



HSTP AE Advisory Committee Meeting Notes

Meeting Date, Time and Location: January 30, 2019, 8 a.m. to 9:30 a.m., 301 Metro Center Blvd., Warwick, R.I. 02886 Room 203

Meeting Facilitators/Presenters: Patrick Tigie, Laretta Converse, CHCS (Rob Houston), Deborah Faulkner (Faulkner Consulting)

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 Tigie (EOHHS), Ray Lavoie (Blackstone Valley Community Health Center), Roberta Merkle (St. Elizabeth’s Community), Sam Salganik (RIPIN), Steve Odell (Prospect Health Services RI, Inc.)

Meeting Notes			
<i>Agenda Item</i>	<i>Time</i>	<i>Facilitator(s)</i>	<i>Meeting Notes</i>
Welcome & Introductions	10 Minutes (8:00 a.m. to 8:10 a.m.)	Patrick Tigie	<p>Introductions</p> <ul style="list-style-type: none"> • Tom Coderre, Senior Advisor joined us this morning to provide: <ol style="list-style-type: none"> a) An update from the Governor’s office regarding the behavioral health initiatives. b) An Executive Order from the Governor’s office on mental health parity. Overview of work with the Office of the Health Insurance Commissioner (OHIC) to ensure parity is enforced. The AE program is a method of implementing the policy initiatives within the executive order and provides encouragement of statewide discussions/conversations to normalize the topic. <p>AE Program Updates: 1115 Waiver</p> <ul style="list-style-type: none"> • EOHHS/Medicaid received full approval of the 1115 waiver (5 years). • HSTP authority is preserved for the next 5 years. Regulatory stability. • Meeting minutes were reviewed and there were no identification of concerns or questions.

<p style="text-align: center;">Accountable Entities and Behavioral Healthcare</p>	<p style="text-align: center;">15 Minutes (8:10 a.m. to 8:25 a.m.)</p>	<p style="text-align: center;">Deb Faulkner</p>	<p>Key Indicators</p> <ul style="list-style-type: none"> • High level facts regarding Behavioral Health and the Accountable Entity (AE) program. <ul style="list-style-type: none"> ▪ Total of over 300,000 Medicaid beneficiaries enrolled in Medicaid managed care. Of the AE eligible population members enrolled in managed care, not inclusive of FFS and duals=253,672. ▪ The share of AE members has grown over time, by SFY 18 about 50% of non-dual managed care and SFY 19 it is about 2/3 of the AE eligible population are attributed to an AE under 9 TCOC contracts through NHPRI. ▪ The goal of reinventing Medicaid and the AE program includes as a priority, BH integration. How many attributed AE members had a BH diagnosis and how many had or are enrolled in a complex care BH program such as ACT, IHH, or Opioid health home? The data is grouped into 3 categories: complex BH, other AE eligible with a BH dx, and AE Eligibles with No BH Diagnosis. ▪ About 1/3 of AE attributed/eligible population had a BH diagnosis and represent 2/3 of the cost/expenditures. ▪ The average cost of the AE eligible population is approximately \$ 367 PMPM, when stratified further by the three categories identified above, no BH dx \$ 187 PMPM, BH dx are almost 4x as those without. Those members with a BH dx have higher medical expenditures, thus the need for medical and BH integration. ▪ The goal is to keep people served in the community. Utilization patterns for individuals w/BH dx is substantially higher than those w/out. Utilization of the ED is 2 x higher, and inpatient stays is 6x higher. These are the targets the program is intended to impact. ▪ The # of AE eligible BH dx seems rather low, it could be accounted for because it is based on an average. ▪ If we looked at SDOH we would likely see similar results. SDOH in addition to BH integration is also critical to the AE program work. ▪ RI has more bed than other states. In addition, RI doesn't have ED boarding, while other states have implemented this policy. ▪ How does RI's numbers compare to other states? In comparison to national numbers, the programs to support BH are very different for complex BH dx than for those who have a less complex BH dx.
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<p>Program Design Levers</p>	<p>15 Minutes (8:25 a.m. to 8:40 a.m.)</p>	<p>Lauretta Converse</p>	<p>The broad goals are to improve the care for complex patients and reduce institutional care. The vehicle for transformation is the AE program: the three legs represent the “how” we are going to achieve this goal.</p> <ul style="list-style-type: none"> • Certification Requirements: <ul style="list-style-type: none"> a) Include, but are not limited to: network capacity, structure, and processes. b) The development of a full continuum of integrated BH services. PY 1 conditions of certification require demonstration on development of BH capacity and integration. AEs must have a coordinated care team that is defined. • TCOC: <ul style="list-style-type: none"> a) Is a value-based payment/financial model inclusive of quality? b) AEs are responsible for an attributed population (cost & quality). Attribution is based first on IHH/ACT enrollment. c) Shared savings are adjusted in part based on quality measures that include BH measures. • Incentive funding: <ul style="list-style-type: none"> a) Opportunity for AEs to earn incentive funds to fund investment in building new capacities, inclusive of BH capacity. b) Outcome metrics are also included in the Accountable Entity Incentive Milestone component which are stratified by BH/high risk populations.
<p>Meaningfully Addressing Behavioral Health in Medicaid ACO Programs</p>	<p>15 minutes (8:40 a.m. to 8:55 a.m.)</p>	<p>CHCS (Rob Houston)</p>	<p>A National Perspective</p> <ul style="list-style-type: none"> • State/Medicaid Program Strategies re: Behavioral Health Integration <ul style="list-style-type: none"> a) 12 states currently operating as Medicaid ACOs. 10 states currently developing ACOs. b) National Medicaid population data: BH is a concern for Medicaid programs nationwide. Overall Medicaid population, the low utilizers of the top 5% and the highest high of top 5%. c) If a goal is to lower cost and improve quality, BH is a key to meeting that goal. • 4 ways states can include BH in their ACO program: <ol style="list-style-type: none"> 1. Include BH in TCOC: <ul style="list-style-type: none"> ▪ At least 7 of 12 states include BH in their ACO total cost of care calculations ▪ Including BH in total cost of care incentivizes ACOs to meaningfully integrate care among physical health and behavioral health providers ▪ Pro: BH cost performance is directly tied to ACO success and shared savings ▪ Con: BH costs may rise as patients are connected to services, though physical health costs may fall as a result. <p>* RI includes BH in their ACO total cost of care calculations</p>

