HSTP AE Advisory Committee Meeting Minutes

Meeting Date, Time, and Location: June 14, 2022, 8:30am – 10:00am, 3 West Road, Virks Building, 1st Floor Training Room, Cranston, RI 02920

Meeting Facilitators/Presenters: Kristin Sousa, Medicaid Director (EOHHS), Charlie Estabrook, AE Program Lead (EOHHS), Amy Katzen, Chief of Strategic Planning, Evaluation, and Monitoring (EOHHS), Pam Jennings (Faulkner Consulting Group); Rick Brooks, Director Healthcare Workforce Transformation (EOHHS), Jessica Mayerni, Program Director, Real Jobs Rhode Island, Rhode Island Department of Labor and Training; Cody Fino, Director of Industry Partnerships and Suzanne Carr, Dean of Health and Rehabilitative Sciences, Community College of Rhode Island (CCRI), Jennifer Giroux, Associate Vice President Professional Studies and Continuing Education, Rhode Island College (RIC); Bryan Blissmart, University of Rhode Island; Rachael Sardinha, RI Health Education Exchange Program Manager, Rhode Island department of Health (RIDOH);

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

<table>
<tr><th colspan="4">Meeting Notes</th></tr>
<tr><th>Agenda Item</th><th>Time</th><th>Facilitator(s)</th><th>Minutes</th></tr>
<tr><td>Welcome, Introductions, Approval of April's Meeting Minutes and Program Updates</td><td>10 Minutes</td><td>Director Sousa/Charlie Estabrook</td><td>Director Sousa: Welcome and Introductions.
April 2022 Accountable Entity Advisory Committee Meeting Minutes were approved.

AE Attribution Update:
As of April - Total attribution across all AEs and MCO contracts reached nearly 210k thousand members, similar to February attribution shared at our last meeting.
AE Program Updates:
Broadly, AEs are wrapping up PY4, have been certified for PY5, and are preparing for the new contract year with MCOs and EOHHS. EOHHS is beginning to plan for PY6.
HSTP Project Plans Status – Overall, EOHHS is pleased with the innovative and "out of the box" thinking.
Certification standards domains 4-8 review – Will be completed sometime in August</td></tr>
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			• Behavioral Health Investment Update – Still moving forward with Part 1 which was sent out to the meeting participants several months ago. The AE flags for BH providers in CurrentCare and/or Care Management Alerts and Dashboards (CMAD) should be available soon; a draft scope of work for Parts 2 and 3 will be available within the next 2-3 weeks.
			• Community Health Worker State Plan Amendment approved by CMS
			• ROI Projects for FQHC AEs
			  o Final report on savings is due on October 31st
			    ▪ Conflicting due date clarified; Reporting Calendar supersedes any other document
			• Butler has agreed to include admissions, discharges and transfers in the Care Management dashboards for all AE patients not on detox units.
			Public Comment: April Attribution reports will be rerun due to an abnormality EOHHS noticed.
			Public Comment: Is there a timeline for Butler to begin including admission, discharge and transfer data in the CM Dashboards?
			• Not at this time.
			Public Comment: Will there be a subsequent narrative report for the ROI Project?
			• No
			Public Comment: Will EOHHS consider allowing for an increase of incentive pool size during a program year if an AE considers acquiring a practice that would increase the size of their patient population by over 15%. By not allowing for an increase in the incentive pool size, this would leave the AE at a disadvantage in terms of "infrastructure funds".
			• EOHHS is open to continued conversations and feedback around this.
			
			OPY4 Q4 Outcome Measure Performance
			Preliminary performance for OPY4 (January 1, 2021 – December 31, 2021) was reported out to the AEs last month.
			• The final OPY4 performance has not been reported yet.
			  o Final performance will be reported out to the AEs in August
			  o Incentive fund distribution will be based on aggregated performance
			• Starting in OPY5 outcome measure targets and final performance will no longer be in aggregate at the recommendation of the AE/MCO Quality Work Group

			AE Program Updates – PY6 Planning Schedule
			EOHHS intends to maintain course (foster stability) and continue focus on sustainability, as we concurrently outline the AE Program's strategic vision for post-PY6
			• **Summer 2022:**
			  ◦ EOHHS drafts necessary modifications to Roadmap and Sustainability plan
			  ◦ EOHHS drafts technical modifications to the PY 6 Requirements
			• **August & September 2022**
			  ◦ Stakeholder Engagement on modifications to Roadmap/ Sustainability plan and PY6 Requirements
			  ◦ Roadmap and Sustainability Plan Posted for Public Comment
			• **October 2022**
			  ◦ PY6 Requirements Posted for Public Comment
			• **November 2022**
			  ◦ Roadmap/ Sustainability Plan submitted to CMS
			• **December 2022**
			  ◦ PY6 Requirements Submitted to CMS

