HSTP AE Advisory Committee Meeting Minutes

Meeting Date, Time and Location: June 4, 2021, 9:00 a.m. to 11:00 a.m., Zoom Conference

Meeting Facilitators/Presenters: Director of Medicaid, Benjamin Shaffer; Director of Health System Transformation, Libby Bunzli; Senior Policy Analyst Amy Katzen; Interim Assistant Director, Workforce Development Services, Department of Labor and Training (DLT), Sarah Bramblet; Faulkner Consulting Group, Olivia Burke; and Executive Director, Rhode Island Parent Information Network, Sam Salganik

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; Katherine Power; Anya Rader-Wallack; Marti Rosenberg; Sam Salganik; Benjamin Shaffer; Sue Storti; Merrill Thomas

Meeting Notes			
Agenda Item	***Time***	***Facilitator(s)***	***Meeting Notes***
Welcome & Introductions	**5 Minutes**	**Director Shaffer**	**Motion to approve the minutes from the April 1st AE Advisory Committee meeting** • Motion Approved
Program Updates	**10 Minutes**	**Director Shaffer and Libby Bunzli**	**Program Updates** • Broadly, AEs are wrapping up PY3, have been certified for PY4, and are preparing for a new contract year. EOHHS is beginning to plan for PY5. • Community Health Worker budget initiative included in the SFY22 budget • Rhode to Equity participants selected for initiative to begin in July • Community Resource Platform has been procured, engagement with Unite Us has commenced
PY2 TCOC	**30 Minutes**	**Amy Katzen**	**PY2 TCOC Context for TCOC performance** • In PY2, MCOs developed TCOC models that complied with EOHHS's TCOC Requirements • TCOC Requirements outlined parameters for these required elements: • Defining a Historical Base • Required Adjustments to the Historical Base • TCOC Expenditure Target for the Performance Period • Actual Expenditures for the Performance Period

			• Shared Savings/(Loss) Pool Calculations, including use of a quality multiplier. Any Shared Savings Pool was multiplied by the AE's overall quality score, such that scores under 100% would reduce the Shared Savings Pool. At least 3 measures had to be P4P rather than P4R. • AE Share of Shared Savings/(Loss) Pool • EOHHS reviewed and approved MCO TCOC methodologies ahead of the program year to ensure compliance with requirements. MCOs' models differed with respect to the baseline years used, risk adjustment methodology, methodology for minimum savings/ adjustment for AE population size, methodology for calculating overall quality scores, and adjustment for AEs' relative "efficiency." • The start of the COVID-19 public health emergency overlapped with the final quarter of PY2 **Overview of PY2 Performance** • Approximately $800M in Medicaid spending, for approximately 70% of Medicaid members, occurred pursuant to AE TCOC arrangements in PY2 (SFY 2020) • Overall, actual medical spending for AEs' attributed members ranged from 9% higher to 9% lower than TCOC targets. • Most AEs earned shared savings under at least one MCO contract • Overall Quality Scores ranged from 77% to 100% **PY3 TCOC and beyond: Methodology Key Points** • All AE-MCO contracts will utilize the same TCOC model, as described in TCOC requirements documents, and will be implemented by EOHHS • Baseline years for setting TCOC targets will always align with the years used to set MCO capitation rates in the performance year. • Trend between baseline years and between the baseline and performance period will reflect changes in the capitation rate. • The same risk adjustment model is used for all AE contracts. This model includes customized weights specific to RI Medicaid. Risk scores are normalized at the rate cell level across the entire Medicaid population. • The minimum savings rate methodology will be used in upside-only contracts as a threshold to ensure that random variation in a small population is not driving savings. • The market adjustment is designed to account for differences in AEs' relative efficiency. In PY3, this adjustment is only made to increase TCOC targets for AEs with risk-adjusted spending below the MCO average, such that they have more

