EOHHS Task Force
December 14, 2015
1:00pm – 2:30pm
Meeting Minutes

I. Welcome – Senator Izzo

Senator Izzo thanked everyone for taking the time to come together today especially during this busy season. He reminded the group that last month there was a healthy discussion around one of the rule updates, and it could have gone longer. In the past there had been discussion around creating ad hoc groups to assist in this work to review the way things arise, the way things are prioritized. If it stays on track then there is an opportunity to communicate electronically with Ann or the state, so we do not have to create ad hoc groups, and there is an opportunity to have additional input. Hopefully that will help.

II. Ongoing Initiatives Update

a. Reinventing Medicaid – Deb Florio

Deb Florio: Last time I was here, I handed out spreadsheets, and went on line by line. Happy to answer any specific questions here today, or by email. Today I thought I would discuss something more specific about one of the initiatives that is rather big and different, and we have made some major progress on it. This is the Accountable Entities (AEs). This is one of those fields where we are building the airplane as we fly it. AE's have been around for a couple of years in the Medicare space. Our health plans, our Managed Care Organizations (MCOs) have been around for 20+ years, first time that there were entities that took risk. In Medicaid we did, with our MCOs, but we wanted to do it carefully. We have some high cost members, i.e. pregnancy is a high cost case, but we didn't want our managed care orgs to shun pregnant members, so we put protections in around those groups. What we did with the health plan was put in risk corridors. We made sure that the health plans never lost too much money, or made too much money. We always tried to set our rates so that they were perfect – though not always so –and at the end of the year we would reconcile. We will still plan to do that, but this new concept is to take that risk, push it down another level, and see if provider organizations also want to take that risk.

Now happening in the marketplace, there are fewer free standing hospitals, or providers, and most are coming together as organizations. In RI we will call these Accountable Entities, AEs. As part of our Reinvent proposals we asked for organizations to come together who were able to think about baring some kind of risk. Now there is upside risk or downside risk. If a patient costs Blue Cross and Blue Shield of RI $1000.00 to insure after all bills were paid, and then this year an AE says it will help that patient stay healthier and at the end of the next year the bills come to $800 as opposed to

$1000, it means $200 has been saved. Gain sharing = upside risk. A sharing of money - $100 to the providers who helped saved that, and $100 to BCBS who went into the relationship with the providers. Downside risk would be $1000 patient who was sick the following year, new bills at $1,500, then downside risk, each loses $250. Now focusing on how we get started, so we are going into gain sharing, upside risk with organizations. The state will use NHP & United as our vehicles to do this. The state will set the stage for all of this. All a pilot until July until we put up application requirements for round one.

We received applications for the pilot from four entities, and what was thrilling was two of those four were community based. We have, as the state, provisionally approved all four based on their application to us explaining who is in their network, who would do this, and how it would be different than a regular FFS entity. We have met with each one of them last week, and all positive meetings. Starting a new dialogue. There is challenging work we haven't done before: attribution, figuring out who their specific members are – who is the main doctor, who do you attribute the patient to in an AE. When you get down to the AE it does matter who the patient is attributed to; also considering other attributions for those with SPMI. It is hard, no silver bullet. Our go-live date is January 1. Our health plans have been in every meeting as well, to make sure that all are on the same page – the health plans, the AE, and the state. We will go into our next phase of other AEs, expecting another two or three applications at that point. We are in a new phase of managed care – pushing down risk, having providers look at how they care for patients differently. Making sure the patient's medical records have been read, not repeating unnecessary tests, being thoughtful.

Maureen Maigret: Could you explain the difference between round 1 and round 2? Also I do not understand the role of the MCO in this. Who is responsible for compliance?
Deb Florio: Phase I was just get started – very basic certification standards – show basic network, basic governance and an ability to do a data exchange. Phase II, a lot more interaction with bigger networks, more specialties. Phase I more PCPs, Phase II more specialists and more lives. Members will be notified, asked if ok, but no one will be moved from PCPs or anything like that. There are two FQHCs, other than those two having kids, the others do not have kids. The next round we expect bigger networks coming in. To your MCO question, the bandwidth that they have…. We need to be on top of this, make sure there is no cherry picking, that the quality standards are very high, and that there are robust data exchanges at the provider level. The state can do this at the MCO level because it is a higher level, and truly I do not think we have the bandwidth that the MCOs do on that. We will conduct the function of oversight of the MCOs who will be conducting the oversight of the AEs.

