Managed Care Procurement Stakeholder Engagement Series
Session 4: Core Contract Elements
Public Meeting Notes

Wednesday, May 3, 2023
8:30 – 9:30 AM

Department of Labor and Training, 1511 Pontiac Avenue, Cranston, RI, 02920, Conference Room 73-1.

Facilitators/Organizers: Amanda Graziosi (EOHHS), John Neubauer (EOHHS), Mark Kraics (EOHHS), Debbie Morales (EOHHS), Deb Faulkner (FCG), Olivia Burke (FCG), Jessica Brown (FCG), Min Tunkel (FCG)

Participants: Alice Msumba (Tufts), Amanda Graziosi (EOHHS), Barry Fabius (UHC), Beth Marootian (NHPRI), Carla Sabotino (Tufts), Carson Colmore (FCG), Catherine Taylor (AARP RI), Chantele Rotolo (EOHHS), Chrisina Amedeo (United Way), Christina Pitney (BCBSRI), Christine Anderson (OHA), Corey McCarty (CCA Health RI), Dan Hammond (Tufts), Dan Moynihan (Lifespan), Dave Boim (Molina Healthcare), Deb Faulkner (FCG), Debbie Morales (OHHS), Desiree Otenti (Tufts), Garry Bliss (Prospect), Heather Mattias (CNE), Jessica Brown (FCG), John Neubauer (EOHHS), Kara Curtis (CVS Health / Aetna), Katie Barrett (BCBSRI), Kevin Cabral (PCHC), Kevin McKay (CCA Health RI), Lisa Fulchino (Tufts), Liz Adler (Integra), Marcy Reyes (CCA Health RI), Mariana Moore (Tufts), Mark Cooper (NHPRI), Mark Kraics (EOHHS), Matt Harvey (Integra), Melissa Campbell (RIHCA), Melody Lawrence (BCBSRI), Mike Florczyk (UHC), Mike Gossner (UHC), Olivia Burke (FCG), Robert Archer (Child + Family), Sam Salganik (RIPIN), Sarah Coutu (UHC), Shamus Durac (RIPIN), Sheila Santos (UHC), Sylvia Bernal (United Way), Stacey Aguiar (UHC), Stephanie Gill (CCA Health RI)

Agenda Item	Key Discussion Points
Welcome & Introductions	Faulkner Consulting Group (FCG) and EOHHS welcomed participants to the public meeting and shared that the session would be an opportunity for participants to provide feedback on new core contract elements being considered. FCG provided a brief background and introduced topics for discussion, emphasizing that the states cancelled RFQ from 2021 is the primary foundation for the upcoming RFQ and should be used as a resource for providing RFI responses.
Care Coordination & Care Management Delegation	• FCG introduced that the first two discussion topics will focus on planned refinements and potential future enhancements to support the Accountable Entity (AE) program and primary care. • How can EOHHS promote delegation? How should requirements be tailored for specific populations? For members with complex medical and social conditions, how to delineate responsibilities?

	○ What is the state thinking about regarding prep for the provider community? ▪ FCG: It is a challenge of delegation – what you'll see in the model contract is "delegate". It doesn't tell the MCOs exactly how to do this, or give specifics, but does require state approval of MCO plan for delegation. ▪ The contract needs to be clear if delegation is required. If it allows but doesn't require (says "you CAN do it"), then the state should live with the reality that it probably won't be done. ▪ Unpopular opinion with providers, but I would recommend that in order for the MCO to delegate care management to an AE, they must be accredited by NCQA. ○ Are we defining care coordination? for whom? and for what? Our traditional care coordination is for the high spenders – it doesn't work for kids, generally. Care coordination for kids and families can be really helpful and the state should keep that in mind. ▪ FCG: The contract now doesn't specify very well by population – so if there are things the state should say regarding specific populations, it would be great to hear. ▪ It's not easy to define. If it [care coordination] stays at the AE, the funds aren't going to flow to kids. ○ The vision is to decrease the number of care managers per family –we talk about BH, SMI, kids with emotional disturbance but we don't talk about the giant middle population. Where does that fall in this? That does lead to confusion – if you're not super severe, where would that fall? ▪ FCG: Agree. How much should the state dictate that, and how much should the provider figure that out? ▪ Where the state can be helpful, and has been done with the AE program, is have aligned quality measures, first-tier, downstream, and related-entity (FDR) requirements – that's what delegation is. However, there are so many different populations in this contract that requiring delegation may lead to pigeonholing certain populations. Health plans are in the position to see where points of care are and design programs for who they are specifically serving. But saying "you are required to delegate to these entities" may be too strict. ▪ Agreed, there should be some flexibility, it shouldn't be a "you absolutely have to". If the AE is ready and able to, then you should proceed. ○ Flexibility is very important. Each relationship is different – there are strengths that a health plan may have that an AE doesn't. The role of the state is to define the outcomes that you want over value-based relationships. The AE program to date is pretty prescriptive. I would rather it say "reach these targets" than actually set the targets.

