Rhode Island
Accountable Entity
Coordinated Care Pilot:

Early Lessons and Recommendations

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Rhode Island's Accountable Entity Coordinated Care Pilot: Early Lessons and Recommendations

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Overview

In 2015, the Working Group to Reinvent Medicaid recommended the creation of Accountable Entities (AEs) to improve health and reduce costs for Rhode Island's Medicaid beneficiaries. Rhode Island's Executive Office of Health and Human Services (EOHHS) worked toward this vision by creating a two-year Accountable Entity Coordinated Care Pilot Program (AE Pilot), which began operation in July 2016 and concluded in June 2018. EOHHS designed the AE Pilot as a precursor to the full AE Program under the Health System Transformation Project (HSTP), which began in July 2018.

EOHHS engaged the Center for Health Care Strategies (CHCS) to distill participants' assessments of the AE Pilot Program by: (1) interviewing individuals and organizations that participated in, or influenced the development or performance of, the AE Pilot; (2) synthesizing interview feedback; and (3) providing recommendations to inform the future development of the full AE Program under HSTP.

In this report, CHCS relays broad themes from those interviews and discusses how participants' assessments of the AE Pilot align with the Working Group's vision for AEs and Medicaid managed care organizations (MCOs). While AEs, MCOs, and other stakeholders expressed some frustration with specific aspects of the AE Pilot, interviewees also expressed a commitment to value-based payment (VBP) and health care innovation, as well as cautious optimism about the future of the full AE Program under HSTP. After analyzing the interviews and the performance data available, CHCS determined that the full AE Program under HSTP could be strengthened by:

1. Ensuring AEs have the data necessary to succeed
2. Fostering open communication and trust
3. Modifying incentives to encourage additional participation
4. Striving for simpler, streamlined requirements, but continuing to provide some flexibility
5. Letting iteration drive innovation

History of the AE Pilot

The Working Group to Reinvent Medicaid

In February 2015, Rhode Island's Governor Gina M. Raimondo signed an executive order establishing the Working Group to Reinvent Medicaid (Working Group).[1] This order tasked the 29-member stakeholder group with conducting a comprehensive review of Rhode Island's Medicaid program and submitting findings and recommendations for quality improvement and cost savings to the Governor for consideration in the Fiscal Year (FY) 2016 budget. Based on the Working Group's recommendations, the Rhode Island General Assembly passed the Reinventing Medicaid Act of 2015, which sought to "achieve significant Medicaid savings while improving quality, controlling costs, and putting Rhode Island on a path toward closing a $190 million structural deficit."[2]

Governor Raimondo's executive order also directed the Working Group to make recommendations for a multi-year Medicaid transformation plan. In July 2015, the Working Group submitted its final report with long-term recommendations for a multi-year Medicaid transformation plan. The report, *Recommendations for a Plan for a Multi-Year Transformation of the Medicaid Program and All State Publicly Financed Healthcare in Rhode Island*, identified challenges, such as: (1) the lack of accountability for cost and quality; (2) separate funding streams and delivery systems for behavioral and physical health care; (3) fragmented "care management" services; and (4) an inability to address social determinants of health. To address these issues, the report laid out four principles and 10 goals to transform the Medicaid program, with a focus on integrated, accountable care and VBP.[3]

AEs, which are similar in structure to accountable care organizations (ACOs),[4] played a key role in the Working Group's "Vision of a Reinvented Medicaid Program."[5] AEs would be "responsible for the total cost of care and healthcare quality and outcomes" for their attributed populations by providing integrated, whole-person. "Next

Generation MCOs" would contract with these provider organizations and develop new competencies that could support AE functions, including producing, analyzing, and sharing data with AEs to manage their populations. MCOs would also be responsible for creating innovative VBP strategies, and AEs would increasingly take on more care management responsibilities.

Shortly after the publication of the report, the legislature enacted the FY 2016 budget.[6] Among other budget initiatives relating to the Working Group's recommendations, the budget included a $24 million reduction to Medicaid managed care capitation rates.