Senator Izzo: Now we have Medicare doing ACOs with that system that works. Now we are creating AEs – for me I am rather confused. In a sense, we just spent all this time with the Integrated Care Initiative (ICI), trying to work out differences, and now trying to set up two different kinds of Accountable organization entities. If something is already

working, then why not use this as the blueprint?
Deb Florio: Medicare does it for Medicare, and ICI will do it for the duals, but no one is doing it for the Medicaid only. We will do that. It gives families, disabled adults, and the special needs kids an AE option. We will not include the duals in this because, you are correct, ICI will do that. Eventually we will get to where ICI is going, but right now we are doing this for our Medicaid only population.

Senator Izzo: Providers, already accountable care, will now have another set of expectations for Medicaid?
Deb Florio: Only if they choose- totally voluntary on the AE part. So why? They want to do it because there will be less requirements overall. At the end of the day, we start with shared savings. They will get the extra money – and they will say we can do it better if we do it our way. Providers constantly tell us we are sick of the widgets. For year one we will give them the extra money they save so they may build into their infrastructure. Then we will pay the provider a set amount to take care of that patient, no matter how many times he is seen. If the patient has good outcomes, and there is patient satisfaction, even when he is sick, then that is good for us. We want to pay for value, not volume.

Kathleen Kelly: If I understand you correctly – there are 250,000 total in Medicaid. How many are LTC?
Deb Florio: I think 30,000- 35,000?
Kathleen Kelly: I wanted to find out so I could see how many who potentially live in assisted living would be in this group.
Deb Florio: At the end of the year, when adding up how much it costs, we take money from the hospital and Emergency Room and the member can stay put. I think there may be some specialty stuff we could do with members in place- haven't thought that through yet, all based on Primary Care Providers at this point. We are trying to know how many lives it will be. I wrote in the health plan contract amendment that they must contract with three or more of these AEs, but there are four. Ideally I would like to put up on the website, by entity, how many total Medicaid lives are in those groups.
Kathleen Kelly: There is probably real opportunity in the LTC group.
Deb Florio: Absolutely, probably more so than with kids.

b. **Integrated Care Initiative – Jennifer Bowdoin**

Jennifer Bowdoin: Brief update today. We have a contract that is now back with CMS. We are still negotiating some of the terms, hoping to have a final version for state approval in early January, and then hopefully final CMS approval and then eventually have something that the plan can see. We have an implementation council, restructured consumer advisory council. Trying to move it to a more consumer driven body, working to see how to do that over the next few months or so – feel free to share that information with Lauren Lapolla. Our next meeting is January 11, 2016 at 2:00pm.

We will have a dedicated call center to be ready for the go-live; they are hiring people now, working on training materials. They will have 12 dedicated call center representatives, weekend and evening hours. We have received funding for an ombudsman, $460,000 over three years, we expect it to continue to the end of 2020 as long as CMS approves an extension for the state, hopefully consistent. We have an RFP going through the state approval process, should be issued soon, plan is to have the ombudsman program ready and running by the time the demonstration goes live. We are supposed to get a notice of award today from the federal government, give or take, to expand ADRC Ship capacity specific to the demonstration. As soon as we have that funding we can begin building that out. We are in process of doing readiness capacity with the health plan. NHP has work to do to prove readiness to the state – the state and CMS has to validate that their requirements meet Medicaid and Medicare requirements. The two big milestones in terms of trying to go forward are to get a contract signed, and NHP readiness. Hopefully at the next meeting we can give you update there. We have a policy in draft which Ann [Martino] will update you on in her portion of the agenda later this afternoon.