			potential to earn savings. This adjustment will increase in PY4 and PY5. Also, in PY4 and PY5, TCOC targets will be reduced for AEs with risk-adjusted spending above the MCO average. The adjustment for AEs with below-average spending will remain larger than the adjustment for AEs with above-average spending. **Questions and Comments**: • Even if they used identical models you could see different results. Some variation will happen naturally, based on statistical "noise." With some of our smaller panel sizes, this will be important to watch. • Were variations on baseline and associated impact or correlation on ability to achieve shared savings considered when the model was developed? o **Amy Katzen**: For PY1 and PY2, MCO's were required to make an adjustment for underlying efficiency, both MCO's approached this differently. For PY3 the adjustment gets more powerful overtime. • As I recall, NHPRI's PY2 methodology had an adjustment responsive to Pano's comment. • Bullet point # 5 it mentions relative efficiency. Can you define what relative efficiency is and how it is calculated? o **Amy Katzen**: For PY3 Each AE risk adjusted spending is relative to MCO risk adjusted average; for example, if an AE is ten dollars more efficient than the average, the AE gets 10% (or one dollar) added to the target which will be added to shared savings pool. In PY4 the adjustment goes from 10% to 20%. If you are an AE that is higher than average, the target gets lowered. • Building on what Pano asked, to what degree was variation driven by/impacted by "Type 2" attribution? In PY2 the SMI/SPMI IHH/ACT were still attributed to the AE. Patients are very expensive, did this drive year 2 and does it have implications for a post Type 2 world? o **Amy Katzen**: The MCO's would be in a better position to answer this question. When we set the PY3 targets and we looked back at the baseline period, risk adjustment can only do so much, so the MCO's did a recast of attribution as if the IHH designation did not exist and we then built into the baselines. • If this is driving costs, is there something fundamental in the TCOC model even when controlled for the IHH spending? o **Amy Katzen**: Milliman created custom weights for RI that allows them to account for the variation in the IHH population and were able to close some

			of those gaps. The key thing is do you have a similar distribution of the IHH population in the baseline as in the performance year? If it is similar, then adjustment is okay. If the IHH population grows disproportionately or is larger in performance year than baseline year, then you have an issue. • IHPs risk adjustment for PY3 is more favorable than in previous years. • You mentioned that the pandemic impacted PY 2. Did you make any effort to guess at what the results would have been without the pandemic? Based on pre-COVID performance? And did this drive any thought into adjustments (or circuit breakers) that might be necessary to account for extrinsic shocks to the system? Those shocks could increase spending just as easily as reducing it... Will be very relevant in PY 3 and could be in other circumstances too. o **Amy Katzen**: The most important thing for developing annual targets is there will be no anomalous baseline year calculated into the performance targets. If some AE's benefit for example from low utilization due to the pandemic, the state chose not to risk adjust for that. The state is monitoring the current state of the pandemic to make any necessary adjustments. **Questions from the chat** *(responses have been added by EOHHS following the meeting and were not provided in real time.)* • How is adverse selection addressed? And should this be broken down by population since the opportunity will vary? o *Response: To the extent that some AEs have sicker attributed members (due to adverse selection or any other reason), this is accounted for by the risk adjustment methodology. An AE with members who are sicker than average in the baseline period will have a higher TCOC target. If an AE's performance year attributed membership turns out to be even more sick than average, the final TCOC target will be adjusted upwards before determining final shared savings results.* • What analysis has been done to assess savings vs outcomes on the populations being served? i.e.) primary medical, primary BH? o *Response: In the AE program, we examine the impact of AE work on total cost of care as well as a range of quality measures and outcome measures. These are all assessed at the level of an AE's attributed membership with a given MCO; EOHHS does not analyze results on spending, quality, or outcome measures separately by any subpopulations. However, starting in Outcome Program Year 4 (calendar year 2021), AEs will begin to report certain quality measures stratified by race, ethnicity, language, and disability.* • Are the specifications of how efficiency adjustments created or applied documented in a particular EOHHS standard If so which one? TCOC guidance maybe?

