HSTP AE Advisory Committee Meeting Minutes

Meeting Date, Time, and Location: September 14, 2021, 9:00 a.m. to 10:30 a.m., 3 West Road, Virks Building Training Room, Cranston, RI 02920

Meeting Facilitators/Presenters: Director of Medicaid, Benjamin Shaffer; Director of Health System Transformation, Libby Bunzli; Senior Policy Analyst Amy Katzen; Associate Director Financial Management, Kim Pelland.

Committee Members: Carrie Bridges-Feliz; Barry Fabius; Scott Fraser; Chris Gadbois; Jennifer Hawkins; Deb Hurwitz; Dr. Jerry Fingerut; Womazetta Jones; Linda Katz; Dr. Al Kurose; Jeanne Lachance; Ray Lavoie; Juan Lopera; Maureen Maigret; Roberta Merkle; John Minichiello; Dr. Nicole Alexander-Scott; Jim Nyberg; Steve Odell; Dr. Ottiano; Maria Palumbo-Hayes; Rebecca Plonsky; Richard Charist; Amal Trivedi; Marti Rosenberg; Sam Salganik; Benjamin Shaffer; Sue Storti; Merrill Thomas and Patrick Tigue.

Meeting Notes			
Agenda Item	*Time*	*Facilitator(s)*	*Meeting Notes*
Welcome & Introductions	**5 Minutes**	**Director Shaffer**	**Director Shaffer:** Good morning and welcome everyone to our AE Advisory Committee meeting, the first in person in a long time, so thank you everyone for joining us. I will kick it off by asking for approval of the June 24 Advisory Committee meeting minutes. **Motion to approve the minutes from the April 1st AE Advisory Committee meeting** • Motion Approved **Director Shaffer:** Before we provide program updates, I wanted to also take a moment to welcome our new AE Advisory Committee Co-Chair, Dr. Amal Trivedi. Unfortunately, he was unable to make it to today's meeting, but he will be providing some guidance to us offline and looks forward to joining this committee. By way of background, Amal Trivedi, MD, MPH is a Professor of Health Services, Policy and Practice at Brown University and a Research Investigator at the Providence VA Medical Center. He is a general internist and health services researcher whose work focuses on measurement of quality in health care, racial and socioeconomic disparities in health care, and the effects of federal and state health policies on vulnerable populations.

Program Updates	**10 Minutes**	**Director Shaffer and Libby Bunzli**	**Program Updates**
			• **First quarter of PY4 is winding down**
			    ○ All TCOC contracts for PY4 have been executed, with 3 AEs accepting downside risk
			    ○ Majority of PY3 incentive funds have been awarded, anticipate that most unearned funds will be achieved early in PY4
			• **Social Determinants of Health Investment Update**
			    ○ Community Resource Platform: Unite Us has engaged with all AEs, anticipated to onboard 4 by end of September

			▪ 153 Community-Based Organizations onboarded into the network, over 300 additional organizations at various stages of engagement 　○ Rhode to Equity: Technical assistance has commenced, teams actively engaged with coaches • Behavioral Health Investment Planning 　○ EOHHS will be engaging in a process to gather input to inform a $3.5M investment to support Behavioral Health in the AE program
AE Program Budget Update	**15 Minutes**	**Kim Pelland**	**AE Program Budget Update** **Overview** • Background: 1115 Waiver enabled RI to establish a Designated State Health Program (DSHP) 　○ CMS matches spending on health professional education at URI, CCRI, and RIC 　○ DSHP Funds: expanded matching authority frees up $115M in state funds, allowing ~$230 million in total funding 　○ Use funds on AE activities per 1115 waiver 　　▪ Administration (50% match) 　　▪ Incentive Payments (approx. 66% match) 　　▪ Workforce Development Projects (0% match, 100% DSHP) 　　▪ Supported Projects (match rate varies) • Kim Pelland walked through the HSTP budget overview for FY17-FY27: 　○ Total funds spent FY17-FY21 equals $109.5M 　○ Projected spend for FY22-FY27 is expected to be $119.9M 　○ Total budget equals $229.4M • **Public Comment:** 　○ **Commenter**: When thinking about sustainability, what is being targeted for that? 　　▪ **Director Shaffer**: On the left side of the table, supported projects are not true infrastructure. Cannot run the program without TCOC. When we look at sustainability, we also look at the incentive program piece. Those are the two items we are most concerned about sustaining or understand how we build the model moving forward. 　　▪ **Libby Bunzli**: Agree, when we look at sustainability, we look at those things that the AEs do to run the program, so broadly that is where we are focused. 　○ **Commenter**: Concerned the AEs will not be able to meet quality gate, it will only get harder. There have so many changes in the benchmarks that will make it harder to achieve. 　　▪ **Libby Bunzli**: Appreciate that. Each year we convene the quality Work Group with the MCOs and AEs to establish targets that are achievable.

