



HSTP AE Advisory Committee Meeting Notes

Meeting Date, Time and Location: August 7, 2019, 8:30 a.m. to 10:30 a.m., 301 Metro Center Blvd., Warwick, R.I. 02886 Room 203

Meeting Facilitators/Presenters: Patrick Tigue, Anya Wallack, Melody Lawrence, & Day Health Strategies

Advisory Committee Member Participants: Becky Boss (BHDDH), Carrie Bridges-Feliz (Lifespan), Dr. Al Kurose (Coastal Medical), Dr. Barry Fabius (United Healthcare of RI), Dr. Jerry Fingerut (EOHHS), Ana Novais on behalf of Dr. Nicole Alexander Scott (RIDOH), Beth Marootian (Neighborhood Health Plan of RI), Domenic Delmonico (Tufts Health Public Plans), John Minichiello (Integra), Marie Ganim (OHIC), Marti Rosenberg (SIM), Michael Lichtenstein (Integrated Healthcare Partners), Patrick Tigue (EOHHS), Ray Lavoie (Blackstone Valley Community Health Center), Roberta Merkle (St. Elizabeth’s Community), Sam Salganik (RIPIN), Steve Odell (Prospect Health Services RI, Inc.)

<i>Agenda Item</i>	<i>Time</i>	<i>Facilitator(s)</i>	<i>Meeting Notes</i>
Welcome & Introductions	5 Minutes (8:30 a.m. to 8:35 a.m.)	Patrick Tigue	Introductions Approval of Minutes (June 19, 2019)
Program Updates Health Workforce Transformation Update	10 Minutes (8:35 a.m. to 8:45 a.m.)	Melody Lawrence	<ul style="list-style-type: none"> • Melody Lawrence updated committee members on the following: <ul style="list-style-type: none"> ○ The structure for the meeting today will be a discussion and public comment after each aim; ○ The RIQI Care Management Dashboard project will Kick-Off in October (Final Date TBD) with a plan to go-live in early 2020; ○ EOHHS will be making centralized investments in infrastructure and workforce, if committee members or stakeholders have any ideas, please share them with EOHHS. ○ New workforce projects now flow through DLT for review and approval. DLT has reached out to majority of AE’s for Workforce needs. • Melody reviewed the updated HSTP budget and the PY3 timeline for the Roadmap and Requirements <ul style="list-style-type: none"> ▪ Schedule is tight but there is still enough time to bring all stakeholders into the discussion. The Roadmap has been dramatically abbreviated and much of the technical detail that belongs in the Requirements documents have been removed. The Roadmap will be posted for public comment by 30-Aug.

			<ul style="list-style-type: none"> ○ EOHHS is planning on conducting informal meetings in addition to the monthly AE Committee meetings through end of year excluding November. The intent of the meetings is to engage stakeholders as EOHHS updates PY3 requirements to allow for as much public input on the decision making process as possible. <ul style="list-style-type: none"> ▪ Director Tigie stated that there would still be a formal Public Comment process, but there will also be a range of informal meetings/working sessions for PY3 requirements to create as open a process as possible ▪ Committee members questioned whether community members be included in the work groups? ▪ Melody responded that the process and structure of the meetings had not yet been fleshed out, but the meetings would be informal and given time constraints, subcommittees are not anticipated, but all are welcome to join as they will be public meetings ● Committee members questioned the budget increase and asked what changed and what will be reallocated? <ul style="list-style-type: none"> ○ As PY 3 requirements and strategic plan for future is finalized, decisions on allocations of dollars will be made ○ Stakeholder comment on the budget was that as presented the total in the “All Funds” column did not add up and was off by 25.2 million dollars. <ul style="list-style-type: none"> ▪ Melody assured the correction to the budget would be made.
<p>DHS Presentation</p> <ul style="list-style-type: none"> ● Aim 1 	<p>20 Minutes (8:45 a.m.to 9:05 a.m.)</p>	<p>Ross Weiler</p>	<p>Key Findings and Recommendations from Day Health Strategies (DHS)</p> <ul style="list-style-type: none"> ● Director Tigie stated that the state has reviewed the findings and recommendations ahead of the Committee meeting, but there will be a separate process for adoption. The recommendations do not represent, in either direction, the state’s view on adoption. <p>AIM 1</p> <ul style="list-style-type: none"> ● Ross Weiler presented AIM 1 finding and stated that there was a lot of strong support for the program, but many opportunities for improvement. AIM 1 is about the global focus of the program. Findings include: ● Clear need for more definition in the program and a desire for ongoing evaluation and an understanding of the future state. ● What is the vision for designing, measuring and evaluation? ● Strong desire for relationship building among key stakeholders. ● Strong desire for simplification of program requirements and an understanding of the roles of all players. ● Strategic vision is meant to guide program effectively in future. In order to meet the vision goals, foundational work needs to occur.