			○ *Response: The market adjustment is described in TCOC Technical Guidance on pages 6-7. Each AE's specific adjustment for PY4 can be found in the TCOC target spreadsheets (TCOC Appendices_PY4_MCO name_AE name) on the Appendix F tab.* • It would be interesting to see if there is a correlation to the negative costs' performances and the # of IHH patients flowing into a particular AE post elimination of Type II attribution. ○ *Response: EOHHS does not expect there to be a correlation between TCOC performance and whether an AE received more IHH members following the change in attribution methodology for PY3. The reason for this is that when PY3 TCOC targets were set, the MCOs reported baseline costs applying the PY3 attribution methodology. That is, PY3 targets were built with the new distribution of IHH members. While an AE might have more IHH members in PY3 than in PY1 and PY2, their PY3 TCOC target was set **as if** they had actually had the higher number of IHH members in the earlier period.* • If 2020 isn't good for the baseline, then why is it good for the performance year? The underlying challenge is that there are many factors way outside control of the AEs, and we need to think about how to account for them. ○ *Response: EOHHS worked with Milliman in late spring and early summer 2020 to examine early data on the impact of the pandemic on spending and determined that it would likely drive down total cost of care relative to what it otherwise would have been. EOHHS decided that as PY2 drew to a close, the AE program would continue to maintain shared savings arrangements for that year rather than canceling the existing arrangements or trying to adjust for the impact of COVID by, e.g., adjusting actual spending upwards to some level that we thought represented a non-COVID version of events. Essentially, EOHHS determined that in light of the incredible difficulties of the pandemic for providers, it was acceptable if the AEs received a "windfall" in the form of higher shared saving than would otherwise have occurred. For PY3, which included six months of 2020, EOHHS and Milliman again estimated that the impact would likely be to increase apparent shared savings as utilization remained somewhat depressed. However, in the case that this was incorrect and the pandemic lead to higher than usual utilization beyond AE control, EOHHS canceled the requirement for any AE to take on downside risk.* • Has EOHHS done any assessment using the Milliman model to evaluate the MCO methodology on PY2 results? IHP, using the 2 different methods, depicted a staggering, clearly aberrant, "resultant trend" based on baseline pmpm differences from PY2 to PY3 for one of the MCOs, while reasonable for the other...resulting in a clearly understated pmpm for the one MCO for PY2 and thus a tremendous loss of

			opportunity for shared savings. As such, is there any room to negotiate for such aberrant differences/outcomes? ○ *Response: EOHHS has not done any assessment of PY2 using the current methodology. While the methodologies in PY2 differed from the PY4 methodology, EOHHS evaluated each MCO's model and deemed them compliant with the TCOC requirements. EOHHS has validated MCO calculation of TCOC in PY2 and views PY2 as complete at this time.*
Workforce Initiatives: HSTP and Real Jobs RI	**30 Minutes**	**Sarah Bramblet**	**DLT/EOHHS Partnership Background** • In spring of 2019, Governor Raimondo's office brought together leadership at DLT and EOHHS to establish a partnership to implement and enhance the healthcare workforce opportunities in Rhode Island. • Leveraging HSTP funds, the intent was to develop and execute Real Jobs RI project activities with HHS providers or supporting entities to expand the workforce needed in the HHS space. • $10.0 million (of the $129.8 million total HSTP funding) for workforce development activities has been allocated to DLT to be used from August 1, 2019, through June 30, 2024. **Agency Roles & Responsibilities** **DLT/Real Jobs** • Allocates funding to partnerships • Leads program design in collaboration with Real Jobs partnerships and holds evaluation meetings on regular cadence to inform healthcare strategy development • Is the point of contact for all RJRI partnership activities **EOHHS** • DLT's point of contact for any questions about use of HSTP funds • Informs DLT on progress of AE goals and advises on program design to support capacity • Receives and reviews funding documentation from DLT **Shared** • Accountable for the success of the HHS partnerships as a portfolio • Ensure that projects meet eligibility for HSTP funding **Rationale for HSTP/DLT Partnership** • Real Jobs RI puts demand at the center of workforce development.

