Rhode Island Health Care Cost Trends Steering Committee

January 19, 2024

Welcome

Agenda

1. Welcome
2. Approval of October Meeting Minutes
3. Blue Cross and Coastal presentation on their primary care capitation arrangement
4. Review of the Steering Committee's work since 2018
5. Future purpose and role of the Steering Committee
6. CMMI AHEAD Model
7. Public Comment
8. Next Steps and Wrap-up

Approval of Meeting Minutes

Approval of Meeting Minutes

- Project staff shared minutes from the October 20th Steering Committee meeting in advance.
- **Does the Steering Committee wish to approve the October meeting minutes?**

Blue Cross and Coastal: Primary Care Capitation

BCBS RI value-based strategy overview

- Invest in primary care to support PCPs and Rhode Islanders
- Reduce PCP burden and increase new capabilities through value-based care
- Design alternative payment models to support PCPs and patients
- Improve clinical outcomes, improve patient and physician experience, and reduce the total cost of care

- PCP capitation is important “tool in the tool kit” for value-based providers
- BCBS RI has 4 PCP capitation contracts in the market today

How does PCP capitation work at a practice?

- Monthly per member per month (pmpm) fixed pre-payment based on run rates
  - Predictable revenue stream

- Incentivizes providers to provide the right care to the right patient; reducing waste in the system becomes profit for the provider

- Designed to invest in practices through incentivizing and supporting:
  - Expanded care teams
  - Risk stratification of members
  - Improved physician recruiting
  - Patient access through expanded panel sizes

A perfect storm

- Four physicians retired in Q4 2022, and Coastal needed to “bridge” 6,000 patients within existing practices until new physicians arrived in the summer of 2023

- Discharging patients violated our commitment to the Patient Centered Medical Home
- The 6000 displaced patients represented $5.8 million in potential lost revenue
  - FFS + Capitation Payments + Quality + Infrastructure Support

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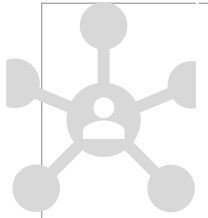
The Patient Support Model

Clinical Practice Nurse

- Triage calls/portal messages/TE's to clinicians
- Review and address Lab/DI/documents

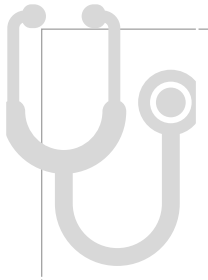


Clinical Practice Navigator

- Monitor and review RPM for PSM patients
- Support for Practice Nurse and MAs for patient outreach/follow up

Medical Assistants

- Dedicated support to each clinician in the practice
- Prioritized access to MA Float Pool

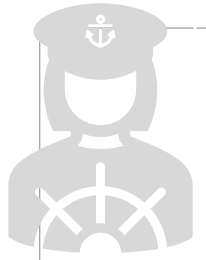


Physician

- Provide care to an expanded panel with greater administrative resources

Advanced Practitioner

- Expands access to provide sick visit care or follow up care
- Additional capacity with Float AP's – for surges or coverage



Practice Manager

- Monitor access and capacity
- Tools for active schedule management

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Capitation made the PSM possible

	Coastal	16 Additional Teams 20 Teams in Total	Total Revenue = $3,976,894 Total Expense = $3,952,413 Net Profit = $24,481
	LPG	5 Teams	Total Revenue = $1,127,563 Total Expense = $1,280,622 Net Loss = ($153,058)