			Our long-term objective is not to create targets that are not achievable. We will continue to monitor program performance in the current year with MCOs and AEs. ▪ **Director Shaffer**: As we get questions about how we have spent and what we plan to spend, collectively, we need to think about this, and we want to make sure the allocations look correct. Excited about the future of the project and the programs and infrastructure we are standing up and supporting.

PY5 Roadmap and Sustainability Plan	**30 Minutes**	**Libby Bunzli**	**PY5 Roadmap and Sustainability Plan**
			Each year, EOHHS must update our AE Roadmap and Sustainability Plan to submit to CMS. The PY5 draft was posted for public comment on 9/3.
			• The AE Roadmap describes the vision for the program and broad program structure
			  ○ The PY5 Roadmap includes programmatic updates and adds detail on the LTSS APM that is currently under development
			• The Sustainability Plan describes a set of strategies that EOHHS will employ to sustain investments necessary for AEs to succeed under TCOC, achieve quality targets, and manage population health
			• The PY5 Sustainability Plan includes the same broad set of strategies described last year and includes key updates:
			  ○ Articulation of EOHHS' conceptual model for sustainability
			  ○ Analysis of budget information received from AEs
			  ○ Report out on EOHHS progress toward advancing the strategies
			• In early 2021, AEs submitted budget information that sheds light on long-term program costs.
			  ○ The total reported budgeted costs per member for Program Year 4 range from $46 to $208 across the 7 AEs. The average was $89. (*Some variation in total costs per member for PY 4 is likely attributed to reporting limitations; AE budget submissions varied in level of detail and categorization of expenses.)
			  ○ Personnel expenditures account for the majority of all costs (70%), followed by Community-Based Organization (CBO) contracts (13%), and information technology expenses (12%). The AEs budgeted considerable expenses for care management, behavioral health, and SDOH screening and referral services.
			• EOHHS outlined strategies aimed at sustaining the critical investments that enable AEs to succeed in managing total cost of care and improving quality. These 4 strategies are consistent with the 2020 Sustainability Plan.
			  ○ Shared savings from total cost of care arrangements will provide some support for AEs.

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  - o EOHHS will seek authority to provide reimbursement for high value services.
  - o EOHHS is exploring mechanisms for delegation of care management functions and associated financing to AEs
- Key Strategy 1: Shared Savings
  - o In the short term, shared savings can support the bending of the cost curve while we build investments into TCOC over time and allow for experimentation and innovation
    - ▪ EOHHS compared <u>PY4</u> budgeted expenses (for which data was most complete) to <u>PY1 and PY2</u> shared savings payments.
    - ▪ In Program Year 1, three AEs earned shared savings in at least one MCO contract.
    - ▪ These payments were equal to 9.6%, 12.2%, and 76.5% of their Program Year 4 expenses, respectively.
    - ▪ In Program Year 2, five AEs earned shared savings in at least one MCO contract.
    - ▪ These payments were equal to 26.5%, 38.8%, 52.6%, 55.4%, and 90.7% of their Program Year 4 expenses, respectively.
    - ▪ Generally, AEs have increased their investments over time, so PY4 expenses were generally higher than in earlier years. Although data were not sufficiently complete to allow a full comparison of PY1 and PY2 expenses to savings results from these years, it is likely based on the data we do see that shared savings from these years covered a higher share of those years' expenses.
    - ▪ Consistent with national ACO trends, we expect AEs to earn more shared savings as they gain experience in managing TCOC and quality
- Key Strategy 2: Centralizing Investments
  - o EOHHS has invested in healthcare infrastructure that is more cost-effective to build in a centralized way.
    - ▪ Community Resource Platform: EOHHS has contracted with Unite Us to provide the CRP. Unite Us is working closely with AEs to onboard users and identify opportunities to integrate with AE EHRs. EOHHS expects that at least four AEs will have at least 75% of their providers onboarded and using the CRP by June 2022.
    - ▪ Rhode to Equity: Rhode to Equity is a learning and action collaborative that supports six geographically based cross-sector teams to build

clinical-community linkages. This work will enable AEs to enhance their capacity to address attributed patients' health-related social needs.