Kathleen Kelly: Is the call center going to be local in the state, or outsourced?
Jennifer Bowdoin: Unfortunately outside the state, largely driven by funding, as we did not receiving money for that. Our best bet in order to have sufficient number of call center representatives and to have expanded evening and weekend hours is out of state. We are working on routes of escalation with them, planning a number of virtual and in person trainings to ensure they know about the demonstration fully and about RI as a whole. Not ideal, but the best way to reach capacity.

Nicholas Oliver: This is in Mississippi right? Are they working on this for other states?
Jennifer Bowdoin: This particular center is focused on us, not with other states, so we are working to be sure they are fully prepped.
Ann Martino: We are building with existing staff to reach capacity, and augmenting that work at the call center.
Jennifer Bowdoin: We are working to be sure that they understand local dialects and vernacular, we don't want accents to be a problem, for example. We have local staff working to build out capacity for the program.

Virginia Burke: As you know, NHP is not yet capable of processing Nursing center claims in a timely way, so there is general concern about taking on Medicare claims. You say that the readiness review will ensure they are prepared?
Jennifer Bowdoin: NORC is CMS's contractor, taking the lead to ensure NHP is meeting CMS standards. I can get information from them around specifically what they will do, and what those processes are. They looked at policies and procedures; onsite will be taking a person, walking through various scenarios. I can get more detail around specifically what claims processing looks like. EOHHS will do some additional readiness review beyond what CMS does to ensure that there are not gaps. I don't want to speak for NHP, but I know they are planning to respond to some of the concerns around

nursing home claims so I do not want to speak for them on that issue.

Nicholas Oliver: Last week EOHHS reported its monthly data on ICI enrollment and one of the data points was RHO LTSS in the community have crossed the 50% mark for opt out rates. Now that we have our more expensive Medicaid population that have opted out of RHO and into FFS, is there a concern for what is happening there?
Jennifer Bowdoin: It has been a concern; have had disparate opt out rates in various parts of the community. There are probably a lot of reasons for it, we do not entirely know why the opt out rates are so high – in other states we see opt out rates of 50%, 60% sometimes for all populations. Sometimes it's issues with a plan, sometimes it's that people do not like change. I do not think we fully understand why the opt out rate for this population is so high. I would like to work with LTSS providers, see what will be meaningful to them, and address this. With Phase II we have an opportunity to deal with some of those issues. Do we have a concrete plan? We have plans around enrollment, we have plans around the LTSS population.
Nicholas Oliver: That is a concern around my members. The providers are incentivized around the MCO to have their patients participate in RHO. As we move to Phase II what is the standard for success to say that for Phase II EOHHS would consider successful the MMEs to be…? Enrollment is not necessarily success, but we have not heard what EOHHS says that realistic goal is 'X.'
Jennifer Bowdoin: Phase II has two different types of enrollment, opt-in enrollment, those who need to take an active state to enroll. We expect about a 10% – 15% uptake in that group, as they have to fill out apps specifically. Half the group is eligible for passive enrollment, we will enroll them if they are already in that group and they can call us if they do not want to be in the plan. We anticipate about 30-40% there, and if we get less than 30% opt out there, that is success. We will do quarterly sweeps for people eligible for the program. We will probably see ups and down around Medicare open enrollment period; certain things may trigger ups and downs.

Jim Nyberg: To clarify the people who phased out during Phase I where are they in Phase II?
Jennifer Bowdoin: If they have already opted out they cannot be passively enrolled, rather they would have to actively opt in. The bulk of those already in RHO Phase I will be passively enrolled.

c. **Money Follows the Person – Jennifer Reid, Jessica Mowry**

Jennifer Reid: Right before this meeting we had our quarterly Money Follows the Person (MFP) steering meeting. The Steering committee is really focused on data in the grant. We provided a high level data set that really got conversation going in that meeting. We are reconvening a subgroup to look at rebalancing activities, I will send out an email shortly to see if anyone has an interest there.
Jessica Mowry: Updates the formation of a housing work group took place. We