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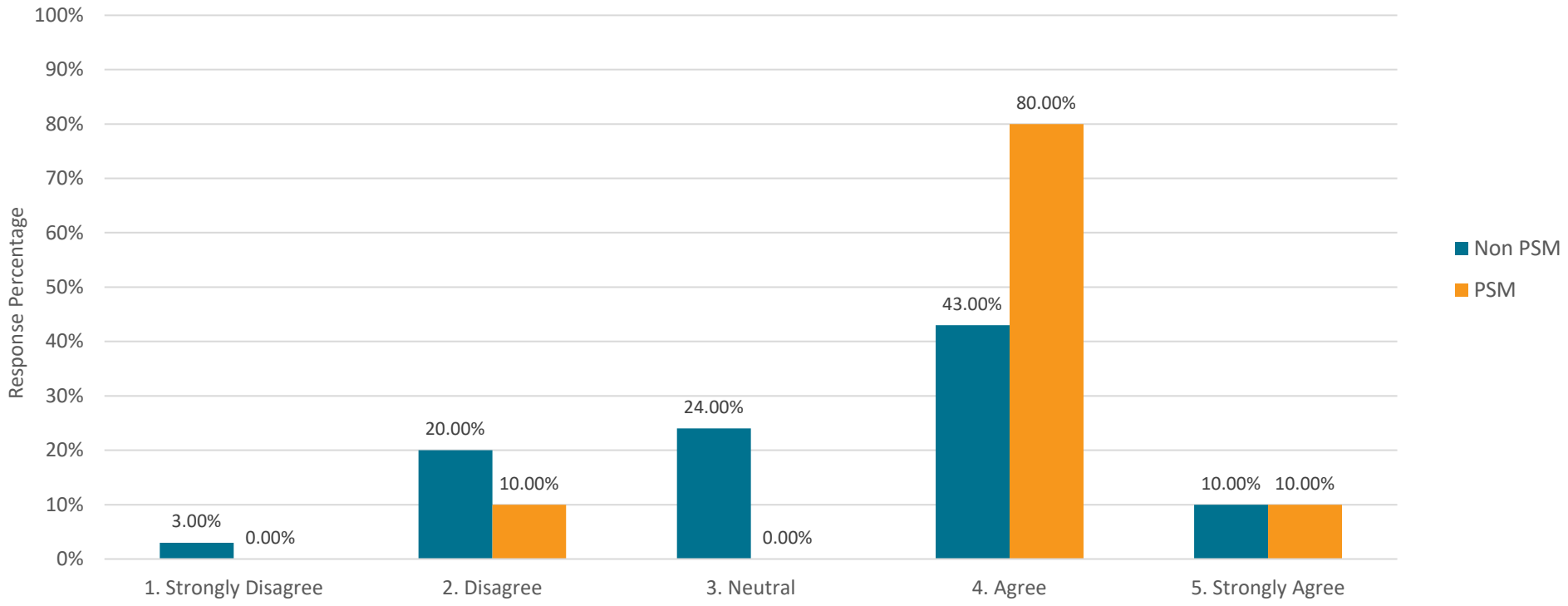
The PSM improves job satisfaction

Q1. Overall, I am satisfied with my current job (Agree, Strongly Agree)



Question	Non-PSM	PSM	Difference	Benchmark
Q1	53.00%	90.00%	**37.00%**	78.3%

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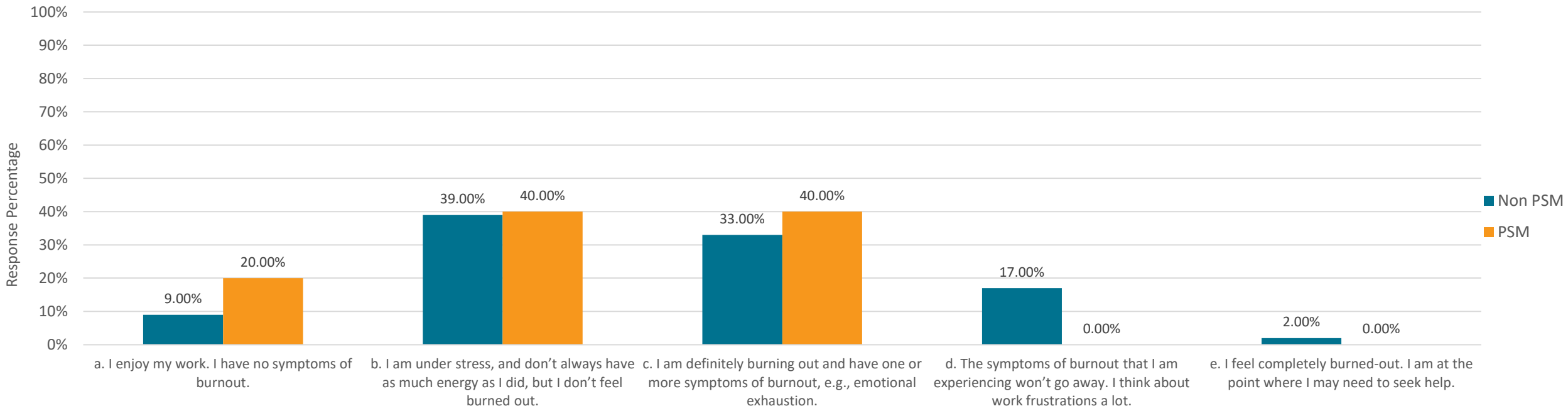
PSM clinicians reported lower rates of burnout