- Care Management Alerts and Dashboards: As of May 2021, every AE has access to the Care Management Alerts and Dashboards system, and providers at every AE accessed the system at least once in the month of May. From January 2020 through May 2021, an average of nearly 43,000 encounters were added to the system each month.
- Quality Reporting System: All AEs are working to report quality data through the QRS, and of the six AEs that participated in Program Year 3, all submit data to the QRS through an electronic health record for at least some of their practices.
- CurrentCare: As of April 2021, every AE had active CurrentCare users, and across all AEs an average of over 4,400 logins took place each month from January 2020 through April 2021.
- Workforce Transformation: EOHHS has partnered with RI DLT to leverage the Real Jobs RI program to support tailored training and workforce development programming for AEs.

- Key Strategy 3: Reimbursement for High-Value Services
  - Medicaid coverage of Community Health Worker (CHW) services is a good test case for this strategy
    - The Rhode Island SFY22 budget includes instructions for EOHHS to seek CMS authority to add CHW services as a covered Medicaid benefit.
    - The proposed State Plan Amendment to add CHW benefits will be submitted to CMS in the coming weeks, following review of public comment.
    - According to submitted budget materials, AEs spent an average of **6% (or $5 PMPY)** of their budgets on CHW services. EOHHS expects that this is an underestimate because some AEs did not break out CHW-specific expenses from other care coordination/care management costs. AE spending on CHWs will largely be offset in future years by the new CHW benefit.
  - In general, by adding appropriate services to the Medicaid payment system, EOHHS seeks to ensure that TCOC captures the cost of delivering efficient, high value care. TCOC should include both the costs and the savings of deploying CHWs and other key services, not just the savings.
- Key Strategy 4:
  - EOHHS is exploring opportunities to shift appropriate care management functions and associated funding to AEs.

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- EOHHS will procure its managed care organization vendors for the RIte Care, Rhody Health Partners, Medicaid Expansion, Children with Special Health Care Needs, and Substitute Care populations.
- EOHHS is exploring opportunities for future subcontractor delegation of functions and the associated financing structures from MCOs to AEs.
- EOHHS is exploring opportunities to delegate the function of delivering certain care programs (e.g., care coordination, care management, complex case management) from MCOs to AEs, and to require that AEs be reimbursed for delegated functions.
  - Respondents to the RFI earlier this year expressed broad support for this transition
- EOHHS is also exploring ways to increase MCO investment in social determinants of health

- Feedback on the AE Sustainability Plan
  - EOHHS held one meeting with AE program participants to receive input on the sustainability plan and tried to incorporate responses within the version that is posted for public comment.
    - Feedback received to date:
      - Show your math!
      - Connect AE Sustainability strategy back to broader state goals and strategies identified by the Cost Trends Advisory Committee
    - Written public comment:
      - The AE Roadmap and Sustainability Plan are currently posted for public comment
      - Written comments are due October 4. Please submit to: jennifer.marsocci@ohhs.ri.gov

- **Public Comment:**
  - **Commenter**: Is there an understanding of the budget variations in the pmpm?
    - **Kim Pelland**: I think there was some variation in the way the AEs categorized some of the expenses that could account for it.
    - **Director Shaffer**: A lot of the work that we need to do over the next few years is to sharpen the analysis and get a better understanding of program expenses through data collection.
  - **Commenter**: Another thing to keep in mind is the unengaged members whose cost is zero dollars. This will impact program cost.
  - **Commenter**: How do we separate out the costs for our members when we have 70% of our members in this program across all lines of business?

