recommendation, or, if stakeholders disagree with the recommendation, allows for the opportunity to advocate for changes. This process is represented here:

Exhibit 1



The substance of the state health care innovation plan will be split into four to six policy areas for the purpose of policy development. Rhode Island will procure the services of a project manager with health care systems and planning subject matter expertise to facilitate the development of state health care innovation plan. The project manager will be required to follow the process of policy development and stakeholder engagement reflected in Exhibit 1 above.

The state health care innovation planning process will build on a strong record of successful multi-payer delivery system reforms development of multi-payer delivery system reforms. Rhode Island has numerous, successful examples of multi-payer models and system innovation projects as well as a robust set of policy levers that can be used for seismic system changes. The development of innovation models, facilitated by and under the direction of the state leadership team, will be the scope of work for the project manager as described above.

The state intends to build upon its successful foundation of patient-centered medical homes to transform its health care system into a health care system organized around patients, with improved community health as its goal, which is firmly rooted in a strong and diverse primary care system. Rhode Island has made primary care practice transformation a centerpiece of its health reform efforts. Through the Chronic Care Sustainability Initiative, Rhode Island's multi-payer patient centered medical home demonstration, the state has made a lasting, multi-payer commitment to a delivery system built upon a base of primary care. Rhode Island seeks to use the model design process to explore and develop new models for delivery system change building upon this project's documented success in using primary care to manage chronic conditions to keep Rhode Islanders healthier and to keep costs under control.

A key element of the model design will be the involvement of community-based leadership. Rhode Island expects community input for specific components of the future system of care. The first is an engagement in community-driven outcomes. Social and environmental determinants of health can have an equal or greater effect on health outcomes and costs of health care as the medical delivery system. If a community is a major participant in determining what outcomes a

medical delivery system is driving toward, that community can structure the other systems that have an effect on health – systems like schools, land use and planning, even parks and recreation – to complement and work with the health care system toward improved community health outcomes. The second is the engagement of community-based organizations that provide social service and supports. By coordinating the services provided by the health care system and community organizations, Rhode Island seeks to make its population healthier, keep it healthy, and in doing so, drive down the overall cost of care.

In addition to the policy development of the model design, Rhode Island will complete a thorough financial analysis of proposed models. This financial analysis will focus on expected health care costs for the state before the model intervention as well as an evidence-based projection of the expected health care costs, broken down by major payer source, as a result of the model intervention. Rhode Island will procure a vendor specializing in data, analytics and actuarial analysis to assist the state with analyzing the financial and health outcome impacts of models under consideration as part of the model development process.

Rhode Island also recognizes that the type of change in the health care delivery system envisioned in this proposal will require significant, ongoing capacity within state government. Achieving the Rhode Island health care system of the future will demand expertise in data collection and analytics, regulatory oversight – on insurance carriers and health systems, ongoing financial and policy analysis, and internal state process change managers. Rhode Island will engage a vendor to complete a statewide resource analysis to identify future needs and gaps in state staffing capacity for health system transformation.

Proposed Activities in Support of the Model Design. During the performance period of the grant the state staff across the participating agencies, supported by contracted personnel and analyses and informed by the stakeholder process will engage in a planning process that includes:

- Review of current state payment and delivery system reform initiatives and state policy levers;
- Description of a detailed future state for the Rhode Island health care system;
- Identification of data sources and baseline data for outcome measures and financial analysis;
- Identification of policy lever changes needed to effectuate the State Health Care Innovation Plan;
- Mapping current state payment and delivery system reform initiatives to the State Health Care Innovation Plan;
- Developing a change strategy to align state payment and delivery system reform initiatives and state policy levers with the State Health Care Innovation Plan;
- Reviewing and incorporating stakeholder recommendations for the State Health Care Innovation Plan and formal adoption of the Plan.

