EOHHS AE Stakeholder Meeting
DXC 2nd Floor Conference Room
301 Metro Center Blvd, Warwick, RI
October 18, 2017 9:30 am to 11:00 am

Facilitator: Paul Loberti, Debbie Morales, Mark Kraics, Deb Faulkner, Jen Bowdoin, Rick Jacobsen
Prepared by: Maria Narishkin
Participants: Beth Marootian (NHP), Brenda DuHamel (EOHHS), Chris Gadbois (CharterCare), Christopher Dooley (Prospect Medical Holdings), Deb Faulkner (Faulkner Consulting), Debbie Morales (EOHHS), Debra Reakes (Coastal), Diane Evans (Thundermist), Garry Bliss (Integra), Hannah Hakim (EOHHS), Holly Garvey (EOHHS), Irene Qi (Hope Nursing HomeCare), Jason Brown (Tufts Health Plan), Jen Bowdoin (EOHHS), Joan Wood (NHP), Joe Cicione (Nursing Placement), John Minichiello (Integra), Karen Statser (EOHHS), Kulwant Babra (NHP), Laurie Ellison (Cowesett Home Care), Libby Bunzli (OHIC), Lisa Tomasso (TPC), Maria Narishkin (EOHHS), Mark Kraics (EOHHS), Mary Barry (Capitol Home Care Network), Maureen Maigret (Long Term Care Coordinating Council), Mike Walker (CareLink), Mykahla Gardiner (EOHHS), Nicholas Oliver (RI Partnership for Home Care), Olivia Burke (Faulkner Consulting), Patrice Cooper (UHC), Paul Loberti (EOHHS), Ray Parris (PCHC), Raymond Lavoie (BVCHC), Rick Boschwitz (Bayada), Rick Jacobsen (EOHHS), Robert Haigh (Health Care Services), Roberta Merkle (Saint Elizabeth Community), Sandy Curtis (EOHHS), Sandy Pardus (BVCHC), Vinnie Ward (Home Care Services of RI)

Agenda Item	Key Discussion Points	Action Items/Follow Up
Welcome & Introductions **Paul Loberti**	• Paul Loberti spoke about EOHHS new leadership and thanked the Conduent team • AE process is complex, and we want to stay transparent, involve stakeholders and seek stakeholder comments. Paul thanked stakeholders for the comments that they submitted. • AE team conducted a thorough review of stakeholder comments, and incorporated changes into documents	
Stakeholder Comment Review **Mark Kraics**	• Mark Kraics thanked stakeholders for their feedback • Stakeholders were given 30 days to review each document • This is a public process and stakeholder comments are posted on EOHHS website at http://www.eohhs.ri.gov/Initiatives/AccountableEntities/AEPublicComments.aspx • Clarification was provided that the CMs deliverables are requirements • There were 200 unique comments from stakeholders, 66% were on Total Cost of Care (TCOC). The remainder were on incentive and attribution. • EOHHS website has the process and list of commenters. There is a link in the PowerPoint presentation http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx • The review process focused on program design, and the team categorized comments based on priority and needs	
Timeline and next steps **Mark Kraics**	• We are moving from planning to implementation • AE application will be released on November 15th for comprehensive AEs and on December 15th for LTSS specialized AEs	