			<p>2. Utilize BH measures in quality measures:</p> <ul style="list-style-type: none"> ▪ Almost all states use 1 measure in their quality measure slate. ▪ Pro: really target how AEs are performing on these measures ▪ Con: Can only track a limited measure set <p>* The two RI has chosen are the most popular (Follow-up after hospitalization for mental illness, and screening for clinical depression & follow-up plan)</p> <p>3. ACO application/regulatory requirements:</p> <p>This is part of RI AE certification process, an opportunity to include it in program goals/mission, and a plan for addressing BH in the application process. Requiring contractual relationship prior to being certified or as part of the certification process.</p> <p>Pro: Ensures that ACOs are committed/ready to address behavioral health needs Cons: Application requirements are only a “gate;” Requirements are hard to enforce in practice.</p> <p>4. Alignment with BH initiatives:</p> <ul style="list-style-type: none"> ▪ PCMH, Health Homes, SUD pilot program. Methods: some states carve out HH ▪ Attributed patients from ACOS, some states attributed based on BH initiative participation. ▪ Pros: alignment ensure you are working towards a common goal. ▪ Con: much easier said than done. <ul style="list-style-type: none"> • Of these four components, RI implements elements of all four. “The devil is in the details”. <ul style="list-style-type: none"> ▪ TCOC: Should all BH costs be included? Are costs benchmarked and risk adjusted correctly? Don’t want to create perverse incentives. ▪ Quality: Are we using the right metrics? Should there be more or less? Metrics being benchmarked, and risk adjusted/benchmarked correctly? ▪ Regulations: Are the right BH regulations in place? Can BH regulations be continually enforced? ▪ Alignment: Care fragmentation occurs when programs are not aligned well. For example, different data not integrated, different care management and duplication of care management, provider burn out, perverse incentives can also be created as financial incentive or program goals don’t always align. • Other challenges: Workforce shortages, lack of data availability to managed referrals, insufficient BH training for primary care providers, different regulatory and billing procedures. • EHR inter-operability, 42 CFR part 2, provider challenges.
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<p align="center">Committee Discussion/ Recommendations</p>	<p align="center">25 minutes (8:55 a.m. to 9:20 a.m.)</p>	<p align="center">CHCS (Rob Houston)</p>	<ul style="list-style-type: none"> • How can RI use its levers to Improve on BH Integration in its AE Program? • Questions/Comments from Committee Members <ul style="list-style-type: none"> ▪ Is there an opportunity to centralize certain functions through the AE program to better leverage resources? ▪ Question re: cost margins specific to behavioral health and their limitations. ▪ Rhode Island currently has several BH integration efforts, how do we align such efforts moving forward?
<p align="center">HSTP/AE Updates</p>	<p align="center">5 minutes (9:20 a.m. to 9:25 a.m.)</p>	<p align="center">Lauretta Converse/Patrick Tigue</p>	<ul style="list-style-type: none"> • Lauretta gave HSTP program updates. • Patrick announced that Lauretta is moving into a Senior Finance role within Medicaid and congratulated her on all the work she has accomplished to date as HSTP Project Director.
<p align="center">Public Comment</p>	<p align="center">5 minutes (9:25 a.m.-9:30 a.m.)</p>	<p align="center">Patrick Tigue</p>	<ul style="list-style-type: none"> • No public comments.
<p align="center">Adjourn</p>	<p align="center">9:30 a.m.</p>	<p align="center">Patrick Tigue</p>	<ul style="list-style-type: none"> • Meeting adjourned at approximately 9:30 AM. • Next meeting is scheduled for April 24, 2019

Public Participants: Maria Viveiros (UHC), Nama Hermiz (NIHPRI), Bryan Blissmer (URI), Ed McGoosken (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 Svalzman (BCBSRI), Marea Tumber (OHIC), Putney Pyles (HAS), Olivia Burke (Faulkner Consulting Group), Cindy Scott (Integra), Steven Den (BHDH)