Using the State Innovation Plan as the core roadmap for future health reform activities, Rhode Island will analyze the changes needed to achieve the goals of the plan in order to identify Model Design options for a Model Test. This will require an analysis of the estimated outcomes and financial impacts of each Model Design option prior to adoption of a particular Model Design model submission in the Model Test application.

During the performance period of the planning grant the Rhode Island project team will convene monthly state leadership meetings to guide the work of the planning process. These will occur in conjunction with parallel monthly state staff meetings, Payment and Delivery System Reform Workgroup meetings and related stakeholder meetings. Stakeholder convenings will incorporate the input of multiple stakeholder groups already guiding and informing the policy levers, strategies and initiatives that will be relied upon to form the basis of the State Innovation Plan.

Payment and Service Delivery Models and State Policy Levers and Strategies. Rhode Island will utilize the innovation plan and model development process to examine all payment and delivery system reform initiatives now underway in order to best design the most effective intervention model for transformational change. Additionally, Rhode Island will be examining all policy levers at its disposal for affecting the delivery system. Through the Healthy RI Task Force process and the RI Healthcare Reform Commission we have developed a comprehensive list of payment and delivery system reform initiatives under way in Rhode Island. These are too numerous to include here however a sampling of high impact current initiatives is highlighted below:

The Rhode Island Chronic Care Sustainability Initiative (CSI) and the Medicare Advanced Primary Care Practice Demonstration (MAPCP). Rhode Island has made primary care practice transformation a center-piece of its health reform efforts. State agencies and commercial and Medicaid insurers have embraced the Patient Centered Medical Home model as a mechanism to improve care, improve health and lower costs. In a state with approximately 1,190 active primary care physicians[1], 443 (37%)[2] are practicing in Medical Homes recognized by the National Committee for Quality Assurance. A major force in this transformation has been CSI. CSI is a multi-stakeholder collaboration convened by the RI Office of the Health Insurance Commissioner, which has led to the implementation of an all-payer Medical Home Initiative. This initiative demonstrates Rhode Island's ability to use State convening authority to bring stakeholders together, and critically, to maintain stakeholder participation over time. The CSI Collaboration began in 2006, and the first multi-payer contracts for the Medical Home were implemented in 2008 in five sites. The program has expanded to 16 sites across the state, serving 59,212 Rhode Islanders. In 2011, RI was one of eight states to be awarded an MAPCP Demonstration, through which fee-for-service Medicare became a full participant in the CSI

[1] 2011 State Workforce Data Book, Assoc. of American Medical Colleges, https://www.aamc.org/download/263512/data/statedata2011.pdf
[2] National Committee for Quality Assurance: http://www.ncqa.org/tabid/74/Default.aspx

program. This initiative demonstrates RI's ability to bring together public and private payers. Participating payers include all of the State's commercial plans and Medicaid MCOs, self-insured employers, and Medicare Advantage plans. CSI has documented the following results: The sustained, six year commitment of a broad group of providers, payers, employers and State agencies to the Medical Home model in RI; Implementation of other commercial and Medicaid medical home initiatives built off the knowledge and experience gained through CSI; Improved professional satisfaction of participating providers; Reduced hospital utilization by patients seen in CSI sites; Improved quality of care in diabetes, depression, prevention and cardiovascular disease, as measured by electronic medical records.

Integrated Care for Medicare and Medicaid Eligible (MME) Rhode Islanders. In July of 2012 the RI General Assembly directed the Medicaid program to pursue improved coordination of care for the MME (also known as dually-eligible) population. RI will be implementing a new "Integrated Care" payment and delivery system for MMEs in 2013 and 2014. These beneficiaries are among the most vulnerable and costly in the Medicaid program. Of the 189,536 RI Medicaid beneficiaries, 31,329 (16.5%) are MME, but they accounted for approximately 43% of total Medicaid costs in FY 2011. The RI Integrated Care Program for MMEs will focus on improving the coordination of care between previously fragmented segments of the healthcare system, notably between primary care, behavioral health, hospital care, long term care, and home and community based services. The Integrated Care Program will emphasize the Medical Home model, and the deployment of robust care coordination to connect the disparate elements of the delivery system. Primary, acute, behavioral and long term care funded by both Medicaid and Medicare will eventually, if approved, be brought under a single payment mechanism through three way contracts between Managed Care entities, RI Medicaid, and Medicare (in the Managed Care option); or will be integrated by a new "Coordinated Care Entity" (for RI's primary care case management program.) RI will also pilot the deployment of a "Community Health Team" to provide ancillary social, transportation, behavioral, peer, nutritional and other supports not