			<ul style="list-style-type: none"> ○ The program needs actionable data and needs to be financially sustainable and less complex. <p>Questions/Feedback</p> <ul style="list-style-type: none"> • Program requires actuarial soundness and financial viability to effectuate population health especially when taking on downside risk. Relationships should be built on populations of scale. Duplication is clearly built into strategic actions but must also be built into action plans. Scalability is crucial for financial sustainability. • Role of “Health” in Quality Outcomes in “roof” of vision statement. • Director Tigie responded that the vision is meant to represent a triple aim • Recommendation to remove language ‘Substance Abuse’ as it is an outdated term. • Program structure is complex, should integrate with and work together with other lines of business. • The initiative is a large piece of the RI health care system and population health should be holistic from a market perspective; the vision should be larger than AE/Medicaid. • Director Tigie agreed that there needs to be alignment in vision and it is equally important to have a Medicaid/AE vision, however Medicaid cannot articulate a vision for the entire system but can only ensure the vision fits into the overall vision for health care for state. • Micromanagement - Looking at outcomes from a management perspective would reduce the level of micromanagement. Setting roles, boundaries and clear measures for the state will reduce micromanagement. • CM: First 1000K Campaign is not mentioned in here, important strategic initiative for state. • The program should maximize the opportunities to keep people in communities. • The ‘AE Program Vision’ and ‘AE Program Goals’ must be aligned. • Health Equity should be included in the overall vision. The language in the AE program Goals should replace ‘improve health equity’ with ‘attain health equity’. • Melody Lawrence requested that recommendations be sent via email.
DHS Presentation Aim 2	20 Minutes (9:05 a.m.to 9:20 a.m.)	Ross Weiler	<p>Aim 2</p> <ul style="list-style-type: none"> • Remove IHH from attribution in favor of moving to a PCP only attribution model. • Attribution is reserved for the entity with the most responsibility for the consumer/participant. This new recommendation will not be without problems but removing IHH from Attribution will alleviate the administrative burden. Other states have chosen to use attribution methodologies that solely recognize relationships with PCPs.