			• Industry partnerships anchor the state's strategy to create pathways to good jobs for Rhode Islanders
			• Strategic Partners include Rhode Island Institutes of Higher Education (IHE's), Community Based Organizations (CBOs), Health and Human Services, Organized Labor, Workforce Boards and K-12 and Adult Educational systems
			• Partnerships have:
			  ○ Demonstratable operational capacity.
			  ○ Reach into industry.
			  ○ Ability to gauge, aggregate, articulate, and respond to employer demand.
			  ○ Presence of responsible fiscal agent and effective industry convener.
			Real Jobs RI Impact Report
			• 11, 922 Served
			• 4634 New hires placed
			• 365 Incumbent workers upskilled
			• 423 Business owners and entrepreneurs served
			• 35 Industry Partnerships
			• 75% Placed upon completion
			• $3,614 Cost per participant
			Executive Branch Priorities
			• New hire trainings
			• Equity metrics and targets
			• Small and local business
			HSTP Project Metrics
			• 15 Active contracts
			• $3.19 Million in awarded contracts
			• 238 Participants hired or upskilled
			• 172 Participants in training
			• 290 Participants targeted to enroll by the end of 2021
			Program Highlights
			• **Workforce Dental Assisting**
			  ○ Lead Partner for Curriculum: Integrated Healthcare Partners

			○ Key Program and Hiring Partners: Integrated Healthcare Partners, Providence Community Health Centers, Blackstone Valley Community Health Care, and Thundermist ▪ There is currently a nation-wide shortage of dental assistants, and our accountable entities were feeling this shortage. ▪ Integrated Healthcare Partners and Providence Community Health Centers met with CCRI to discuss their options to gain a well-trained and qualified workforce. ▪ CCRI took the most important clinical aspects of their existing year-long program and added in a CODA-accredited radiography class to create a workforce dental assisting program that will meet the accountable entities needs, while also ensuring the dental talent entering the field is well trained and qualified. ▪ This 13-week, entry-level (non-CDA) Workforce Dental Assisting Program prepares students to perform basic dental assisting skills and will qualify students to sit for two out of the three DANB certification examinations. • **Patient Support Specialist** ○ Lead Partner for Curriculum: Coastal Medical ○ Key Program and Hiring Partners: Coastal Medical, Providence Community Health Centers, Integrated Healthcare Partners, Care New England. (Other partners utilized for hiring as necessary.) ▪ This program began due to hundreds of jobs each year within Rhode Island that focused on the administrative side of a medical office. ▪ Coastal Medical, the initial partner identified and explained the struggled of finding administrative talent that was either not someone who looking to be a clinical medical assistant but settling or someone with no training at all. ▪ The Patient Support Specialist Training was then created for people who want to work with patients in a medical environment in a non-clinical position. ▪ Graduates that complete this program can expect to begin careers as medical administrative assistants, patient service representatives,

			unit secretaries, medical customer service agents, and other related positions.
			• **Care Manager Certification**
			  ○ Lead Partner for Curriculum: Providence Community Health Centers
			  ▪ This program grew out of the need for accessible and evidence-based certification education related to the nurse care manager role, which promotes positive health outcomes for individuals, families, and populations throughout the life cycle.
			  ▪ Two Rhode Island College nursing faculty delivered the online course with support and outreach to participants. The faculty also delivered coaching and exam preparation. Through combining flexible learning NCM focused coaching (4 sessions of 2 hours each), the participants were given the enhanced opportunity for success in completing the course and be optimally prepared for the Certified Case Management (CCM) exam.
			  ▪ By augmenting nursing staffs' knowledge and skills related to variables that are correlated with risk and poor outcomes for consumers, nursing staff will be better equipped to engage, support, retain, and promote physical and behavioral health in the face of social determinants of health that reflect adversity.
			  ▪ The program had 100% training completion rate and 87.5% first time pass rate on the CCMC Exam (the national average is ~70%).
			Anticipated Future Initiatives
			• Telehealth
			• CNA Apprenticeship
			• Enhanced Medical Assistant
			• CAN-BSN Career Ladder
			• Data Science
			Public Comment
			• Really nice work!
			• Must these Real Jobs partnerships be hosted by AEs? Is that an HSTP funding requirement? Or can other employers in the sector participate?

