



Accountable Entity Advisory Committee

October 24, 2018

Agenda

- Welcome and introductions
- Overview: Health System Transformation Project
- Center for Health Care Strategies: Early Learnings and Recommendations
- Next steps
- Recommendations for future meetings
- Public comment
- Adjourn



Overview:
Health System
Transformation Project



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Working Group to Reinvent Medicaid developed a multi-year plan to transformation



Value-based payments
Coordinated care delivery
Focus on population health

Fee based
Limited ability to manage complex conditions
Lack of emphasis on social factors that affect health



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Two programs to get us there

The vehicle: Health System Transformation Project (HSTP)

A five-year program to incent MCOs and providers to provide care through accountable entities (AEs), the next generation of managed care
 Includes one-time Hospital and Nursing Facility Incentive Program
 Makes investments in healthcare workforce transformation

The gas: Designated State Health Program (DSHP)

New time-limited CNOM authority
 CMS will match existing spending on health professional education at the state's public colleges and university
 Creates a \$160M pool to support the establishment of AEs



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HSTP transformation: coordinated care

Instead of individual providers each treating a patient's health issues one by one, AEs coordinate a team of providers to treat the whole person

Primary Care

Behavioral Health

Community-based providers



Hospitals

Specialists

Physical Therapists

Pharmacists



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HSTP transformation: accountable care

AEs will take on increasing financial responsibility for members' care

If an AE can keep its patients healthy for less than a targeted amount, they keep some of the savings



If care costs more than the targeted amount, AEs are responsible for some of those extra costs

AEs to assume downside risk beginning in Program Year 3



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Where we've been: design to implementation

SFY 2016
Design and Development

SFY 2017-18
Pilot Program

SFY 2019-23
Full Program Implementation



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Where we've been: design to implementation



SFY 2016
Design and
Development



SFY 2017-18
Pilot
Program



SFY 2019-23
Full Program
Implementation

AEs met requirements of certification and quickly executed shared savings contracts with partner MCOs

MCOs and AEs committed resources to the program in the absence of any new funding

MCOs established key program implementation processes and applied new reporting requirements

AEs established organizational authority to support Medicaid AE Program



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Rhode Island's Accountable Entities Pilot Program: Early Learnings and Recommendations

Rob Houston and Diana Crumley
Accountable Entities Advisory Committee
October 24, 2018

Today's Presenters



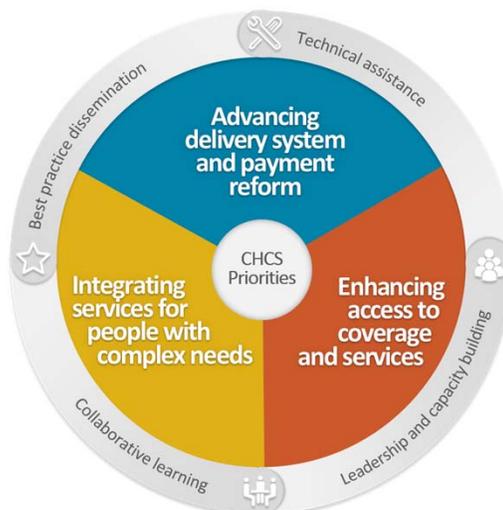
Rob Houston
Associate Director, Payment Reform



Diana Crumley
Program Officer

About the Center for Health Care Strategies

A non-profit policy center dedicated to improving the health of low-income Americans



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CHCS Working with Rhode Island

- CHCS is a subcontractor to the University of Rhode Island working with EOHHS to provide insights on the Accountable Entities (AE) program
 - » Gather key lessons from the AE Pilot Program
 - » Sponsor a learning collaborative and conduct group learning sessions for AEs and MCOs
 - » Provide 1:1 technical assistance to AEs on a variety of subjects

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Agenda

- Share key learnings from the AE Pilot
 - » Methodology for Report
 - » Overview of AE and MCO Accomplishments
 - » Key Findings
 - » Recommendations
- Q&A



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Methodology

- Goal: Perform qualitative research on AE Pilot program
- Used the Working Group's vision for AEs and "Next Generation MCOs" to define parameters
- Conducted 16 interviews with:
 - » All 6 AEs
 - » 3 MCOs
 - » 6 additional stakeholders
 - » EOHHS leadership and relevant AE program staff
- Compiled findings and made recommendations



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Reinventing Medicaid: A Framework

AEs: Accountable Care

- (1) Care Management and Integration
- (2) Accountability for Cost and Quality
- (3) Accountability for an Attributed Population
- (4) The AE Pilot Program as a “Fast-Track Path” and Learning Opportunity