	○ I would urge the state to expand what it is considering beyond PCP capitation to a global capitation – and for delegation of integration. I don't think PCP capitation is sufficient for the impact on utilization. We should have total cost of care (TCOC) for the AEs. ○ We also need to make sure that we bring in CCBHCs – it's been difficult to get a relationship and be inside of Butler and such – we have to be intentional about bringing in CCBHCs – they're still taking risk. I'd love to see a system where they're part of the value-based arrangement with the AEs. ○ I agree with everyone. What we experience now is a disjointed approach to the payment system. The state should be very flexible – being more prescriptive hasn't been successful. As you lead to delineation – that automatically puts the MCO in the driver seat as it talks about money for the MCO. The more you allow the MCO and the provider to do a contract, you have to talk about how you're going to delegate funding. It's a very confusing industry for the patient. ○ For someone with severe needs – my recommendation would be that we drive to one lead care manager – primary care should be first and foremost, but the main issue we have is that we have too many needs.
Primary Care Capitation	• FCG introduced primary care capitation as something the state is considering and outlined the benefits of this approach including how it could be a vehicle for funding PCPs and AEs. • Are there other specific models the EOHHS should consider? Any key risks and opportunities? What other value-based payment (VBP) methods should MCOs be required or strongly encouraged to adopt? ○ When the funding flows up to the ACO level, is there a mechanism to guard against payment being based on total head count? There's no expectation that the funding work with the demographics of the AE's total head count. For example, you could have a huge number of children, get a lot of money, and then spend only a little on children. When the dollars flow up to the AE level, can we ensure that they're spent on their population? ▪ FCG: You can certainly do that, risk-adjust the payment. ▪ When I hear risk adjustment, I hear that you're going to pay pediatricians less. I understand the argument for that, what I'm concerned about is that the pediatrics get the resources they need. ▪ I think there are some payment models where there is a proportionality, meaning a pediatric spend that would have to be in proportion. Not one-to-one, but an acknowledgement that if we use traditional risk scoring, we take money away from kids. Like Medicaid in this country, 25% are kids, 25% of money should go to kids.

	○ I'm interested in the intersection of this and the MCO capitation rate because of risk corridors. I also want to state the impact on providers - they will have to do a lot of work to administer PCP capitation services. The Mass government was overly prescriptive about how this works – it was to protect the community, but the end result was incredible administrative complexity. The state should talk to folks at Mass Health to see how it's going. ○ Is the state suggesting that we prescribe an ACO cap across the board? ▪ The state could, and how much can be prescribed is still a question. But it's a mechanism to ensure that dollars get passed down to PCPs. ▪ There are diverse populations in the core contract – there should be flexibility to get the right payment to whomever it's getting delegated to. A global cap model is risk-adjusted to the individual – the flexibility to do that affords the state the best opportunity to ensure dollars are being spent well. PCP is a really small part of a whole – where we see issues in complex patients, it's not happening with PCPs. Whoever's accountable, they should be able to build off those services and work with community organizations. • FCG: You're saying, if you have a PCP capitation, it needs to be those services *and* include care coordination, beyond traditional PCP visits? • Yes, we shouldn't limit down to a small portion of the dollars. • To build off this, if you don't include those services, it would affect the most complex patients with the most spend. • FCG: Yes, we would want to support those enhanced visits – whether PCP is the place to do it, it's a starting point. • These services are being provided under PCP, but we aren't being reimbursed. ▪ There needs to be some ability to aggregate and keep data – if we want PCPs to be capitated and do care coordination, which is great, data sources and data aggregation are necessary and so difficult to do. • FCG: Yes, and you'll see that in the model contract too. I'm not sure how the state can make it more specific. That's where the state is looking for specific feedback, make sure to include the specifics in your RFI responses.
Health Equity & Health Related Social Needs (HRSN)	• FCG introduced key terms for the discussion including HRSN, social determinants of health (SDOH), and health equity and outlined CMS's Framework for Health Equity as an opportunity for Rhode Island to make progress on these priorities. • What additional actions should the state and MCOs take to address equity and HRSNs? Are there specific needs that EOHHS should prioritize? Should EOHHS pursue in-lieu-of services (ILOS) authority in