			○ **Libby Bunzli**: HSTP funded real jobs projects do focus on AE driven projects. Recently we have begun expanding into the LTSS/HCBS space to align with our thinking on the LTSS APM • https://dlt.ri.gov/documents/pdf/realjobs/ProgReportRJRI.pdf • Great Program!
LTSS Resiliency Updates	**30 Minutes**	**Libby Bunzli/Olivia Burke**	**Our Vision**: **A High Functioning, Resilient LTSS System** • The State of Rhode Island invests >$297M annually to provide long-term care to approximately 11,000 beneficiaries over aged 65. Currently, 80% of those services are delivered through nursing facilities. Our vision for the LTSS system is to foster a more balanced, sustainable and responsive continuum of long-term care services that delivers the right support, at the right time, and the right cost, while promoting choice, community & quality of life for R.I. elders & disabled. • **Key Elements**: ○ Access and Choice: Promote choice + options. Ensure that services are person-centered + conflict-free ○ Communication: Promote regular communication amongst stakeholders. ○ Quality: Committed to improving consumer experience + quality of life. Promote workforce capacity. ○ Accountability: Uses data-driven management + clear governance to improve internal ops & drive continuous improvement. • **The Opportunity: Rebalancing**: ○ Rhode Island has a significant opportunity to encourage and enable LTSS eligible and aging populations to live successfully in their communities. ○ As of FY 2018, RI had the lowest share of Medicaid LTSS spending on HCBS in the nation. • **Rebalancing Goals and Barriers**: ○ **Nursing Homes**: ▪ **Goal**: Reduce utilization of nursing facilities for Medicaid members who can be appropriately served in an HCBS setting. ▪ **Major Barrier**: Large supply of nursing facility beds. 48 NF beds per 1,000 people 65+, the 9th highest rate in the country, compared to 30 nationally. ▪ **Approach**: Incentivize nursing facilities to develop specialized capacity/ repurpose beds to care for complex populations that

			cannot be served in HCBS settings - e.g., ventilator patients and patients with BH needs. ○ **Assisted Living**: ▪ **Goal**: Increase capacity and access for Medicaid members by incentivizing AL providers to participate in Medicaid LTSS. ▪ **Major Barrier**: Significantly under-utilized amongst RI Medicaid beneficiaries; limited provider participation. 10.9 Medicaid NF residents for 1 Medicaid AL resident, compared to 5.5 nationally. ▪ **Approach:** Improve rates and align with best practices by establishing an acuity-based payment system that expands ALR participation and broadens the scope of services available in ALRs. Reduce administrative complexity. ○ **Home Settings**: ▪ **Goal:** Expand home based care capacity and access for Medicaid members – overall and in specialized areas. ▪ **Major Barrier:** Substantial workforce shortages – difficulty filling all authorized hours, especially for off hours shifts, certain geographies, and complex patients. 22% of home care hours in beneficiary care plans are currently unfilled[3] ▪ **Approach:** Improve rates and incentivize worker training/ certification to develop capacity to care for complex patients and establish career ladders/pathways that strengthen direct care workforce. Reduce administrative complexity • **Leveraging Different Funding Sources to Achieve LTSS Resiliency** ○ EOHHS is working to leverage a variety of existing and new funding pathways to promote a high functioning, resilient LTSS system including Cares Act, FY22 budget initiatives, HSTP LTSS APM, Money Follows the Person and American Rescue Plan Act • **HSTP LTSS APM Goals:** ○ The LTSS APM will be developed within the HSTP Program, in partnership with managed care. ○ Encourage and enable LTSS eligible and aging populations to live successfully in their communities

