# State of Rhode Island Office of the Health Insurance Commissioner
# Health Insurance Advisory Council
# Meeting Minutes
# March 25, 2019, 4:30 P.M. to 6:00 P.M.
# State of Rhode Island Department of Labor and Training
# 1511 Pontiac Avenue, Building 73-1
# Cranston, RI 02920-4407

## Attendance

**Members**

Co-Chair Commissioner Marie Ganim, Co-Chair Stephen Boyle, Teresa Paiva Weed, Deb O'Brien, Al Charbonneau, Shamus Durac, Daniel Moynihan, David Katseff

**Issuers**

Liz McClaine, Neighborhood Health Plan of Rhode Island
Tinisha Richards, United Healthcare

**State of Rhode Island Office of the Health Insurance Commissioner Staff**

Cory King

**Not in Attendance**

Vivian Weisman, David Feeney, Karl Brother, Hub Brennan

## Minutes

1. **Welcome, Introductions, and Review of February Meeting Minutes**

   Stephen Boyle called the meeting to order and welcomed all Health Insurance Advisory Council (HIAC) members and others in attendance. After introductions, minutes were accepted as submitted.

2. **RIREACH Consumer Update**

   Shamus Durac gave an update on RIREACH activities. Shamus welcomed Mark Gray to the team as their communications lead. Recently, RIPIN had a case involving a woman travelling abroad in Taiwan who received emergency services – As expected, there was not a lot of difficulty with coding between the Taiwanese hospital system and the American insurance system, so it took time to resolve. Ultimately, RIPIN was able to save the patient nearly $40,000.

   Steve Boyle asked if RIPIN is seeing any trends in the calls they are receiving. Shamus replied that facility fees cases are ongoing and they are starting to see confusion in terms of educating consumers.

3. **Community Health Team (CHT) Update**

Deb Hurwitz gave a short version of a presentation previously delivered to the SIM steering committee on the SBIRT project and updates on the Community Health Team. The goals of the two grants as they were braided together was to introduce SBIRT into the community health teams, SBIRT being an evidence-based screening and referring mechanism for people with substance use disorder. Also to implement initially twelve clinical studies, and are already up to over twenty-five places around the state that are doing SBIRT only screenings. The next goal was to expand the CHTs, and they have 8 teams across the state. The last goal was to have a centralized network management and data reporting hub that holds all of the pieces together.

The CHTs are primary care focused; to get outside of the four walls of the primary care practice into the community to find the people who are high-risk, difficult to reach, hard to engage and have complex social needs and behavioral health needs. The CHTs consist of a licensed behavioral health clinician, a SBIRT screener, as well as two community health workers –acting as an extension of the primary care clinician.

SBIRT is funded by a five-year grant from US SAMHSA. The process is geared towards making substance abuse screening more normalized. The average age of the patients being referred is 54, with a wide-range from 18-96, mostly women. Over 50% are covered through Medicaid, and nearly 30% have commercial insurance. When patients are screened for social determinants, the top results are housing, finance, transportation, and food security, most of the patients will have more than one of these. There is a quality of life measure for the patients and when asked, patients said that 17 days out of a month they are functioning poorly due to physical or mental health. Additionally, there is a well-being measure that asks patients if they are thriving, struggling or suffering, and 95% of patients responded that they were either struggling or suffering. Part of the team is the behavioral health clinician, which is looking at anxiety and depression – the GAD is the screener for anxiety and PHQ9 is the screener for depression. So what we can see is that over a period of time, from intake to discharge, patients' anxiety and depression scores are going down significantly. Over 20% of those screened using SBIRT are positive for risky alcohol use and or drug use, and we have given interventions to over 2,400 people who needed it. Early results from Brown University show a decrease in total cost of care for CHT enrollees.

In terms of SBIRT, it's funding will continue through 2021. From a sustainability standpoint they have been embedding trainers in the organizations where SBIRT is being done so that there is an ongoing ability to keep it going.

Dan Moynihan asked what the credentials of a community health worker are, and whether or not they are clinically licensed social workers. Deb answered that community health workers are non-licensed but have gone through the state training to become certified as community health workers. They are generally folks who live in the geographic area of the team, so they are culturally and

linguistically tuned in to the population they serve. The behavioral health workers are generally licensed social workers. Teresa Paiva weed added that the recovery navigation folks are very similar to the community health workers in terms of the non-licensed professionals. Deb mentioned that community health workers on their teams have a really specific skill-set that nobody else has.

Steve Boyle asked if they interact with Dorcas International at all because they help coordinate when immigrants come here, helping to house them etc. Deb replied that they could be, the way that this model was constructed was to be an extension of primary care, so the referrals come from primary care.