Q3. Using your own definition of “burnout,” please select one of the answers below



Question	Non-PSM	PSM	Difference	Benchmark
Q3	52.00%	40.00%	**-12.00%**	33.9%

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Review of the Steering Committee's Work Since 2018

Reflections on the Steering Committee's Accomplishments to Date

- As we begin the year, let's review what the Steering Committee has accomplished since signing the original Cost Trends Compact in December 2018.

- Over the last five years, the Steering Committee has:

1) guided the implementation of the cost growth measurement and reporting (2019-20)
2) created and signed a value-based payment compact (2022)
3) developed a hospital global budget model design (2023)
4) adopted public health and health equity measures and targets (2023)
5) adopted cost growth targets for 2023-2027 under a new compact (2023)

Reflections on work that has not been achieved

- The Steering Committee has not:

1) carried out all actions laid out in the 2022 value-based payment compact.
2) agreed upon a specific strategy to address rising drug prices.

Role and Purpose of Steering Committee

Why We Came Together in 2018

- As was described during the Committee's first meeting in August 2018, "by [voluntarily] agreeing to serve on the Steering Committee, you are committing to participate in a thoughtful and respectful process to consider the Steering Committee's charge and make recommendations to the State".
- The vision statement for the Cost Trends Project was "to provide Rhode Island citizens with high-quality, **affordable health care** through **greater transparency** of health care performance and **increased accountability** by key stakeholders".
  - The 2018 Compact stated, "we agree upon and support [the] cost growth target and methodology, and commit to taking **all reasonable and necessary steps** to annually keep health care cost growth below the target…while maintaining or improving access."

A Moment for Reflection

- The Committee's co-chairs recognize that there have been changes in leadership of organizations represented on the Steering Committee over the past two years.

- In this context, and in recognition of achievements and non-achievements, it is time to reflect on where this Steering Committee stands and is heading as we start a new year.

Discussion

Do you believe that the Steering Committee can be an effective agent and fulfill its original purpose of advancing affordability in the state?

- *If so, to what type of specific actions can members commit in order to do so?*
- *If not, is there an alternative valuable purpose that the Steering Committee can serve?*

Details on the CMMI AHEAD Model

CMMI AHEAD Model

- When we met in October, OHIC indicated that it had begun to have internal state discussions about the CMMI States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.
- Since then, CMMI has published more details about this model, as well as a Notice of Funding Opportunity (NOFO).
  - OHIC and EOHHS are currently considering drafting an application.
- The following slides provide an overview of the AHEAD model, details on why Rhode Island is a strong candidate for consideration, and how the Rhode Island could benefit from participating.