developed a strategic plan to get access to affordable housing. We are looking at things like alternative models to LTC housing opportunities. The HUD 811 for example will be an initiative that we talk about as implemented, the HUD811 is a grant awarded to the state, and unit based vouchers for individuals. It is a complicated area. The second is the Hoarding work group. That is based on information discovered in the first years of the MFP grant with emphasis placed on treating folks who would like to transition out of a nursing home, or were unable to keep their homes due to hoarding tendencies. There is a goal to increase the capacity of providers to treat hoarding; develop a mechanism based payment for treating hoarding, and care coordination to shepherd people through the system. Upcoming Housing work group is January 15 in the Garden Conference Room. Next Monday 12/21 Leann Bern the Housing lead from the Coalition for the Homeless will give an update.
Ann Martino: Why is that under MFP?
Jessica Mowry: The federal intention of the MFP demonstration is to balance the LTC system – one of the barriers to balancing it is housing stability, and we know that there is a significant overlap between homelessness and folks who use care.

Maureen Maigret: I think the data you showed us was 19% of the referrals had some indication of homelessness, which is significant.
Jessica Mowry: One of our activities was to obtain an HMIS license. We have been working with Eric Hirsch a sociology professor who evaluates programs in the state to match Medicaid data with programs in the state. Looked at folks who had high charges of Medicaid dollars over a year and I could see which of those overlapped with homelessness indicators.

III. **Rules Update – Ann Martino**

Ann Martino: We handed out today a tentative rulemaking timeline. It is indeed tentative. Our goal is to have all the rules which have not been rewritten up to date and ready by Phase II of the integrated eligibility system (UHIP) in July. In the world of Medicaid there are three groups: Children & families, adults [expansion, disabled], and then those getting LTSSS. That will happen next: we already did children &families and prepped for the Medicaid MAGI standard, so next will come the rules for community Medicaid, those who have an SSI category but who are not LTC eligible. We are hoping to get the LTC ones done by March 1. Consolidation, elimination (drafts only), streamlining. It is a huge challenge, and we are trying to do this in a way that is both systematic, makes the rules easier to follow, and cognizant that there are legal, policy and systems changes all happening at the same time in the way that people can understand. We do not have a section of the rule that deals with providers and payments. Being challenged in some ways as we are being innovative. Positively, the rule that I presented last month, went to the Office of Regulatory Reform (ORR) and made it out in five days. We will be initiating the process, will have a public hearing posted in the next 30 days. As Jennifer Bowdoin mentioned, there are some draft rules in play concerning managed care for adults, including those in Rhody Health partners. We are consolidating into one rule so can find all the regulations that mange LTC in one

place. A copy will be vetted internally, then it will come here, and we will initiate the regular rule making process. Hopefully by the end of next month.

Regarding Community Medicaid – we are using the eligibility categories that were in use when Medicaid was created. There are about 65 eligibility categories when they should just be about five – want to collapse those 65 down and make it easier for folks to determine if they are eligible. We will keep you involved and welcome input.

On the LTSS side, the challenge will be the transfer of assets. The mechanisms that we use to evaluate the transfer of assets, how to do more effectively and efficiently, and we are looking to see if states around us had success in keeping the integrity of the program while streamlining the work. Legal staff is working on estate recoveries, language associated with some of the initiatives in the Reinventing Medicaid Act as well. There are significant changes coming on the estate recovery side, no question about it. While we are trying at the same time to look at new and innovative ways to process information that is inherently complex and confusing. At any moment, something can slow us down though, so please know that this is a tentative timeline, whether it be waiting for a federal piece or what have you. We do have to have them done, adopted and in effect by July 1, but soon enough so that there is an active interactive process with all of you.

a. Input – no questions at this time.

IV. Public Comment

Nicolas Oliver: At the end of the last legislative session the leg granted more authority to the Office of Program Integrity (OPI) at the request of Secretary Roberts. I would like to request that we invite OPI to an upcoming meeting to update us on what they are doing with their expanded authority.
Ann Martino: We can do that.

Comment: As a recipient of SSI and a Medicaid recipient only I am confused as to what I am enrolling in? Can you clarify?
Jennifer Bowdoin: Let's talk offline about specifics, absolutely.

V. Adjourn – Next meeting January 25, 2016