			○ Improve and ensure equitable access to home and community-based services (HCBS) that prevent LTSS eligible populations from needing institutional LTSS ○ Foster a sustainable network of high quality HCBS providers that are equipped to meet the diverse needs of LTSS members • **LTSS APM Implementation Considerations** ○ Acknowledge unique challenges including but not limited to: ▪ Multiple payers (Medicare, Medicaid) ▪ Small populations subject to highly volatile cost experience ▪ Highly fragmented delivery systems ▪ Chronic LTSS workforce shortages • **What is an APM** ○ An Alternative Payment Model (APM) is a payment approach that offers added incentive payments to provide high-quality and cost-efficient care. ○ APMs are intended to move the health care delivery system away from fee for service (FFS) towards models that link payment to quality and value. ○ APMs fall along a broad spectrum of complexity and risk – an APM can be as simple as a pay for reporting measure, or as complex as a population-based payment model ○ The LTSS APM is being developed as a first step towards linking payment for HCBS services to quality and value • **LTSS APM Landscape** ○ States take a variety of approaches to LTSS APMs; we are targeting models best suited to our context and goals. RI's LTSS APM program will: ▪ Focus on HCBS settings to maximize the impact of available program funding ▪ Be administered through, and in partnership with, managed care – as required by HSTP rules ▪ Start with simple pay for performance incentive measures as a first step on the APM continuum • **HCBS Focus Area: Home Care Agencies** ○ Home care agencies are by far the highest volume HCBS setting, accounting for 61% of HCBS eligible

			○ HSTP program goals are best aligned with addressing gaps in home care agency services ○ The current assisted living rate methodology is a major barrier to provider participation; the FY 22 budget includes significant assisted living payment reforms to address this critical gap ○ Infrastructure and member awareness are significant gaps for self-directed programs – these challenges are currently being addressed through other initiatives/ funding sources • **Identifying Home Care Agency Gaps and Priorities** ○ Our number one priority is improving equitable access to home care agency services. ▪ **Priority 1:** • Improve equitable access to home care agency services • General workforce shortages • Shortage of off hours care • Geographic shortages ▪ **Priority 2:** • Drive progress towards rebalancing goals after addressing fundamental capacity and access limitations • Specialized capacity for complex patients • Appropriate financial incentives • Coordination with other providers • **HSTP LTSS APM Guiding Principles** ○ Within the constraints of the HSTP STCs and Roadmap – i.e., as a value-based incentive-based program, not a rate initiative ○ Through, and in partnership with, managed care - starting as a pilot program administered through the Medicare-Medicaid Plan (MMP) demonstration, per the HSTP STCs ○ Focusing on home care agency capacity – recognizing home care supply shortages to be the most fundamental challenge to improving equitable access to home care services and enabling LTSS eligible populations to live successfully in their communities ○ Starting with simple pay-for-reporting and pay-for-performance incentive measures as a first step along the APM continuum – acknowledging and

			accommodating the challenges to implementing an incentive program for home care agencies o Including aligned incentives for home care agencies, direct care workforce, and managed care - ensuring all parties are working towards the same goal and encouraging partnerships that maximize program impact • **Program Design Considerations to be Explored with Stakeholders** o The LTSS APM program structure will be refined and articulated in detail in partnership with the MMP, and with input from stakeholders. o Key Considerations**:** ▪ What are the home care agency participation criteria? ▪ LTSS eligible duals enrolled in the MMP; home care agency workforce employed by participating home health agencies ▪ Are there any exclusions or adjustments? ▪ Aligned measure set with a home care wait time reduction/ home care capacity and access focus (with potential to add more advanced measures over time, or with tiers) ▪ What are the measures? ▪ $25 M to support a meaningful 5-year incentive program allocated roughly equally between home health agencies, home health agency workforce, and managed care ▪ Program budget to build on and be more targeted than HCBS FMAP investments ▪ How are funds allocated and structured? ▪ What are the detailed measure specifications and performance standards? ▪ EOHHS/MMP partnership ▪ What are the responsibilities of each entity? • **Timeline and Next Steps:** o Complete LTSS APM requirements by FY2021/Q3 o Conduct stakeholder process and collect input on key program design dimensions o Draft program requirements to be posted for public comment in Fall 2021 o Program requirements to be finalized by the end of 2021 o 18 Month LTSS APM Pilot to begin FY2023 o LTSS APM Full Program to begin FY2024