Next Generation MCOs

- (1) Data to Support AE Functions
 - (2) Value-Based Purchasing Strategies
- “New Competencies”

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Pilot Accomplishments



- 6 AEs met certification requirements
 - » Took on the challenge of coordinating care and moving toward VBP, committed resources to this goal
- 7 AE-MCO contracts
 - » MCOs developed contracts, and AEs and MCOs both committed to moving forward with these arrangements
 - » 3 of 7 contracts generated shared savings in Pilot Year 1
- Gained experience with data-driven care coordination and tracking quality and costs
- Gained experience coordinating physical health behavioral health, and social determinants of health

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Findings: AEs



- Care management and Integration
 - » AEs were committed to improving and coordinating care, with the AE Pilot shaping new partnerships and some quality improvement and social determinants of health-focused initiatives.
- Accountability for Cost and Quality
 - » AEs expressed dissatisfaction with the amount of shared savings payments they received, or expected to receive, from MCOs under the AE Pilot. Some interviewees suggested that state budget cuts may have contributed to these low payments.

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Findings: AEs



- Accountability for an Attributed Population
 - » AEs noted that the attribution methodology for a member enrolled in an IHH, combined with that member's choice of providers, often split the member's physical and behavioral health services across unaffiliated organizations, complicating true accountability for health outcomes for the member.
- AE Pilot as a "Fast-track Path"
 - » Interviewees were generally supportive of the transition to VBP reinforced by the AE Pilot and HSTP. However, most interviewees felt that the AE Pilot was implemented too quickly, and they attributed many of its shortcomings to this accelerated timeline.

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Findings: AEs



■ AE Pilot as a Learning Opportunity

- » All AEs and MCOs noted that the state was responsive to participants' concerns about the AE Pilot, and as a result, program requirements for the full AE Program under HSTP improved. However, several interviewees recommended that the state should have evaluated and applied lessons from the AE Pilot, among other health care reform efforts, before formalizing future iterations of the AE Program.

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Findings: MCOs



■ Data to Support AE Functions

- » MCOs have created several care management tools, data feeds, and reports to support AE functions. However, most AEs noted they need more complete and actionable data.

■ VBP Strategies

- » While five AEs established at least one VBP contract, many AEs noted that they did not actively negotiate their shared savings contracts with MCOs. Both MCOs participating in the AE Pilot felt that state requirements did not provide enough flexibility to allow for much negotiation or customization.

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Recommendations

1. Ensure AEs have the data they need to succeed
2. Foster open communication and trust
3. Modify incentives to encourage additional participation
4. Strive for simpler, streamlined requirements, but continue to provide some flexibility
5. Let iteration drive innovation



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AE Learning Collaborative

- First meeting: November 30th
- Full-day program
- Includes speakers who will bring insights from their ACO experience
- Practical, actionable break-out sessions on topics such as member engagement and making the most of partnerships with community-based organizations.



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Question & Answer 

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Next steps



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Program Year 1 leverages pilot learnings

Five AEs have contracted with MCOs for a total of 9 contracts for Program Year 1

Initial Program Year 1 incentive payments totaling \$2.4M were made last week

Changes to program requirements for Year 2 likely to be minimal and reflect pilot learnings

Began to design a more robust quality program to monitor and improve healthcare delivery and outcomes

Adding substantial resources and expertise that will allow us to measure and evaluate our progress toward care transformation



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AE next steps to develop their current capacities

Move beyond referrals

to meet the social determinants of members' health by engaging in meaningful contracts with community partners

Develop beyond co-locating behavioral health services

within primary care and build data systems that truly integrate care management and allow for communication across providers

Reach out beyond currently engaged patients

and develop strategies, protocols and capacities to reach those who do not seek care independently



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Key challenges remain

Value-based payment in Medicaid, given annual state budget cycle

Program simplification and EOHHS/MCO/AE partnership development

Flexibility and innovation vs. standardization

Balancing the pace of reform with partner readiness

Program sustainability over time as care management and other services are increasingly funded by AE shared savings rather than by HSTP incentives

Improving data capacity of all partners to better manage populations and to measure progress towards goals



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Recommendations for future meetings



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Committee recommendations for future meetings

Identifying and addressing the barriers to integrating behavioral health care into primary care

Effective use of AEs as a lever to address social determinants of health and integration with other statewide initiatives

Design considerations for a value-based long term supports and services program

AE transition to and capacity for downside risk in value-based payment arrangements

Other recommendations?



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Public Comment



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