Historical Context

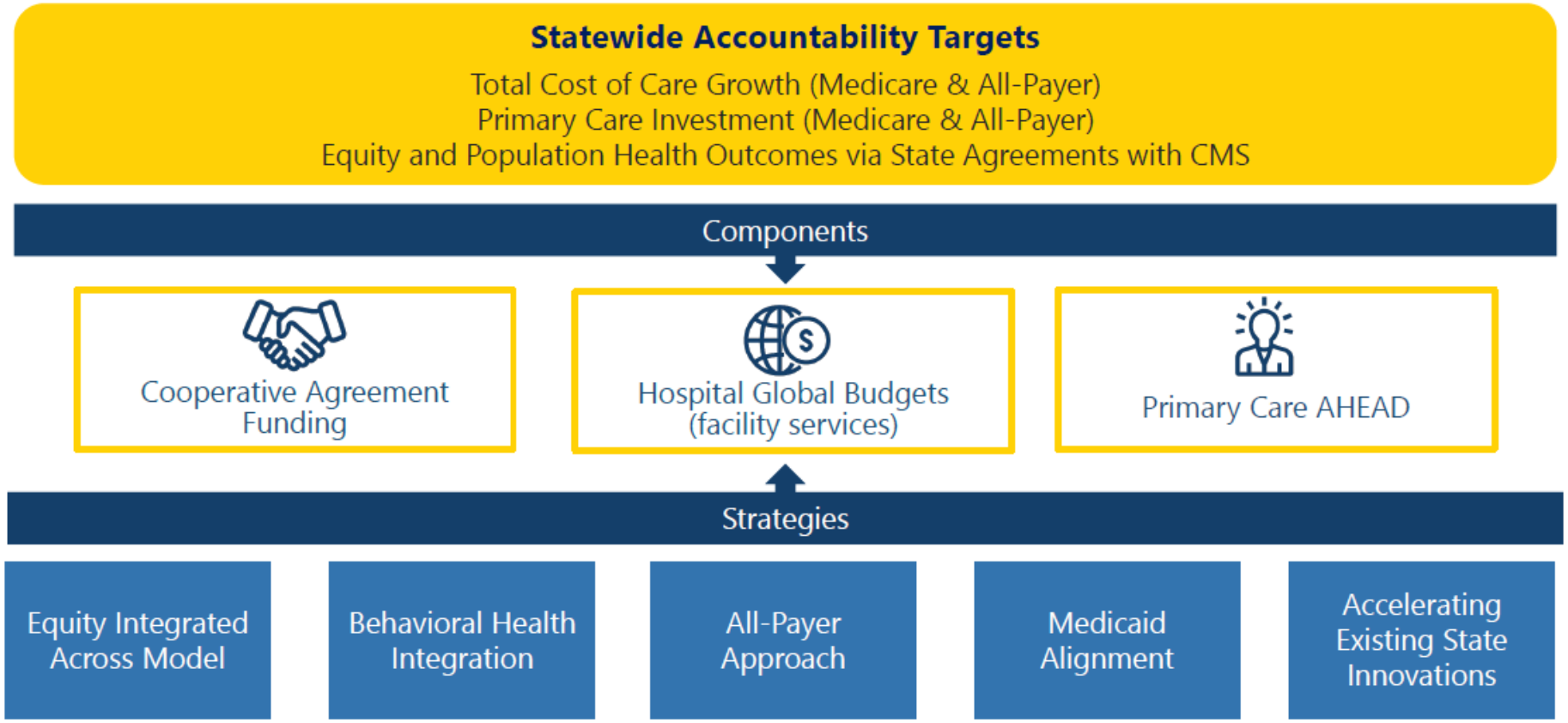
- To date CMMI has operated, and FFS Medicare participates in, three state payment models. These models are all customized to the state.
  - **Maryland Total Cost of Care Model**: Builds upon the predecessor Maryland All-Payer Model. Includes hospital global budgets, a primary care payment model, and equity incentives. The state is fully accountable for the cost and quality of care for each patient with Medicare.
  - **Pennsylvania Rural Health Model**: Tests care delivery transformation in conjunction with hospital global budgets in rural Pennsylvania.
  - **Vermont All-Payer Accountable Care Organization (ACO) Model**: Tests an ACO payment model involving Medicare, Medicaid, and commercial health care payers.
- CMMI has decided that it will no longer participate in customized state models. Instead, it will participate in standard model: AHEAD.