			Public Comment • It appears adult day was not on the pie chart or considered for this APM. They do have capacity as they emerge from COVID restrictions. • Consider opportunities to expand education and connection between home care and primary care - these providers tend to operate separately. • We also need to support home modifications and promote the development of in-community housing that is amenable to aging-in-place. • We can't lose focus on building self-directed care capacity • Our housing stock -- particularly in the urban core -- is not amenable to aging in place. • I guess my question is why was adult day overlooked in this analysis? • I have significant concerns about limiting these incentives to managed care enrollees. Depending on how incentives are structured, it might just pull resources away from other RIers in need of HCBS. Only about half of duals are in managed care. For that reason, I strongly recommend designing incentives that support the agencies' whole workforces and general capacity. • Good questions here - there are a number of other initiatives addressing many of these other areas of focus - remember, this is a program thru HSTP, so through managed care and with a value-based payment model. • Agree that this should only move forward as part of overall strategic plan for all the pieces for expanding access to HCBS… And let's call it 'balancing' because we've never been in balance… just a peccadillo of mine! • Agree, self-directed Care needs to be strong to transform. • Thank you for the comprehensive approach. I'm excited for the design phase. Neighborhood made considerable progress on a home care APM during PY1. The initial AE Road Map included LTSS Medicaid reimbursement for pre-Medicaid population to keep folks at home - might be an idea to resurface for CMS approval. • Do we have an inventory of who in the state might be participating in bundled arrangements and who would therefore be very interested partners in this? • Expansion of income eligibility for the Healthy Aging homecare program will provide some help for non-MA eligible folks. • I agree with Beth. The PRE Medicaid idea is a real opportunity -- though one whose complexity I readily admit. One simple way of looking at this -- Once a

			person is in a nursing home and on Medicaid it is, simply put, "too late" to get them back home (sold) or other community options.
Hospital Care Transitions Initiative	**30 Minutes**	**Sam Salganik**	**About RIPIN** • Founded 30 years ago (1991) by parents of children with disabilities • Statewide nonprofit, serving tens of thousands of Rhode Islanders every year • Support for navigating healthcare, education, and healthy aging • 110 employees, almost half now focused on supporting older adults • Peer-to-peer model. Most staff are parents of kids with special needs or caregivers to older adults **The Challenge** • Rhode Island long-term care spending is heavily weighted toward institutional care o In FY 2019, nursing home care accounted for 78% of LTC spending on elderly (excluding DD) Medicaid beneficiaries o Long-term care for elderly Medicaid beneficiaries in Rhode Island in FY 2019 costs 3.7 times more, on average, than spending for home and community-based services • Rhode Island Ranks **Last in the Nation** in Terms of HCBS Spending • The Vast Majority of Nursing Facility Admissions Are from Hospitals: o The SNF path is often the smoothest option for discharge planners ▪ There is significant pressure to find timely, suitable post-acute services ▪ HCBS services are typically harder to find and requires additional resources and family supports • **The Opportunity** o How can we connect individuals leaving the hospital to home and community-based post-acute support? o The Hospital Care Transitions Initiative - RIPIN will embed **Community Health Workers** within hospital discharge planning team to: ▪ Help coordinate community supports to facilitate a safe discharge to home ▪ Follow-up post-discharge to ensure smooth transitions across care settings • **HCTI Target Population** o Patients aged 55 and over;