TCOC Performance – Program Year 3 Review	**10 Minutes**	Amy Katzen	**Overview of AE TCOC Performance in PY3** In PY3, all AE-MCO contracts utilized the same TCOC model, as described in TCOC requirements documents, and was implemented by EOHHS (working in close partnership with MCOs). • Approximately $1,107 million in Medicaid spending, for over 250k Medicaid Managed Care members, occurred pursuant to AE TCOC arrangements in PY3 (SFY 2021) • Overall, actual medical spending for AEs' attributed members ranged from 3.7% to 16.2% lower than TCOC targets • All AEs earned shared savings under their MCO contract(s) • Overall Quality Multipliers ranged from 77% to 100% • Note, PY3/SFY21 was the first year when contracts with Downside Risk were allowable, although was not a requirement for non-FQHC based AEs due to the start of the pandemic **AE performance under contracts with UHC:** Overall, savings percentage varied from 7.2% to 10.5% of targets -- All AEs achieved savings relative to their targets and subsequently earned

			shared savings after application of the adjustments defined in the TCOC requirements and technical guidance.
			AE performance under contracts with Neighborhood: Overall, savings percentage varied from 3.7% to 16.2% of targets -- All AEs achieved savings relative to their targets and subsequently earned shared savings after application of the adjustments defined in the TCOC requirements and technical guidance.
			Total Cost Savings Pools – Program Years 1-3
			Across MCO contracts in PYs 1-3 the AEs' actual expenditures were $103M less than targets, in aggregate.
			• Although the TCOC target-setting methodology generally aligns with the MCO capitation rate setting process, there are several factors that can cause shared savings payments and MCO profits to diverge, including MCO administrative expenses, community-rated vs. MCO-specific base data, effects of high-cost claimants, and the impact of maternity case rates paid to MCOs. For instance, if costs in excess of the high-cost claimant threshold are materially higher in the performance year than in the base year, MCOs will be responsible for the full value of these costs, while AE shared savings payments are based only on costs below the threshold.
			PY4 TCOC and Forward
			No changes to overall TCOC model in PY4; limited technical updates for PY5
			• PY4 is first year of required downside risk for non-FQHC AEs; optional for FQHC-based AEs in PY5
			• Implementing two technical updates for PY5; overall goal is to better align TCOC methods with the MCO rate setting process and methods.
			  • Delivery Costs: At the conclusion of the performance year, EOHHS/Milliman will adjust AE TCOC targets to account for changes in the statewide number of maternity events that occurred between the Baseline Years and the Performance Period.
			  • Market Adjustment: Implement a statewide market adjustment to compare the AE to its peers across all MCOs in the AE program (currently compares an AE's historical experience to its peers within the same MCO), which creates further alignment with the managed care capitation rate development process as capitation rates are set based on statewide experience and not individual MCO experience.
			• Preliminary PY5 targets provided to MCOs on 6/1; do not yet reflect final risk adjustment or statewide delivery adjustment for the performance year and subject to

			change based on finalized SFY 2023 rate certification. Milliman will update targets with the first PY5 quarterly report, to incorporate any capitation rate updates relative to the 4/15 draft that preliminary targets are based on. Additional Notes on Delivery Cost Update: The current methodology means that in a year with fewer deliveries than expected, it is easier for AEs to achieve TCOC targets because the expected costs are built into the TCOC targets while the AEs' actual TCOC results only count the deliveries that actually occurred. This is mis-aligned with MCO outcomes, because in a year with fewer deliveries than expected, the MCO still only receives a supplemental payment for the deliveries that actually occurred. In a year with a higher number of deliveries than expected, the outcomes would be reversed – it would be more difficult for AEs to achieve TCOC targets because the targets would account for expected births while actual spending would include the higher number of actual births (and MCOs would receive supplemental payments for the higher number of actual births). By reconciling TCOC targets based on the actual number of deliveries, this misalignment is corrected. ***Public Comment:*** What changed with the delivery of care that generated the savings? • We can potentially understand this question by looking at performance on outcome measures, which measure utilization – e.g., re-admissions and ED use; varies from AE to AE on how they implemented their programs.