currently available to these members and essential to achieving improvements in care coordination and health outcomes.

The Rhode Island Health Benefits Exchange. Rhode Island is pursuing a state-based Health Benefits Exchange. The Exchange will provide value and choice to both the individual and small group purchasers that buy the products it offers. It will be a robust partner with other state agencies, like OHIC, Medicaid, and DOH, which regulate or pay for health insurance products. The technology infrastructure for the Exchange will be fully integrated with Medicaid for eligibility and enrollment in one unified system. It is supported by a large stakeholder engagement effort so that the Exchange will be responsive to the needs of the community. The stakeholder engagement includes an Advisory Board appointed by the Governor, a community based Work Group comprised of payers, providers, consumer advocates, patients and business representatives and an Expert Advisory Committee, appointed by the Governor. The Expert Advisory Committee incorporates the expertise of health insurance brokers, health insurers and medical providers who are precluded from serving on the Exchange Advisory Board by the board's conflict of interest provisions.

Central to the vision for Rhode Island's Exchange is the need for it to serve as a catalyst for change in the health care delivery system. Using an active purchaser approach, the Exchange will ensure that the products it sells include significant payment reforms and innovation. It will align with other public purchasers to leverage those payment reforms to affect the delivery system. It will also align closely with the regulatory environment for plans sold outside the Exchange to maximize the impact of payment and delivery system reforms. Ultimately, these reforms will help Rhode Island achieve better care at lower cost.

Office of Health Insurance Commissioner Hospital Contracting Conditions Standard. In 2009, based on the advice of its Health Insurance Advisory Council, OHIC directed commercial health insurance issuers with significant market shares in the state to comply with a set of four criteria, collectively termed the Affordability Standards, aimed at improving the

affordability of health care in Rhode Island. Specifically, the Affordability Standards required issuers to:

1. Expand and improve primary care infrastructure
2. Spread the adoption of the patient-centered medical home
3. Standardize electronic medical record incentives
4. Work toward comprehensive payment reform across the delivery system

The Affordability Standards went into effect in 2010. To support the fourth standard ("work toward comprehensive payment reform across the delivery system"), OHIC issued six conditions for issuer contracts with hospitals in Rhode Island (commonly known as the "hospital contracting conditions standard") in July 2010 as part of its rate factor decisions. These contracting conditions were required to be implemented by issuers upon any subsequent contract execution, renewal, or extension. The conditions impose specific requirements on the method of contracting that:

- Realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS and/or contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.
- Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract.
- Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract over the previous contract year by

attaining mutually agreed-to performance levels for all or a subset of measures in the CMS Hospital Value-Based Purchasing Program for Medicare.

- Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes.
- Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO) in a format and on a schedule determined by the Medicare QIO its performance for best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care.
- Include terms that relinquish the right of either party to contest the public release of any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the issuer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

Rhode Island Global Consumer Choice Medicaid Waiver. Rhode Island operates its entire Medicaid program under the State's Section 1115 Global Consumer Choice Compact Waiver (Project No. 11W-00242/1), with an aggregate budget ceiling for Federal reimbursement.[3] The Global Waiver is built upon three goals: (1) Rebalance the State's long-term care system, (2) Integrate care management across all Medicaid populations, (3) Complete the transition from a payer to a purchaser of care. Rhode Island's Global Waiver was approved by the Centers for Medicare and Medicaid Services on January 16th, 2009, under the authority of Section 1115(a)(1) of the Social Security Act. The State sought and received Federal authority to promote the following goals:

- To rebalance the publicly funded long-term care system in order to increase access to home and community-based services and supports and to decrease reliance on inappropriate institutional stays

[3] With the exception of disproportionate share hospital (DSH) payments, administrative expenses, phased Medicare Part D contributions, and payments to local education agencies (LEAs).