			<ul style="list-style-type: none"> • Reconciliation of consumers with PCP's outside of network will still be required. There will be a trade-off regardless of the decision to remove IHH from attribution. <p>Questions and feedback:</p> <ul style="list-style-type: none"> • Should AE's contract a centralized service model? <ul style="list-style-type: none"> ○ This still must be attributed to the AE's. Outcomes are more than the specific items defined at present. There are populations that will be overlooked when it comes to IHH (i.e. Elenore Slater Hospital). • TCOC - Regarding benefit plan design/modification and alignment with TCOC we cannot go to a smaller design without communication to members/consumers. • Network - 'Narrow network' is a red flag. A 'system of care' is a better option and should be identified with benefit design. • Social Determinants of Health (SDOH) – SDOH needs a community approach and allow for local and regional access. It would make sense to incorporate this in benefit design. • Attribution requirements should indicate that there is consumer choice. • Data – there are issue around providing data. There are two key areas around data. Program evaluation and attribution; these are foundational and built into the plans. • Ground rules must be set for Attribution and TCOC and a model must be chosen to move in one direction or another. • TCOC should clearly include the idea of movement to APM and the program should consider the providers' willingness to move toward innovation. Currently the providers are all at different levels of readiness and this needs to be recognized. • Balance and attribution – How will we know the State's capacity to support AE's? There may be programmatic changes and we must evolve as the market changes, this will be an ongoing issue. • Collaboration - Relationships should extend beyond Medicaid, the approach and financials may be different between organizations, but this is valuable for AE/ACO's and MCO's.
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<p style="text-align: center;">DHS Presentation Aim 3</p>	<p style="text-align: center;">20 Minutes (9:20 a.m.to 9:40 a.m.)</p>	<p style="text-align: center;">Ross Weiler</p>	<p>Aim3</p> <ul style="list-style-type: none"> • Recommendations for investment strategies within the program values a strategic framework and a focus on the 8 domains and specific allowable expenses within five key areas. There should be as much coordination and collaboration to ensure greater success which will require recognizing the considerable cultural differences between the organizations. • Recommendations for the integration of AEs and the 211 database as a central repository of truth. <p>Questions and feedback</p> <ul style="list-style-type: none"> • Collaboration - How do AE’s leverage their work and relationships? These are valuable investments that should be supported. • TCOC - AEs need a clear path when it comes to TCOC. The role of Community-Based Organizations (CBOs) and a need to address TCOC and manage cost. CBOs may need some education to enable a successfully transition to a new approach required by TCOC. We understand what drives health outcomes: education/training and support for clinical data. • Data - There is a lack of clarity around what data can be shared. Data sharing will create awareness and understanding around specific topics and access to behavioral health (BH) data should be improved. • Consumer-centered solutions - There are infrastructures within the community (SDOH, transportation, housing, health equity zones (HEZ) etc.) that require coordination, and integration to better support consumers. The consumer should be at the center solutions and this will improve health outcomes. It is critical to use the AEs to address most issues, but the approach must be intentional. The program must ensure that the AE system is consistently documenting issues in order to get more state investment to alleviate problems and build infrastructure in these areas. • Health Equity Zones (HEZs) do not focus on traditional issues of health but focus on community issues. Each HEZ within a specific community will conduct an assessment and implementation that puts the community at the center. Interventions and solutions that come from the community-level are valuable. • Health Information Technology Team - A vendor (Brillgent)has been chosen for the HIT Roadmap and will be reaching out to meet with representatives from AEs. This planning should dovetail with recommendations and strategic planning. • Family-centered solutions – kids and families are entwined with the state support and system reviews around families show that there are system boundaries. Solutions should be family-centered solutions to improve the system barriers that are discovered when looking at families entwined in the state system.
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<p>DHS Presentation Aim 4</p>	<p>20 Minutes (9:40 a.m.to 10:00 a.m.)</p>	<p>Ross Weiler</p>	<p>Aim 4</p> <ul style="list-style-type: none"> • This Aim extends beyond HSTP and the AE program; we recognize this is a broad inter-agency issue. This broader discussion needs to apply to a larger strategy where Long-Term Services and Supports (LTSS) comes into play. Most Dual Eligible consumers do not receive LTSS. <p>Questions and feedback</p> <ul style="list-style-type: none"> ○ Integration - Fragmentation is the enemy; systems developed to deal with populations that have complex needs and need to be integrated. Fragmentation should be remediated with coordination and integration and supported by a financial strategy. ○ Data - What data do we have from serving complex populations (i.e. MAGI eligible consumers vs people who are aging)? Consider how we are providing for and serving these complex populations of consumers before thinking of a different model. What is the interaction for people in these programs? We need a big picture of what is happening now. The foundational work of LTSS needs to be done which must address workforce and nursing home quality. ○ HCBS - This discussion needs to fit under the HCBS mission. There are concern around spending funds and over-engineering a solution. It is imperative to consider consumers' access to care. • Collaboration with the Centers for Medicare and Medicaid Services (CMS) - CMS is open to being flexible to new LTSS models and open to collaborating on improving the existing model or creating a new one. It a good discussion to have at a more in-depth level. We must consider adults in the LTSS community and think globally about this population and how it fits into the LTSS model. MA is a good example since they use two models to account for the different needs of different populations (consumers above or below age 65).
<p>DHS Presentation Aim 5</p>	<p>20 Minutes (10:00 a.m.to 10:20 a.m.)</p>	<p>Ross Weiler</p>	<p>AIM 5</p> <ul style="list-style-type: none"> • This is a visual of the Strategic Plan document outlining the short term, medium-term and long-term goals. • Discussions and feedback will continue.



			Continued Feedback should be communicated via email.
Adjourn	10:30 a.m.	Patrick Tigue	<ul style="list-style-type: none"> • Meeting adjourned at approximately 9:30 AM. • Next meeting is scheduled for September 13, 2019 8:30 a.m. – 10:30 a.m. DXC conference room #203, 301 Metro Center Blvd, Warwick, RI.

Public Participants: Maria Viveiros (UHC), Nama Hermiz (NHPRI), Bryan Blissmer (URI), Ed McGookin (Coastal), Sarah Reinstein (Carelink), Mike Walker (Carelink), Ben McToctin (Neighborhood), Carrie Feliz, Kristen Fournier (CCRI), Liz Tobsin-Tyler (Brown), A. Scott (RIDOT), Jamie Goulet (BHDDH), Michael Cronan (EOHHS-PA), Grace Medeiros (NHPR), Gary Bliss (PHSRI), Sandy Parous (BVCHC), Mary Ricci (THP), Nicholas Oliver (RIPHC), Sue Bomer (Optum/United), Karen D’antonio (HCH), Tinisho Richards (UHC), Loren Sidman (UHC), Shannan Alsireld (UHC), Libby Bunzli (EOHHS), Rick Brooks (EOHHS), Leah Del Giudice (EOHHS), Jennifer Marsocci (EOHHS), Rebekah LaFontant (EOHHS), Deborah Morales (EOHHS), Lisa Tomasso (HARI), Chris Ferraro (Coastal), Kaitlyn Goodman (FCG), Diane Evans (IHP), Ray Parris (PCHC), Sandy Crotis (UTTZ), V. Ward (MCSRI), Mark Kraics (HCH), Rich Slvalzman (BCBSRI), Marea Tumber (OHIC), Putney Pyles (HAS), Olivia Burke (Faulkner Consulting Group), Cindy Scott (Integra), Steven Den (BHDH)