Model Purpose & Goals

- AHEAD is a state total cost of care model that seeks to drive state and regional health care transformation and multi-payer alignment, with the goal of improving the total health of a state population and lowering costs.
- A participating state is to use its authority to assume responsibility for managing health care quality and costs across all payers. States are also to assume responsibility for ensuring providers in their state deliver high-quality care, improve population health, offer greater care coordination, and advance health equity by supporting underserved patients.
- CMS' goal is to collaborate with states to **improve population health**; **advance health equity** by reducing disparities in health outcomes; and **curb health care cost growth**.

Model At-A-Glance (1 of 3)

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.



Source: CMS Presentation from September 18, 2023 AHEAD Model Overview Webinar

Model At-A-Glance (2 of 3)

- All-Payer and Medicare FFS **primary care investment targets** will be set by measuring primary care expenditures for beneficiaries residing in the state as a percentage of state TCOC for those beneficiaries.
  - The Medicare FFS primary care investment targets will be set by CMS. CMS anticipates each state's target will be between 6-7% of Medicare TCOC.
  - States will have flexibility to set all-payer targets, subject to CMS approval.
- States set **all-payer cost growth targets** which include Medicare FFS, Medicare Advantage, Medicaid, commercial, state employee health plans, and Marketplace-qualified health plans.
- The model will include quality measures across these components: **statewide quality measures, primary care measures, and hospital quality programs**.

Model At-A-Glance (3 of 3)

- There are three Model components to assist states in meeting accountability targets.
  - **Cooperative Agreement Funding**: Funding provided by CMS to support initial investments for states to begin planning activities during the Model's pre-implementation period and the initial performance years of the model.
  - **Hospital Global Budgets**: Provide hospitals with a pre-determined, fixed annual budget for a specific patient population or program to encourage hospitals to eliminate avoidable hospitalizations and improve care coordination between hospitals, primary care providers, and specialists. Increased investments in primary care under the Model can be offset over time by statewide savings generated by hospital global budgets.
  - **Primary Care AHEAD**: Eligible primary care practices can participate in Primary Care AHEAD, the primary care program component of the model. Primary Care AHEAD will align with ongoing Medicaid transformation efforts within each participating state and aims to increase Medicare investment in primary care.

Key Stakeholder Roles

States

- Establish model governance
- Set all-payer cost growth targets
- Increase primary care investment
- Implement statewide health equity plan
- Design Medicaid hospital global budgets and primary care transformation
- Facilitate multi-payer alignment and can engage State Employee Health Plans and Marketplace Plans

Hospitals

- Can participate in hospital global budgets, transform care, and improve population health
- Pursue opportunities for quality improvement (e.g., CMS hospital quality programs and other metrics) and identify other efficiencies
- Create hospital health equity plans to reduce disparities in care and outcomes within the hospital and community

Primary Care Practices

- Can participate in Medicaid transformation efforts and Primary Care AHEAD for Medicare FFS
- Meet care transformation requirements for person-centered care
- Pursue opportunities for quality improvement and improved care coordination

Payers

- Contribute to the All-Payer Cost Growth Target and All-Payer Primary Care Investment Targets
- Participate as an aligned payer in hospital global budgets and primary care transformation

Source: CMS Presentation from September 18, 2023 AHEAD Model Overview Webinar

Hospital Global Budgets – Value Proposition

- The AHEAD Model aims to rebalance health care spending across the system, shifting utilization from acute care settings to primary care and community-based settings.