	managed care programs to address HRSNs? How can EOHHS encourage supplemental benefits and value add services to address these needs? o To clarify, is your question referring to the value add bucket or the in-lieu-of service (ILOS) bucket? ▪ For example, if MCOs are using admin funding to pay for housing, this is a value add service. MCOs would then give data to the state to measure effectiveness, and then that may lead to formalize the benefit as an ILOS through a state plan amendment and become part of the waiver authority like California and their housing waiver. ▪ Our waiver lays out a lot of this, but it defines providers and folks who engage with these services too broadly – we want the AEs involved in housing stabilization, providers in respite – we need more flexibility under the waiver in terms of which providers could manage these programs. o Workforce is at the heart of this, all kinds of workforce issues are fundamental to being able to get the care to those who need it – starting with PCPs – there's such a short supply but since they're physicians they often don't get included in this conversation. o Encouraging flexibility with value add services and using dollars in an innovative way to address major barriers – that's the beauty of allowing FIDE SNPs to use dollars in that way. Value add is a way for plans to test some of these services for effectiveness. ▪ Should the state offer a menu of potential services and say, "you should offer at least do one of these"? ▪ No, populations are so different, the state shouldn't specify that much. ▪ The state should think about the impact of these efforts on systemic change. If you're asking each provider to look at an individual's needs, will you affect the community as a whole? I would recommend that the state take a step back and look at the system overall and decide what's appropriate for a managed care entity to work on, and what's appropriate to fund. o Regarding housing security, maybe the state could create an all payer housing development pool, so that you don't end up with a fragmented system – you're addressing a problem where the state could take the lead.
Certified Community	• FCG provided an overview of the CCBHC program goals, services, and payment system. • What are the opportunities and risks in the implementation of the CCBHC model? What enhancements to the model do you recommend to help the state address BH needs and disparities? As the state develops

Behavioral Health Centers (CCBHCs)	the Operations Manual, what technical specs should we consider for attribution, billing, and quality program requirements? o From the designated collaborating organization (DCO) side, one of the things that seems to be unclear is if it is for existing services we are providing today, versus new services. We shouldn't limit just to new services, there are things being done today that need to be done better. o We should be cautious about the time it'll take for providers to transition to a new way of billing, into managed care, into FFS, and be very generous about training and the time it'll take for that to happen. If you start billing in February without any trial or practice, we'll see a lot of issues. Delays in payment are devastating. We should allow providers the time and testing needed to make sure the billing systems work. o The fundamentals are so critical, it feels a little bit of a primary care cap merged with a wrap arrangement – it'll be complicated administratively. How does it work with IHH/ACT? The sooner you get out the draft of the operations manual to us and the providers, even drafts – the better. o Even attribution is a challenge, setting that up is important – echoing the importance of the operations manual. o MCO involvement will be critical.
Behavioral Health Services	• Where are the most significant gaps in BH service capacity and access? Are there significant operational or administrative barriers impacting the member experience? Beyond CCBHCs, what payment and/or service delivery reforms might EOHHS consider? o Where do DCYF and mandated services fit in here? There's a whole BH system that deals with a population not captured here. I get that it's described, but wondering how they're doing to fit in… ▪ FCG: Some are included in "HCBS for Children", a lot are DYCF-mandated services. ▪ Some of the managed care organizations don't pay for DCYF-mandated services the way they're currently defined. That's part of the CCBHC conundrum – what's the incentive for them to work with us rather than bill themselves? The service list in the MCO contract needs to be aligned with the CCBHC service list. o Not sure of the wisdom of bringing court ordered BH benefits into the plan, there's no control over that at all and they may not be even close to medical necessity. o DCYF and BHDDH need to be part of this conversation – the services they manage and the role they play with their providers get between the MCO and the member. How are they endorsing this, embracing this, thinking about changes in their own roles and responsibilities?
Quality	• What are the key considerations about a new quality strategy and the alignment of quality measures?

	○ Encourage the use of HEDIS measures, they're very well researched. When you use "home grown measures" they're very problematic to build and measure over time. We'll have to make changes over years, they won't trend, etc. ○ The state's been doing well with aligning the MCO measures with AE measures, but there are some AE measures outside of this list – we should make sure they're consistent and aligned. ○ Also consider the number of measure so that' it's doable for an MCO. You want to give 100%. ○ Consider stratifying for race/ethnicity • Should member satisfaction be measured as part of a quality strategy? ○ I think member satisfaction should absolutely be included in the quality performance plan. Maybe also provider satisfaction. Especially with a delegated model, understanding the insurance model, barriers of coverage, that's very important. ○ Regarding member satisfaction, the state would love feedback on the CHAPS – adult and pediatric is a question. ○ Agree about member satisfaction, but it's hard to get members to do a 60-question survey. Response rates aren't great. We'll continue to advocate to NCQA on streamlining the surveys.
Closing Remarks	• Participants requested a link to the cancelled RFQ when slides and meeting minutes are shared. • EOHHS asked for public comment before ending the meeting. No comments received.