- To ensure that all Medicaid beneficiaries have access to a medical home
- To implement payment and purchasing strategies that align with the Waiver's programmatic goals and ensure a sustainable, cost-effective program
- To ensure that Medicaid remains an accessible and comprehensive system of coordinated care that focuses on independence and choice
- To maximize available service options
- To promote accountability and transparency
- To encourage and reward health outcomes
- To advance efficiencies through interdepartmental cooperation

As Rhode Island articulated in its application to the Centers for Medicare and Medicaid Services (CMS), *the overarching goal of Rhode Island's Global Consumer Choice Waiver is to make the right services available to Medicaid beneficiaries at the right time and in the right setting*.

Joint Committee on Healthcare Oversight. In 2011, the Rhode Island General Assembly reactivated the Joint Committee on Healthcare Oversight, specifically to address federal health reform as well as ongoing state reform efforts. The committee is co-chaired by the Chair of the Senate Committee on Health and Human Services, and Rep. Brian Patrick Kennedy, Chair of the House Committee on Corporations. Those committees are responsible for health care-related legislation in the House and Senate, respectively.

The committee receives input by taking testimony from both executive branch agencies and external members of the health care system. The committee's diverse membership provides an opportunity for a cross-section of legislators to develop an in-depth understanding of complex health care issues and how state statute translates to effects in the health care system. Previous briefings have covered areas where the ACA will supersede state statute as well as the impact of federal grants on the statutory responsibilities for regulatory agencies.

Comprehensive Health IT Implementation. Many health care system transformations are being advanced nationally, yet, virtually none of these reforms can reach their full potential as long as health care remains mired in paper-based record keeping and decades behind other industries in the effective use of information technology. While Health Information Technology (HIT) alone isn't the answer to problems in the health care system, it is an essential foundation for almost all promising reforms. HIT's real value is as a key enabler in the improvement of health care quality, safety, and value. Rhode Island sees tremendous opportunity in assuring that health information is available where it's needed, and when it's needed to produce the most benefit for the individual and the population as a whole. RI has a long-standing commitment to working together to do whatever is necessary to bring this vision into reality. For many years RI has been considered a national leader in the area of HIT. Efforts to address the fragmentation of health care information go as far back as 1994 when the RI Department of Health (HEALTH) created one of nation's the first integrated child health information systems known as KIDSNET. KIDSNET, in many ways a forerunner to today's HIE, assures the provision of timely and appropriate preventive health services by electronically integrating health data from 10 different child health programs and making it available to healthcare providers, maternal and child health programs, and parents.

The concept of KIDSNET was expanded upon in 2004, when HEALTH in collaboration with the Rhode Island Quality Institute (RIQI), began to develop a statewide HIE, known as **current*care*. *c*urrent*care*** organizes the health information of the state's population in an information hub and facilitates the authorized exchange of clinical data, supporting national and local goals of safe, timely, efficient, effective, equitable, patient-centered care. **current*care*** serves as a platform for providing services to health care providers. Not only is it a repository of health care information, which provides clinicians via a web portal with an integrated and longitudinal medical record for individuals who have chosen to enroll in **current*care*** regardless of where they sought care, it also allows providers to receive a notification when a patient is

admitted to, or discharged from a hospital. **current*care*** currently collects data from Rhode Island hospitals, commercial laboratories, and importantly health care providers' (including behavioral health) Electronic Health Records (EHRs).