**4. State Innovation Model (SIM) Update**

Marti Rosenburg gave a presentation with updates on the State Innovation Model (SIM). SIM was the $20 million grant that we got from the Centers for Medicare and Medicaid Services (CMS) to transform the way we deliver and pay for care and address population health. We are one of twenty-four states that received this grant. Our ultimate goal has been to meet the triple aim (healthier people, better care, and smarter spending.) Specifically:

1.) Strengthening the community/clinical linkages to support value-based payments. An example of this is the community health teams. There are other projects as well that connect the community folks to the providers. They have also seen data that shows more people filling out end-of-life forms.
2.) Integrating physical and behavioral health. What they are learning from primary care providers is that they would never want to go back to a system where behavioral health isn't integrated into their practices.
3.) Building workforce capacity. Needed to build up our workforce in a variety of ways, including making sure to 'train the trainers' so that the work will be sustainable and continue on.
4.) Integrating health information technology and data. The electronic health records are essential, and the project is trying to make it more useful and central for how providers reach their goals.
5.) Overall, the theme has been that we are working together. OHIC's work is SIMs work, and SIM's work is OHIC's work, and the same can be said for EOHHS. This sentiment is true for the Department of Health, DCYF, HealthSourceRI, and more agencies.
6.) Other SIM priorities include Integration and Alignment, Addressing the Social Determinants of Health, Population Health Planning, and Institutionalizing Activities through Training.

SIM's final year includes completing the program implementation, deep into data collection and evaluation with the University of Rhode Island. They are continuing to explore additional funding and non-financial support for those projects for which sustainability is indicated and determining how to communicate SIM's values and lessons. The child psych access project has received a five-year grant through the Rhode Island Department of Health, the SBIRT training and resource center is being funded through September 2020, PCMH Kids is in the Medicaid budget, Hope Health trainings

for end of life are going to be funded by the Department of Health. We are going through our programs every single day to make sure they stay funded and our sustainable.

Since better health looks at population health, social determinants of health, oral health, etc., the focus is on both short-term and long-term cost savings and finding ways to work across various agencies.

Al Charbonneau commented: The triple aim that I am familiar with has the third leg lowering the per-capita cost. Was it a CMS thing or a Rhode Island thing that switched that? Marti responded that it was CMS that changed that last line.

Commissioner Ganim commented that she didn't realize just how critical and what a great resource SIM has been until joining OHIC. It has been very much integrated into OHIC's work and much of it will be continued.

Steve Boyle asked: Where do you see RIDE fitting into all of this? Marti commented that it is crucial that we figure that out, since it matters a lot in youth behavioral health. We need to figure out the social determinants of health within the school.

Teresa commented that she wants to follow-up with Marti afterwards about improving the education system, behavioral health is very important and in high demand– we are currently looking at what Massachusetts has done and trying to figure an initiative going forward.

Deb O'Brien commented that the schools in Providence have contacted them and provided counseling in elementary schools, middle schools and a high school. The parents have been able to come and participate because it's in the neighborhood.

David Katseff asked Marti: Do you plan to get something out to the public about what has been done so far and making it easy for the public to understand?

They are going to write a final report. They are also going to guest edit a set of articles for the Rhode Island Medical Journal, and are looking at different ways to make their accomplishments public.

5. **Cory King gave an update on the Affordability Standards.**

These standards are designed to improve the affordability of health insurance by addressing the underlying cost-drivers. The last time OHIC did a comprehensive revaluation of these standards was in 2014. OHIC will reassess each component of the standards: primary care investment, care transformation, payment reform and then traditional cost-containment strategies, to ultimately come up with a set of policy proposals that in some cases keep the present configuration of standards in place, but in other ways may represent a marked policy shift. Some of the themes may be:

A broader perspective on care transformation and to particularly drive the continued integration of behavioral health into primary care.
Aligning the ACO budget growth cap with the cost-trends work that has been on-going.
Looking at disparities in hospital payment rates.

Teresa commented to say thank you, I know how hard you have been working. Are you looking at any possibility of expanding what you would ask the insurers to invest in?

Cory responded that OHIC is looking at the primary care spending closely. Perhaps adding additional categories that can be construed as primary care would be beneficial.

Teresa commented that it might be time to expand and see if it might make sense to invest in community health workers, in various other aspects, like integrated behavioral health, in addition to primary care.

Al asked: Is this process going to be open/will we be able to comment and make suggestions about affordability?

Cory said that it will be an iterative process.

Al discussed how much an average family ends of paying for health care, which in some cases is 25% of their income. He noted that affordability standards has slowed spending, but he wanted to ask, besides the affordability standards, what are we doing to help affordability for these families?

The Commissioner commented one example is the integrated behavioral health model which shows significant potential cost saving, so getting to the medical spending is our shared mission.

Teresa commented that we saw a chart that Cory presented that commends the affordability standards, it showed our premiums are the lowest in New England.

The Commissioner commented that this discussion shows that we have a lot of work to do, and a lot of open conversations are needed to develop new affordability standards.

Teresa commented that the affordability standards worked. Al agreed that they worked. They worked and have stopped costs from getting worse, but Al hopes they can do more because families are still spending 25% of their income.

6. **Public comment:**
Steve Boyle commented that he switched his prescriptions to an independent pharmacy and talked to the pharmacist there. They talked about DIR charges that independent pharmacies receive. When they dispense a pill, they will get a back charge from the PBMs, and they don't

know what that charge will be. Steve is inviting her to a future meeting to talk about these issues.

Teresa commented we should discuss advancing the reinsurance program at a future HIAC meeting. The Commissioner gave a brief update about the status of this effort contained in the Governor's proposed budget article 14.

**Next Meeting:**

- Tuesday, April 16, 2019 from 4:30 – 6:00 PM at the State of Rhode Island Department of Labor and Training, 1511 Pontiac Avenue, Building 73-1, Cranston RI 02920-4407