Incentives for Hospital Participation

- Initial investment to support transformation in early years of the model
- Increased financial stability and predictability
- Ability to share in savings from reduced potentially avoidable utilization and more efficient care delivery
- Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community
- Potential use of waivers to support care delivery transformation
- Opportunity to participate in system learning opportunities when moving to a population-based payment

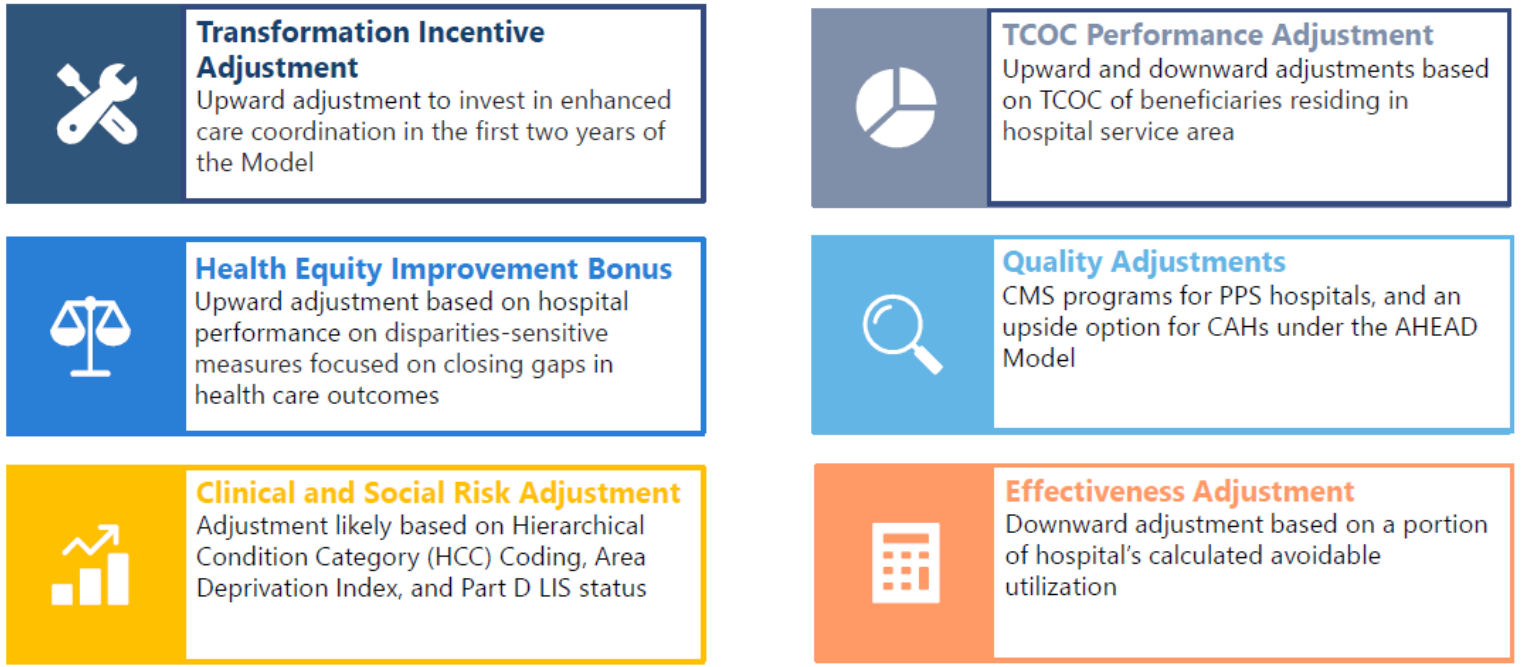
Source: CMS Presentation from September 18, 2023 AHEAD Model Overview Webinar

Hospital Global Budgets

- Hospital global budgets are the primary mechanism for achieving all-payer and Medicare FFS TCOC targets, improving hospital quality, and helping to curb cost growth. Each participating payer provides a global budget, determined prospectively, to the participating hospital for facility services.
  - Medicare FFS: States with statewide rate setting or hospital global budget authority and experience in value-based care can develop their own hospital global budget methodology. States without these authorities will use a CMS-designed methodology. (*RI falls into the latter group*.)
  - Medicaid: States will be required to implement an aligned Medicaid hospital global budget payment by Performance Year 1. The state Medicaid agency will be responsible for developing its Medicaid-specific hospital global budget methodology with alignment principles outlined by CMS.
  - Commercial: Participation is voluntary; however, states must recruit at least one payer to participate in hospital global budgets by Performance Year 2. States will develop a methodology with high-level alignment principles outlined by CMS. Commercial payers include state employee health plans, Basic Health Plans, Qualified Health Plans, and Medicare Advantage plans (including Dual Eligible Special Needs Plans).