It is critical that RI's health care providers, in particular hospitals, primary care providers and specialists, implement and meaningfully use EHRs. RI also serves as a leader in promoting the adoption of EHRs. Since 2008, HEALTH has publically reported on provider use of EHRs. RI was the first state in the nation to require physicians, under its public reporting program, to fill out an annual HIT survey, to measure the adoption and use of EHRs and e-prescribing through out the state. The 2012 survey data indicates that 48% of physicians in the state have adopted an EHR and 71% of prescribers are e-prescribing. To support the adoption of EHRs, the state works closely with RIQI's Regional extension center, administers the RI's Medicaid EHR incentive program, and has worked to align multiple initiatives around patient centered medical homes, the Beacon community, quality reporting and feedback efforts, private payers incentives for EHR use etc, to support the use of EHRs and meaningful use. RI has been, and continues to be, dedicated to promoting the use of HIT to support health care reform efforts by significantly increasing the meaningful use of EHRs and the HIE across Rhode Island's health care providers.

Evidence2Success Initiative. Providence, Rhode Island was chosen as the first location for the Annie E. Casey Foundation's Evidence2Success initiative. Evidence2Success seeks to coordinate existing local, state, and community resources aimed at promoting healthy child development. The initiative will use the Foundation's research and resources on evidence-based interventions to recommend better uses of existing resources to improve specific education and health outcomes. Providence Public Schools, the RI Department of Children, Youth, and Families, and community agency Family Services of RI will lead the effort. Other state and communities agencies will be involved in order to comprehensively address the full spectrum of health and other social determinants to educational success on a community level.

B. Stakeholders: Consultation and Community Involvement. Rhode Island has already effectively established a stakeholder advisory group that will be leveraged to engage stakeholders in the development of the state health care innovation plan and model design. Upon passage of the Affordable Care Act, Lieutenant Governor Elizabeth Roberts immediately organized a 150- member stakeholder group (the Healthy Rhode Island Task Force) that convened regularly from May to September 2010. Stakeholders participating in this group included: government officials; health plan representatives; consumer advocates; insurance brokers; small business representatives; health care providers; and other community members.

The task force was organized into subcommittees. The Payment and Delivery Reform subcommittee, led by Tricia Leddy and with active participation from a broad range of stakeholders, examined the need to prioritize both changes to the way health care is purchased and changes to the way the health care industry is organized to deliver health care in Rhode Island. In September of 2010, the subcommittee identified three main principles of payment and delivery system reform in Rhode Island:

- Payment reform and delivery system changes for R.I. should build upon the innovations and successes already under way in this state and should be aligned across all components of the delivery system, not fragmented.
- Although payment and delivery system changes are only mandated in PPACA for Medicaid and Medicare, not for private insurers, there are so many payment realignment and delivery system reform funding incentives and opportunities in the federal law that it will be necessary to prioritize which of these R.I. will pursue. In order to set priorities R.I. must develop one statewide, strategic, public-private vision for priorities in health care payment and delivery system reform and establish progress measures to determine the success of these efforts.
- There should be a careful examination of whether the Health Insurance Exchange may

provide an opportunity to leverage payment and delivery system changes.

These principles were included as part of the task force report released in September 2010.[4] This report provided a strong, early foundation for the Rhode Island Healthcare Reform Commission, which was formally established through an Executive Order by Governor Lincoln Chafee in January 2011.[5] The Executive Order established a formal structure for stakeholder engagement, comprised of the Executive Committee of the Commission and a broad-based full public Commission, the members of which can participate in issue-specific workgroups and stakeholder-specific leadership councils.