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			▪ **Director Shaffer**: EOHHS is thinking about reimbursement for high-value services for example, we want folks to have access to CHWs if they need it. This will be an iterative process.
			▪ **Libby Bunzli**: Agree that working to improve upon the data collection surrounding program costs will help us to better understand program costs for sustainability.
			▪ **Director Shaffer**: CHWs is an area where we think the AEs underreported spending.
			 o **Commenter**: Is there a parallel between success in Medicare vs Medicaid.
			  ▪ **Libby Bunzli**: I am not sure there has been substantive analysis done in that area to provide any detailed feedback, but it provides directional support for advancing value-based payment and provider risk.
			 o **Commenter**: Thank you for the partnership.
			 o **Commenter**: We can't just rely on shared savings to sustain AE activities, especially as future capability of an AE to earn shared savings is uncertain.
			  ▪ **Libby Bunzli**: Agree and heard concerns about the race to the bottom. Our conception of this is that shared savings will happen over many years and cannot be our only strategy.

PY5 Requirements Updates	**30 Minutes**	**Amy Katzen**	**PY5 Requirements Updates** **Process for Stakeholder Input:** • The stakeholder input process for Program Year 5 includes two virtual stakeholder meetings to walkthrough proposed changes to Accountable Entity Program requirements. The meetings were held September 3rd and September 10th with MCO's, Accountable Entities, and interested parties. • Proposed changes to PY5 requirements will be discussed at a larger, public meeting of the Accountable Entity Advisory Committee on September 14th. • Accountable Entity Program Year 5 Requirements will be posted for a formal 30-day Public Comment period in the first week of October. • EOHHS will post responses to public comment and the final Program Year 5 Requirements on the EOHHS Accountable Entity Website • EOHHS will submit to CMS for approval by December 15th. **Objectives for PY5** • Maintain course: Minimize structural changes to the program to foster stability and enable AEs to continue to gain experience under TCOC • Focus on sustainability: Changes to program requirements are meant to support EOHHS' sustainability plan for Accountable Entities

- Advance strategic priorities related to equity and whole-person care

Program Year 5 Requirements: Total Cost of Care
- TCOC requirements will be similar to Program Year 4 requirements, with the following proposed revisions:
  - Add clarifying language to confirm that AEs fully certified for downside risk by OHIC in PY4 are considered pre-qualified for PY5
  - Update quality framework to reflect decisions made by AE-MCO workgroup
  - Option for FQHC-based AEs to take on downside risk

Program Year 5 Requirements: Incentive Program
- Incentive Program requirements will be substantially similar to Program Year 4 requirements, with the following proposed revisions:
  - AE and MCO PMPM rates updated to $5.54 and $1.05, respectively
  - Update RELD (race, ethnicity, language, disability) measure to align with final OPY4 measure
  - Revise weights for the three outcome measures per the recommendations of the AE-MCO workgroup
  - Revise to account for new FQHC-based AE downside risk option
- If proposed changes are adopted, AEs may earn Incentive Funds through the milestones and measures below.

Milestone/Measure	PY5 Allocation
Evidence of participation in downside risk contracts	5%
Submission of performance for select AE Common Measure Slate measures stratified by race, ethnicity, language and/or disability status (RELD).	5%
Outcome Metrics: • All-Cause Readmissions (20%) • ED Visits for Members with Mental Illness (12.5%) Potentially Avoidable ED Visits (12.5%)	45%
HSTP Project Measures: At least 3 core projects with at least 2 measures per project. Allocation across each measure to be agreed upon by AE and MCO	45%