CMS-Designed Medicare FFS Global Budget Methodology

- Hospital global budgets are built "bottom up" from past net patient revenue within the facility (inpatient and outpatient), including hospital outpatient departments.
- This historic baseline will be adjusted for inflation, demographic shifts, and other trends for each performance year before applying the adjustments to the right.



Source: CMS Presentation from September 18, 2023 AHEAD Model Overview Webinar

Hospital Participation

- States must have participation from hospitals representing a minimum of 10% of Medicare FFS volume in the state in Year 1, and 30% of Medicare FFS volume by Year 4.
- CMMI does not require states to have formal commitment from hospitals at the time of state application to CMMI. OHIC and EOHHS, however, would seek indications of serious interest from individual hospitals prior to proceeding.

Funding Opportunity

- Eligible applicants are state agencies with the authority and capacity to enter into an agreement on behalf of their state and accept funding. The State Medicaid agency must be included on the Cooperative Agreement and receive funding as a sub-recipient if not the award recipient.
- AHEAD Model agreements include: (1) a **Cooperative Agreement** for which the NOFO is soliciting applications, (2) a **State Agreement** to memorialize the negotiated accountability targets and other Model requirements, and (3) **Participation Agreements** that participating hospitals and primary care providers will execute with CMS.
- CMS expects to award cooperative agreements to up to eight states, including up to five awards for cohorts 1 and 2. CMS will provide funding for up to six years with a maximum award of $12 million dollars to support planning and implementation activities.

Application & Implementation Timeline

		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Model Year			MY1	MY2	MY3	MY4	MY5	MY6	MY7	MY8	MY9	MY10	MY11
1st NOFO Period	Cohort 1	NOFO	Pre- Implementation (18 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	PY9
	Cohort 2		Pre-Implementation (30 mos)			PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
2nd NOFO Period	Cohort 3		NOFO	Pre-Implementation (24 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8

Source: CMS AHEAD Model Website

- CMMI created three cohorts to accommodate variation in readiness among participating states and providers. The first cohort pre-implementation period is scheduled to begin in summer 2024 with a performance period scheduled to begin as soon as January 2026.
- The Model is scheduled to operate for a total of 11 years, from 2024 through 2034.

Rhode Island is a Strong Candidate

Rhode Island is well-positioned to apply for the AHEAD Model:

- Framework for a global budget model designed with hospitals and payers *(developed through the OHIC-convened summer work group)*
- Existing statewide cost growth target and a primary care spend target (commercial market only), with a mechanism for annually measuring both
- Long-standing commitment to primary care transformation and the PCMH
- Commitment to, and activities in place, to advance health equity, e.g., SDOH screening and referral, HEZ, statewide health equity targets
- History of multi-stakeholder collaboration
- Established CMMI interest in Rhode Island's participation in AHEAD

Benefits of AHEAD to RI

- **Extensive funding for the state to aid implementation** and to help advance the state's priorities and ongoing efforts related to affordability, primary care transformation, and health equity and align these efforts across payers.
- **Medicare participation** in RI's significant multi-payer efforts.
- **Stable and predictable funding for hospitals** using hospital global budgets, potential savings generated from reductions in avoidable utilization, and gains in care delivery efficiency. Hospitals can also use benefit enhancements available under the Model to support care redesign.
- **Increased investments for primary care practices**, for which Rhode Islanders will benefit from strengthened primary care, including whole-person care and improved supports and connections to community resources to address unmet health-related social needs.

Public Comment

Next Steps and Wrap-up

Upcoming Meetings

- Our next meeting will be scheduled for April 2024.
- The annual Cost Trends public forum will be held on May 13th from 9 AM – 12 PM at the Crowne Plaza in Warwick. Project staff will send out a meeting invitation soon.