The Executive Committee consists of five state leaders: Lt. Governor Elizabeth H. Roberts (Chair), Secretary of Health and Human Services Steven M. Costantino, Health Insurance Commissioner Christopher F. Koller, Director of Administration Richard Licht, and Policy Director for the Governor Kelly Mahoney. The Executive Committee is charged with coordinating state level health care reform efforts and acting on the deliberations and recommendations from the broader Healthcare Reform Commission to make recommendations to Governor Lincoln D. Chafee for the implementation of specific reforms. In addition to these state leaders on the Executive Committee, the state's Director of Health, Health Benefits Exchange Director and Director of Human Services are closely engaged in the ongoing coordination efforts of the Healthcare Reform Commission and its Executive Committee.

There are seven issue-specific workgroups of the broader Healthcare Reform Commission, each charged with key deliverables. One workgroup is focused specifically on Payment and Delivery System Reform. This workgroup is charged with examining the current payment and delivery system reform initiatives underway in Rhode Island, as well as innovations being tested in other states and by the federal government.[6]

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[4] The full text of the report is located at http://www.ltgov.ri.gov/taskforce/index.php
[5] A copy of the Executive Order is available at http://www.ltgov.ri.gov/rihrc/executiveorder.pdf.
[6] A summary report of the Payment and Delivery System Reform Work Group containing a scan of initiatives is available at http://www.healthcare.ri.gov/documents/Payment%20workgroup%20report%20032612%20final.pdf

Rhode Island proposes to use this workgroup as the core group for stakeholder feedback throughout the process for the development of the state health care innovation plan and the model design. The workgroup includes patients, consumer advocates, a range of medical providers, all Rhode Island payers and other community participants. A wide array of viewpoints necessary to effectively discuss and debate innovation plan details and model design options are represented in this workgroup. In addition to the stakeholders currently active on the Payment and Delivery System Reform Workgroup, Rhode Island intends to recruit additional stakeholders who represent the viewpoints of the entire range of clinical providers, community government leadership and community-based organization, especially those that focus on the health of the community.

While the Payment and Delivery System Reform Workgroup will be the primary stakeholder engagement vehicle for day-to-day feedback, there are a number of additional stakeholder groups focused on discreet areas of health care policy and programs, that will provide valuable insights during the planning and development process. These groups include but are not limited to the Health Insurance Advisory Council, the Global Waiver (Medicaid) Task Force, the Health Care Planning and Accountability Advisory Council, the Rhode Island Health Benefits Exchange Advisory Board, and the Expert Advisory Committee to the Exchange Board.

In addition to the Payment and Delivery System Reform Workgroup, the Lt. Governor has also established stakeholder-specific leadership councils under the umbrella of the Healthcare Reform Commission. These role-alike leadership councils advise on Rhode Island's implementation of the ACA from their role-specific perspectives. The Leadership Councils include non-hospital institutional providers (health centers, community mental health centers, clinics, large group practices, nursing homes, etc.); hospital leadership; clinicians (defined broadly); business and labor; municipal leaders; health care consumers; and payers (public and commercial as well as brokers).

The leadership councils will provide critical input to the state health care innovation plan and model development. These councils provide a forum through which issues will be vetted and tested with informed and focused sets of stakeholders. The leadership councils specifically include the most senior leadership in their respective fields. For example, CEO's of the largest insurance companies doing business in Rhode Island attends the payers' council. The engagement of senior leadership has proven to be critical in coming to consensus in controversial issues facing health reform to date.

The Municipal Leaders Leadership Council will be an important group to assist in ensuring broad community involvement in the process of developing the State Innovation Plan. Mayors and town administrators come together in this setting to discuss the many initiatives under way at the municipal level to improve community health outcomes. This is a critical link between medical system change and broader community changes that affect the non-medical determinants of health across the population. In addition to engaging local government leaders the established stakeholder engagement process surrounding the RI Healthcare Reform Commission is a robust mechanism for broad participation by almost all of the health and human service NGOs in the State of Rhode Island that include a focus on health improvement.