			○ At risk for a SNF discharge and longer term SNF stay; ○ But could be discharged to home (whether immediately or following a brief SNF stay) with the proper supports. ○ **ANY** insurance status: Medicare, Medicaid, Commercial, Dual, Uninsured, etc. • **HCTI's Four Key Principles** ○ Support patients and caregivers ○ Build relationships ○ Serve as care management option of last resort ○ Decrease length of a patient's hospital stay • **Participating Hospitals** ○ Kent ○ South County ○ Rhode Island ○ Miriam • **Core Community Health Worker Services** ○ Eligibility Counseling and Application Assistance ○ Benefits and Options Counseling and Person-Centered Transition Plan ○ Expedited LTSS Applications ○ Identifying, Coordinating and Securing Community Resources and Natural Supports ○ Post-Discharge Supports • **Operational Update and Early Data** ○ It is too early to try to draw conclusions from the data. Even our training and data QA processes are very new. Please take this more as indicative of the *kind* of data we can collect/report. ▪ Launched at: • South County in March, • Kent in April, and • RI Hospital and Miriam in May. ▪ Total Referrals thru May: • South County: 36 • Kent: 28 • RI Hospital: 14 • Miriam: 2

			▪ Payer Mix (thru 6/18) • 41% Medicare • 12% Commercial/Other • 25% Duals • 13% Medicaid ▪ Status at Discharge (thru 6/18) • 40% Home (with skilled care) • 27% Skilled Nursing Facility • 10% Home (no home care) ▪ Supports provided included • Caregiver Support, Home Modifications/DME, Housing, Memory/Dementia, Health, Meals, Transportation, Financial Support, and HCBS. **Public Comment** • Impressive and well-constructed intervention that nicely complements and overlays current services. Thank you • Great program Sam, would be really nice to have gaps in care flagged to have the members close those also, can be a good VBP from MCOs... • Important point, Beth. • Thank you all for listening. Please feel free to reach out to me or my colleagues with any follow up.
Adjourn			Meeting adjourned at approximately 11:00 a.m. The next AE Advisory Council Meeting is scheduled for Thursday, August 5, 2021 8:30-10:00 a.m. Venue to be announced.

Meeting Participants: Marti Rosenberg (EOHHS), Matthew Harvey (Integra), Mellissa Campbell (RIHCA), Holly Garvey (Integra), Garry Bliss (PHSRI), Rick Brooks (EOHHS), Domenic Delmonico (Tufts Health Plan), Stacey Aguiar (UHC), Marea Tumber (OHIC), Sam Salganik (RIPIN), Merrill Thomas (Providence Community Health Centers), Chris Gadbois (CareLink), Beth Marootian (NHPRI), Patrice Cooper (UHC), Pano Yeracaris (CTC-RI), Jonathan Mudge (Blackstone Valley Community Health Center) Libby Bunzli (EOHHS); Amy Katzen (EOHHS), Jennifer Marsocci (EOHHS), Debbie Morales (EOHHS); Ryan Erickson (BHDDH); Randi Belhumeur (RIDOH); Monica Broughton-Rix(UHP); Debra Reakes (Coastal Medical); Jerry Fingerut (EOHHS); Christopher Ottiano (NHPRI); Gary D'Orsi (IHP); Samantha Morton (MLPB); Chris Ausura (RIDOH); Rebecca Plonsky (IHP); Steve Odell (Prospect); Marie Palumbo-Hayes (FSRI); Patrick Tigue (OHIC); Linda Katz (EPI); Tom Douglas (PCHC); Michelle Bicket (NHP); Tarah Provencal (BCBSRI); Christopher Ottiano (NHP); Jan Begert (EOHHS); Mark Cooper (NHP); Deb Faulkner (FSG); Kacey Booth (IHP); Ted DeNicola (EOHHS); Amanda Graziosi (EOHHS); Rosemary Mulandi (EOHHS); Ryan Driscoll

(BHDDH); Olivia Burke (FSG); Director Shaffer (EOHHS); Lisa Tomasso (HARI); Jim Nyberg (LeadingAge); Debra Hurwitz (CTC-RI); Allegra Scharff (RIDOH); Matthew Roman (Thundermist); Kimberly Chapman (UHC)