- **Public Comment:**

			o **Commenter:** Will there be modeling that shows the delta between amount of dollars at risk and the PPS? What is the level of effort for RBPO process?
			  ▪ **Amy Katzen:** Defer to those that have gone through the process.
			 o **Commenter:** Not a huge lift, described process.
			  ▪ **Amy Katzen:** My experience is that the OHIC staff has been very responsive; any questions that you have you can reach out.
			  ▪ **Commissioner Tigue:** Agree, great partnership between EOHHS and OHIC. Happy to field any questions.
			  ▪ **Amy Katzen:** RELD Data hard to collect nationally. Disability data coming from MCOs, not perfect but better than not tracking.
			 o **Commenter:** Most recent quality meeting, data was quite alarming. When will the updated QIM be posted? Will that include the proposed PY5 or is there another iteration.
			  ▪ **Amy Katzen:** In process of doing final read-through. PY5 will be the same as PY4. Earliest we would approach changes to RELD would be PY6.
			  ▪ **Libby Bunzli:** Need time to gain experience in collecting the data, EOHHS' intention is to reduce disparities.
			  ▪ **Amy Katzen:** Data lag is also a challenge.
			 o **Commenter:** Not just data lag, but data gaps. It is the wild west in terms of collecting this data.
			 o **Commenter:** Any improvement on the Medicaid application side on collecting this data?
			  ▪ **Director Shaffer:** Still an active topic. Barrier is always the duals and SNAP. Rules are clear on the number of questions you can ask to proceed with a snap application. Challenge from system perspective is balancing the regulations with the need to collect the data. Adding additional questions on REL, the belief is, that it will prohibit people from applying for benefits. The change will be slower going than anyone would like.
			 o **Commenter:** Avoidable ED and MI Avoidable ED, are they mutually exclusive?
			  ▪ **Amy Katzen**: I believe there would be overlap.
			 o **Commenter:** I see you moved 20% from one measure to another, they should be equally weighted. I will note this in my comments.
			 o **Commenter:** I spoke to some of the FQHC AEs, they expressed apprehension with respect to down-side risk. Losing out on incentive dollars may make the ROI project more favorable. I would ask that you take under consideration keeping the ROI project in the program.

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o **Commenter:** Will there be a change in the way the allocations will be structured with respect to down-side risk?
  - **Amy Katzen:** CMS Guidelines.
o **Commenter:** Echo the sentiment on the ROI project.
o **Commenter:** Doesn't down-side risk provide more upside opportunity.
  - **Amy Katzen:** Yes, when we meet with the FQHC's we hope to model that.

Program Year 5 Requirements: Certification Standards
- EOHHS updated Certification Standards relating to care management activities to clarify minimum standards for AE-led care program activities in support of a path toward delegation of these functions
  - o In the MCO procurement RFI, EOHHS heard broad support for better delineation of roles between AEs and MCOs, more AE ownership of patient-facing care management functions, and delegation of these functions. EOHHS sees this as critical to the sustainability of AEs.
  - o In Domain 6 of the draft version of the PY5 Certification Standards, EOHHS articulates a vision for a system of care that is person/family centered, collaborative, community-based, equitable, population health focused, and oriented toward outcomes.
- EOHHS updated Certification Standards relating to care management activities to clarify minimum standards for AE-led care program activities in support of a path toward delegation of these functions
  - o The draft version of the PY5 Certification Standards also includes a framework to organize our conceptualization of the continuum of care programs. The standards within domain 6 are organized according to this framework.
    - Differentiates and defines health promotion, care coordination, care management, and complex case management, which should be designed to address patient needs as they increase in complexity/acuity.
    - Describes core standards under each program type. Substantively, most of the standards are consistent, with some added expectations for AEs across these program types.
- **Public Comment:**
  - o **Commenter:** Thank you for holding all the stakeholder engagement.

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Meeting adjourned at approximately 10:30 a.m.
The next AE Advisory Council Meeting is scheduled for Thursday, November 18, 2021 9:000-10:30 a.m. Venue to be announced.

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Meeting Participants: Marti Rosenberg (EOHHS), Holly Garvey (Integra), Garry Bliss (PHSRI), Domenic Delmonico (Tufts Health Plan), Stacey Aguiar (UHC), Chris Gadbois (CareLink), Patrice Cooper (UHC), Jonathan Mudge (Blackstone Valley Community Health Center) Libby Bunzli (EOHHS); Amy Katzen (EOHHS), Jennifer Marsocci (EOHHS), Charlie Estabrook (EOHHS), Monica Broughton-Rix(UHP); Jerry Fingerut (EOHHS); Kacey Booth (IHP); Patrick Tigue (OHIC); Tom Douglas (PCHC); Tarah Provencal (BCBSRI); Kim Pelland (EOHHS), Donna Marshall (UHC), John Tobin (NHP), Nancy Hermiz (NHP), Tinisha Richards (UHC), Gayle Dichter (NHP),

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