C. Public and Private Payer Participation. The State Innovation Plan process will have the involvement of many of the state's public and private payers. Public payers to be engaged will include Medicaid (administered by EOHHS) and the State Employees Health Benefit Program (administered by DOA). Private payers to be engaged will include: Blue Cross Blue Shield of Rhode Island, United Healthcare, and Tufts Health Plan (the state's three commercial health insurance issuers with significant market share), Neighborhood Health Plan of R.I. and the Rhode Island Business Group on Health (which represents a wide array of businesses including self-insured employers). All of these payers have previously demonstrated a commitment to meaningful participation in statewide efforts to address health policy challenges. For example, many have maintained an active membership in the Rhode Island Healthcare Reform

Commission and their work has been integral in supporting the state's implementation of the ACA thus far.

D. Project Organization. Rhode Island proposes that the Office of Lt. Governor manage the project proposed in this application on behalf of the Governor. As the project is cross-cutting, engaging nearly every aspect of the health care system, the Office of Lt. Governor is well situated to play the role of convener and administrative coordinator for the project envisioned in this proposal given the expansive membership and scope of the Healthcare Reform Commission chaired by the Lt. Governor on behalf of the Governor. The Office of Lt. Governor has functioned in this role for the Rhode Island Healthcare Reform Commission since its establishment by the Governor in January of 2011. The Office of Lt. Governor also serves as the coordinating entity for Rhode Island's participation in the State Health Reform Assistance Network, a project of the Robert Wood Johnson Foundation that provides technical assistance and inter-state learning and collaboration opportunities for participating states.

The Office of Lt. Governor proposes that Daniel Meuse serve as the project administrator. In this role, Mr. Meuse will be responsible for budgeting and contracting, vendor management and project timeline and reporting, in consultation with the project leadership and staff teams. Mr. Meuse serves in a similar role for the State Health Reform Assistance Network Project. Additionally, Mr. Meuse has served as facilitator of the Payment and Delivery System Reform Workgroup since its inception, as well as the Rhode Island Exchange Stakeholder Workgroup and the Rhode Island Health Benefits Exchange Expert Advisory Council. Mr. Meuse currently serves as Deputy Chief of Staff in the Office of Lt. Governor, a position he has held since 2008.

Overseeing the project will be a group of cabinet and sub-cabinet officials. These officials represent leadership from the Office of the Governor, the Office of Lt. Governor, the Executive Office of Health and Human Services, the Department of Health, the Office of Health Insurance Commissioner, and the Health Benefits Exchange. This Leadership Group will provide strategic direction and decision-making for the state staff managing the project.

In addition to Mr. Meuse from the Office of Lt. Governor, each organization represented in the state Leadership Group will assign staff to the project to make up the internal staff working group. This working group will direct and be supported by the technical assistance vendor to complete the project.

E. Provider Engagement. Rhode Island is confident that the project will have the involvement of many of the state's provider groups. Provider groups to be engaged will include: the state's large primary care practices (Coastal Medical of Rhode Island and University Medicine), the state's hospital systems (Care New England, Lifespan, and CharterCARE Health Partners), the state's community health centers (the Rhode Island Health Center Association, which represents a wide array of community health centers including federally qualified health centers), and the state's community hospitals (the Hospital Association of Rhode Island, which represents a wide array of hospitals including community hospitals). All of these provider groups have previously demonstrated a commitment to meaningful participation in statewide efforts to address health policy challenges. For example, many have maintained an active membership in the Rhode Island Healthcare Reform Commission and their work has been integral in supporting the state's implementation of the ACA thus far. The State's largest primary care physician groups and health centers are founding members of the CSI Stakeholder coalition, and have maintained active, leadership-level participation for over six years. These stakeholder processes have laid important groundwork for provider engagement in the thinking around healthcare reform, and have cultivated a provider community that is engaged and knowledgeable about delivery system and payment reform issues. There are multiple on-going forums in which the model development team will engage providers, including the Medicaid Medical Care Advisory Committee and the Health Department's Primary Care Physician Advisory Committee.