	○ There will be public reviews on the documents: ▪ Comprehensive: December 4th, 2017 ▪ LTSS: January 4th, 2017 • Questions: ○ What will be the effective date for AEs? ▪ Step 1 – application - (due Feb 1, 2018 for comprehensive AEs – TBD for LTSS) ▪ Step 2 – contract(s) with MCO(s) ▪ Goal is to start by June 30th 2018 to coincide with the state fiscal year. ○ Will the first year be 18 months? ▪ Start date is to be negotiated with MCOs ○ When will the first fund distribution take place? ▪ No funds will be distributed until the first milestone is completed ▪ First milestone has been changed and is now the execution of contract between the AE and MCO,. ○ Will there be a limit set for the number of LTSS AEs that can be certified? ▪ There must be a minimum of 2 qualified LTSS AEs to distribute funds ▪ Funds available to each AE will be dependent on number of certified AEs ○ What are the specifications for AE year 2? ▪ Year 1 is a pilot program for the Specialized LTSS, no specifications set for year 2	
CMS Deliverable Key Modification	• Modifications to the documents were made based on stakeholder comments ○ Small edits for clarification will not be discussed today ○ Comparison versions of the documents will be available on the website. • <u>Funding stream</u> ○ Increased total program commitment from $77M to $95M ▪ Does that increase the overall incentive pool? Yes ▪ What percentage is for comprehensive vs. LTSS? • Year one 70/30 of $30M ○ MCO/AEs must have an executed contract to receive funding ▪ Each AE must reach an agreement on each project with each MCO • Potentially different projects with each MCO ▪ Are there standard criteria for MCOs to administer projects and milestones? • EOHHS provides guidance to MCOS • Each project must be set up based on partnership between the AE and the MCO • Looking for innovation between AEs and MCOs	Post comparison versions of documents online

	○ MCO incentive pool increased from 5-8% to 8-10% of total incentive pool. This decision based in part from comments and from high expectations of the MCOs relative to the administration of the program ○ Execution of AE and MCO contract will now be the first milestone ▪ AEs can contract with multiple MCOs. What if an AE has a provider who is not contracted with the MCO, or leaves the plan? • Provider agreements with MCOs stay in place. AE contract is a separate contract focused on total cost of care model for shared savings • <u>Attribution</u> ○ MCOs must provide a monthly roster of people attributed to the AE ▪ How does the MCO get that list if some of the attributed lives are in FFS? (Specific to the LTSS AE's) • Detail not worked out yet. ○ LTSS attributed beneficiaries will remain attributed for 9 months after service has ended as opposed to the original 12 months ○ Comprehensive AEs – member attributed to AE based on IHH will continue to be attributed to the AE for 12 months after service has ended. Exceptions: Member assigned to different IHH or member requests change of PCP to one participating in another AE ▪ If the patient is no longer in the IHH, why is the AE still responsible for coordination of care? AE has lost the ability to have impact on the patient. ▪ LTSS AE attribution continuing after termination – same question • Intent is to continue care of people who are at risk ▪ Comment was made that AEs will not want to accept non-compliant patients due to ruining shared savings • Avoiding risk cannot be a consequence of what an AE is. ▪ LTSS AE attribution that continues for 9 months after services have ended – what if the new agency is doing a terrible job and we are still responsible for that individual? This is forcing responsibility beyond our control. • Case management could still be in AEs work scope ○ We will set up a meeting dedicated to these questions, and will have a process flow to discuss this. • Total Cost of Care (TCOC) ○ Much more standardized to be consistent – comments came in for both more and less standardization ○ Comprehensive AE threshold changed from minimum 5,000 members per MCO to 5,000 members across all MCOs	How will MCOs get a complete list of AE attributed lives inclusive of FFS population? Set up follow-up meeting regarding attribution

	○ Risk requirements and definition of measures are aligned with OHIC's definitions ○ Progression to downside risk ▪ To assume downside risk, AEs must meet the financial reserves requirements ▪ Interagency process to approve AEs to assume downside risk ▪ OHIC perspective (Libby) • Minimum requirements for downside risk were developed last year for commercial payers, amount should be meaningful enough to change behavior • There are yearly meetings to review – stakeholders encouraged to attend • <u>Quality Framework</u> ○ Quality is a central component of the AE model ▪ Establishing workgroups ▪ Technical specifications will be released for both comprehensive and LTSS AEs ▪ Health status measure and Social Determinants of Health measures will be released for stakeholder feedback ▪ New measures will be pay for reporting in the first year • These are highlights of some of the changes, stakeholders are encouraged to look at documents online (comparative documents will be posted soon) • Quality assurance has now turned into quality improvement? ○ Benchmarks are adjusted based on current performance • At minimum performance should stay the same as reflected in those benchmarks	
Public Comments	○	