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<td>EOHHS and RIDOH Participatory Budgeting Pilot Project</td>
<td>20 Minutes</td>
<td>Pam Jennings/Allegra Scharff/Charlie Estabrook</td>
<td>Contacts:
Pam Jennings
Participatory Budgeting
Faulkner Consulting Group
Technical Assistance Provider
Allegra Scharff
Chief of Healthcare Equity
RI Department of Health
Charles Estabrook
Program Lead
EOHHS
Background about Participatory Budgeting: worldwide effort involved in PB processes, an opportunity to engage members of the community
Participatory Budgeting Process Flow
1. <u>Design the Process</u> A steering committee that represents the community creates the rules and engagement plan
2. <u>Brainstorm Ideas</u> Through meetings and online tools, residents share and discuss ideas for projects.
3. <u>Develop Proposals</u> “Budget Delegates” develop the ideas into feasible proposals.
4. <u>VOTE</u> Residents vote on proposals that most serve the community needs
5. <u>Fund the Winning Project</u> The government or organization funds the winning projects.
What are the benefits of PB?
• PB opens-up government and makes it accessible to people who have faced historical barriers to participation and voting
• PB generates more equitable and effective government spending
• PB leads to greater confidence in public institutions
• PB opens a gateway into civic engagement that creates a path to lifelong participation and has been shown to improve voter turnout
• PB supports new community leaders, as people who participate in PB gain more confidence in becoming civically engaged
• PB expands financial literacy and civic education opportunities for residents
• PB has improved health outcomes in Brazil, where PB is linked to lower infant mortality rates

PB & HSTP with the Health Equity Zones</td>
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			• HSTP PB gives community members control over investments to impact social determinants of health
			• Two HEZ were selected through an application process
			    • Pawtucket/Central Falls (P/CF)
			    • Central Providence Opportunities (CPO)
			• Each HEZ will receive $450,000 for community improvement projects and implementation of the process
			    • CPO will also allocate $550,00 of Blue Meridian grant funds for a total of $1,000,000
			PB will provide Medicaid and AEs with a deeper knowledge of the investments needed in communities, as seen by the community members themselves
			Participatory Budgeting Timeline: July 2022-June 2023
			• July – August: Steering Committee Creates Rulebook
			• September – October: Idea Collection
			• November – March: Proposal Development
			• April – June: GOTV and Vote
			Opportunities for AE involvement
			PB presents an opportunity for AE's to strengthen community linkages. Opportunities for partnership include:
			• Members of AE Community Advisory Committees or Community Health Workers can apply join PB Steering Committees
			• Support outreach by notifying members about idea collection events and voting
			• Provide communities with health and/or SDOH data related to their geographic area
			• Provide technical expertise when projects are being developed
			• Reach out to the HEZs to discuss additional ideas
			PB Contacts for Questions after Information Session
			• Chief of Healthcare Equity, RI Department of Health
			    ➢ Allegra Scharff - Allegra.Scharff@health.ri.gov
			• Pawtucket Central Falls HEZ leads
			    ➢ Becki Marcus - Rbmarcus2@lisc.org
			    ➢ Robyn Hall - RHall@lisc.org
			• Central Providence Opportunities HEZ leads
			    ➢ Dominique Resendes - resendes@onenb.org
			    ➢ Lucy Berman - berman@onenb.org

			Public Comment: Great opportunity for the community to give their feedback and engage with community partners.

Healthcare Workforce Initiatives	**45 Minutes**	Rick Brooks	**Healthcare Workforce Development**
			Overview and Context
			• Workforce shortages
			• Work and family stressors
			• Rates and wages
			• Recruitment & retention
			• Labor market trends
			
			EOHHS workforce partner updates
			• RI Department of Labor & Training
			• Community College of Rhode Island
			• Rhode Island College
			• University of Rhode Island
			• RI Department of Health
			• Enhanced HCBS FMAP workforce investments
			• Healthcare Workforce Planning
			
			Enhanced HCBS FMAP workforce investments
			• Workforce recruitment & retention incentives
			• Certifications, professional development, and Continuing Education
			• Health Professional Equity Initiative
			  o Partnership with RI Office of the Post-Secondary Commissioner
			  o $3M investment
			  o Objectives
			    ▪ Increase career advancement opportunities for HCBS paraprofessional workforce
			    ▪ Increase racial, ethnic, and linguistic diversity among HCBS health professionals
			  o Free tuition and other financial, academic, and social supports
			Healthcare workforce planning
			• Build upon recent Health Workforce Summit and other planning efforts
			• Public /private collaboration
			• Cabinet-level sponsorship (EOHHS, DLT, and RIOPC)
			• Online plenary session **(Thursday, June 16 at 2:00 PM)**

			• Solutions-focused workgroups ○ **Health Career Pathways and Pipelines (Wednesday, June 22 at 2:00 PM)** ○ **Health Workforce Data Collection and Analytics (Thursday, June 23 at 9:30 AM)** ○ **Health and Human Services Partnerships with Higher Education (Tuesday, June 28 at 11:30 AM)**
Public Comments	**5 Minutes**		***Public Comment:*** Does EOHHS know when they will present NORC's AE Interim Results? • EOHHS is not sure; however, we are on track with the process.
Adjourn			Meeting adjourned at approximately 10:00am Upcoming Important Dates: **2022 AE Advisory Committee Meeting Schedule** • 18-Oct – 8:30-10:00 • 14-Dec – 8:30-10:00