



EOHHS AE Stakeholder Meeting
DXC 2nd floor conference room
07/17/17 2-3:30pm

Facilitator: Deb Faulkner

Prepared by: Maria Narishkin

Participants: Chris Gadbois, Christopher Dooley, Craig DeVoe, Cristina Almeida, Deb Faulkner, Deb Florio, Debbie Morales, Hannah Hakim, Jason Lyon, Jen Bowdoin, Karen Lally, Karen Statser, Kathleen Peirce, Libby Bunzli, Liz Boucher, Maria Narishkin, Maria Petrillo, Mark Kraics, Mary Barry, Neil Shunney, Nicholas Oliver, Rick Boschwitz, Trish Gleason, Ray Parris, Alan Post, Raymond Lavoie, Jason Brown, Rick Brooks, Lisa Tomasso, John Bonin, Cristina Amedeo, KathleenHeren, S. Pardus, Kathleen Gerber

Agenda Item	Key Discussion Points	Action Items/Follow Up
Welcome & Introductions	Introductions <ul style="list-style-type: none"> • Deb Faulkner: AE Office hours – open meeting laws need to be followed – We want to be here on the meeting dates to answer questions for any of the stakeholders. Today we will discuss the Alternative Payment document that was sent to you. • Proposed agenda items and questions must be emailed to Deb Morales Deborah.morales@ohhs.ri.gov and Maria Narishkin Maria.Narishkin@ohhs.ri.gov , 24 hours in advance. • We will have an issue log to keep track of questions. 	
Alternative Payment overview by Deb Faulkner	<ul style="list-style-type: none"> • Sent out TCOC documentation to stakeholders • The plan is to improve the management of high cost, complex conditions and populations (physical, behavioral and social) by providing more integrated care at point of service for the members. • Three Pillars <ul style="list-style-type: none"> ○ Certification of AEs – Define what we want ○ Alternative Payment Methodology – Change the way providers are paid, we need to provide guidance and rules of engagement ○ Infrastructure Incentive Program – rare opportunity • Guidance addresses the comprehensive AEs, not specialized AEs. 	
Questions and discussions	<ul style="list-style-type: none"> • Sam – process wise, when do we expect this to be finalized? <ul style="list-style-type: none"> ○ Deb Faulkner – We are seeking written comments now. Technically, the document needs to be public for 30 days, we will finalize on August 14th. We need stakeholder comments and feedback asap. • Sam questioned the quality measures and methodology EOHHS will use 	