Project Plan and Timeline

Task	Entity Responsible	Due Date	Status
State Health Care Innovation Plan			
1. Review current state payment and delivery system reform initiatives and state policy levers	OG, OLG, EOHHS, OHIC, Exchange, HEALTH, DOA, PM	12/4/12 (start date), 1/31/13 (end date)	Not started
2. Facilitate development of detailed future state of health care delivery system	PM	12/4/12 (start date), 1/31/13 (end date)	Not started
3. Identify data sources and baseline data for outcome measures and financial analysis	AM	12/4/12 (start date), 2/28/13 (end date)	Not started
4. Identification of policy lever changes needed to effectuate desired future delivery system	PM	2/1/13 (start date), 3/29/13 (end date)	Not started
5. Map current state payment and delivery system reform initiatives to needed policy lever changes	PM	2/1/13 (start date), 3/29/13 (end date)	Not started
6. Develop change strategy to align state payment and delivery system reform initiatives w/ needed state policy levers to produce desired delivery system; together these will comprise Rhode Island's State Health Care Innovation Plan	OG, OLG, EOHHS, OHIC, Exchange, HEALTH, DOA, PM, CB	3/1/13 (start date), 4/30/13 (end date)	Not started
7. Review draft State Health Care Innovation Plan w/ project-specific stakeholder groups	PM	4/1/13 (start date), 4/30/13 (end date)	Not started
8. Adopt State Health Care Innovation Plan	OG, OLG, EOHHS, OHIC, Exchange, HEALTH, DOA	5/1/13 (start date), 5/31/13 (end date)	Not started
Health System Model Design			

Entity Responsible Key: (1) the State of Rhode Island Office of the Governor (OG), (2) the State of Rhode Island Ofice of the Lieutenant Governor (OLG), (3) the State of Rhode Island Executive Office of Health and Human Services (EOHHS, which serves as the Medicaid single state agency), (4) the State of Rhode Island Office of the Health Insurance Commissioner (OHIC), (5) the State of Rhode Island Health Benefits Exchange (Exchange), (6) the State of Rhode Island Department of Health (HEALTH), (7) the State of Rhode Island Department of Administration (DOA), (8) Project Management/Stakeholder Convening/Payment and Delivery System Reform Technical Assistance Contractor (PM), (9) Actuarial Modeling/Financial Analysis/Simulation Analysis Contractor (AM), and (10) Capacity and Business Process Analysis Contractor (CB)

Task	Entity Responsible	Due Date	Status
1. Identify Model Design options implicit or explicit within State Health Care Innovation Plan	PM	1/2/13 (start date), 3/29/13 (end date)	Not started
2. Analyze estimated outcomes and financial impacts of Model Design options	AM	2/1/13 (start date), 3/29/13 (end date)	Not started
3. Finalize report of estimated outcomes and financial impacts of Model Design options	AM	4/1/13 (start date), 4/30/13 (end date)	Not started
4. Adopt Model Design option for Model Test application	OG, OLG, EOHHS, OHIC, Exchange, HEALTH, DOA	4/1/13 (start date), 4/30/13 (end date)	Not started
5. Develop Model Test application	OG, OLG, EOHHS, OHIC, Exchange, HEALTH, DOA, PM	5/1/13 (start date), 5/31/13 (end date)	Not started
Administration			
1. Hold monthly state leadership meeting	OG	10/1/12 (start date), 5/31/13 (end date)	Not started
2. Hold monthly state staff meeting	OLG	10/1/12 (start date), 5/31/13 (end date)	Not started
3. Procure contractor services (awards made contingent on grant award)	OLG, DOA	10/1/12 (start date), 11/30/12 (end date)	Not started
4. Hold monthly Payment and Delivery System Reform Workgroup meetings	OLG	12/4/12 (start date), 5/31/13 (end date)	Not started

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