	<ul style="list-style-type: none"> ○ Deb Faulkner said we have a draft to be shared soon and welcomes comments in iterative form. ○ We are trying to have a standardized quality score card for alternative payment model for TCOC (not for incentive payments) ○ Quality multiplier approach/methodology ○ We want to reduce cost while maintaining or improving quality <ul style="list-style-type: none"> ▪ Sam stated that quality should be emphasized more, what if the cost stays the same, but quality improves? ● Libby – What will we be using for quality metrics? <ul style="list-style-type: none"> ○ Debbie Morales said the intent is to use the 10 SIM core measures (except colon/rectal cancer, and adding child); plus 5 optional or additional from the SIM menu measure set for comprehensive AEs. There would be no more than 10-15 measures in total ● Libby – part of the process will be to reconvene annually, to take out or add measures, there is a public meeting in August. ● We need similar guidance for specialized AEs, when can we expect that? <ul style="list-style-type: none"> ○ Deb – the goal is to get close on this with comprehensive, we should have a draft of specialized, within a month. ● Sam – transition progression to risk, technically seems like as long as AEs and MCOs progress this way, EOHHS may add a financial review of an AE seeking to include downside risk, EOHHS adding protection in guidance as AE’s progress to risk. <ul style="list-style-type: none"> ○ At a minimum, a withhold and pre-approved model ○ For year one we needed to have protections. It is likely to change over time. Likely to be addressed in year 2 guidance. ○ Two models one for hospital and for primary care based AEs. ○ We want to ensure financial stability and sustainability ● There is very little data on risk, when will that be publicized? <ul style="list-style-type: none"> ○ There will be an annual certification process, this year’s application/certification standards include a component on describing AE’s current risk mitigation strategies. ● Ray – the goal is to create shared saving within specified limits – what are the limits? <ul style="list-style-type: none"> ○ Deb Faulkner: Shared savings limits/cap at 2%. ● Sam – how to calculate the base and the performance. Could the data/information EOHHS uses to develops its trends be in the guidance. <ul style="list-style-type: none"> ○ Deb Faulkner – Currently there are no plans that would take savings off the top of the AE program. ● Delegation or sharing responsibilities, will we see that soon? <ul style="list-style-type: none"> ○ MCO responsibilities are consistent with the Medicaid managed care rule. Some things cannot be delegated. Thoughts and suggestions welcome. 	<p>Draft of specialized AE APM guidance within a month Estimate 1c: claims threshold for high cost claims</p> <p>Provide a minimum and maximum for the required progression to risk based arrangements table.</p> <p>Add details related to EOHHS cap rate based trends in guidance</p> <p>Delegation Guidance</p>
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	<ul style="list-style-type: none">• Libby – TCOC must include payments that are not HSTP funds, for example CTC payments.	
Deb Faulkner	<ul style="list-style-type: none">• Certified AEs are eligible for infrastructure incentive funds• Lessons learned from the pilot program is the need and preferences for more standardization, transparency and consistency for evaluation/comparison purposes as it relates to oversight and monitoring of the program. EOHHS would like to strike an appropriate balance of standardization, with allowances for some flexibility.• Payment model must move out of FFS, the goal is to reduce cost and increase quality.<ol style="list-style-type: none">1. Sustainable- we need to retain historical savings from year to year2. Small populations – random variation is higher with small populations. The shared savings adjustment factor as described in the guidance, includes the Monte Carlo analysis, which adjusts the savings/losses based on the probability of true savings and not random variation.<ul style="list-style-type: none">• Deb Florio – special populations are more expensive and risky, so do they need a bigger population or small population. There isn't much experience nationally with LTSS. Delivery systems, changing for consumer and patient, full continuum of care for patients. LTSS can be with comprehensive. There are ways to come together to decrease risks.• Sam – is the population requirement 5000 for each carrier? We need to clarify• Deb Faulkner – LTSS AEs are a pilot, we need a couple of AEs to try it out3. Incorporating quality metrics – get draft language soon4. Establish progression to meaningful risk – is a structural goal to change the system. We have learned from Medicare, other states, and commercial models. CMS wants to see this, by year 5 to accomplish our goals. We welcome comments5. Increasing standardization – TCOC methodology – to be able to measure better and create a level playing field.<ol style="list-style-type: none">a. Pilot ACOs what has been successful?<ol style="list-style-type: none">i. Evaluation of pilot in developmentii. FQHC based, for profit hospital, one non-profit hospital, private practice without hospital – we have three types of models to compare.b. Deb Florio – contracting took a lot longer than we thought, what is tricky at the end is the sharing of the cost data, claims and cost, with OHIC and private plans, this is proprietary information. It is going to be an issue. Doctors will have to know how much the patient is costing. Plans may not be able to share that information.c. Paco – trend in savings in these models.d. Jason – does year one mean January or when the contract starts?<ol style="list-style-type: none">i. Deb Faulkner will get back with additional details, Deb Florio, it's also based on CMS waivers	<p>Will send out electronically</p> <p>Population requirements/attribution live of 5000 for each MCO or across board</p> <p>Quality Metrics draft language</p> <p>Clarification of “Year One” contract start dates</p>

	e. Sam – this is a guidance from EOHHS, are carriers submitting their guidance? Will there be transparency?	Determine if there will be a public review process of MCO total cost of care methodology?
Next steps	Stakeholder comments are due by 8/14. Next Medicaid AE office hours are scheduled for Monday, July 31st, 2-3:30 PM. -Tentative agenda item: Quality component of APM guidance	