EOHHS Implementation: AE Pilot and HSTP

The AE Pilot

The AE Pilot was designed to function as an "onramp" toward the full AE Program under HSTP. During the two-year pilot, providers could develop experience working under a VBP model, improving care coordination and management for an attributed population, and working with additional organizations outside their walls without the fear of financial penalty.

After publishing a request for information in August 2015, EOHHS released a program description and application for the AE Pilot in late October 2015. It outlined the capabilities necessary for pilot AEs to demonstrate readiness for the program, as well as guidelines for applications. Required capabilities were organized into the domains of: (1) responsible entity and governance; (2) leadership and management structure; (3) readiness to develop and/or provide an integrated multi-disciplinary system of care; (4) minimum population threshold and linkage to provider network; and (5) data and analytic capacity. Applicants were required to specify whether they would be a Type 1 entity, with authority to contract for all attributed populations enrolled in managed care, or a Type 2 entity, with authority to contract for a specialized population – i.e., individuals with serious mental illness (SMI) or severe and persistent mental illness (SPMI). The two Type 2 AEs were aligned with Type 1 "Comprehensive" AEs and were not distinct entities. The AE Pilot encouraged provider organizations to form unique partnerships with other provider organizations and community-based organizations (CBOs), and develop processes to serve the needs of the Medicaid population. This organizational structure was designed to create shared incentives among traditional and non-traditional health care providers, and drive innovations in care management and population health strategies.

EOHHS identified two high priority AE capabilities for the Medicaid population: (1) integration and coordination of long-term services and supports; and (2) physical and behavioral health integration, with an emphasis on high-cost users with co-occurring mental and physical health needs. In an interview with CHCS, state staff at EOHHS recognized the strengths of Rhode Island's established Medicaid managed care program, but noted that EOHHS designed the AE Pilot and the full AE Program under HSTP to better address the needs of high-risk and rising-risk populations by bringing care coordination closer to the provider level, in hopes of better managing cost and quality of care. The AE Program sought to align AE and MCO incentives, and to break through disconnects between payment and delivery systems. AEs would contract with Rhode Island's Medicaid MCOs to encourage cooperation between AEs and MCOs, which was consistent with the state's overall push for VBP in Medicaid managed care. The state designed the AE Program structure to become the primary contracting model in the Rhode Island Medicaid program, providing a key mechanism for achieving the Working Group's goals.

EOHHS identified the following AE Program objectives:
- Substantially transition away from fee-for-service models;
- Define Medicaid-wide population health targets, and, where possible, tie them to payments;
- Maintain and expand on Rhode Island Medicaid's record of excellence in delivering high-quality care;
- Deliver coordinated, accountable care for high-cost, high-need populations;
- Ensure access to high-quality primary care; and
- Shift Medicaid expenditures from high-cost institutional settings to community-based settings.[7]

The AE Pilot was purposefully flexible, with EOHHS establishing the broad outlines of a shared savings program and directing MCOs to fill in the details in its contracts with AEs. EOHHS required MCOs to contract with at least two AEs, and to develop a total cost of care (TCOC) benchmark and a set of quality measures by which AEs would earn portions of any realized shared savings.

Each AE would be responsible for an attributed population. EOHHS designed the attribution methodology to recognize existing provider-member relationships and enable "providers who have historical responsibility for member costs to earn savings by reducing those costs in the future."[8] Because historical data showed that populations with SMI/SPMI primarily seek care from their behavioral health providers, EOHHS developed an attribution methodology by which patients enrolled in an Integrated Health Home are attributed to an AE according to where they receive behavioral health services rather than according to where they receive primary care services, provided their behavioral health provider is part of an AE.

EOHHS certified six pilot AEs to participate in the AE Pilot, eligible to enter into shared savings contracts beginning January 2016. Most MCO contracts with pilot AEs began around July 2016.

Full AE Program under HSTP

EOHHS designed the AE Pilot as an "onramp" to the full AE Program under HSTP, and many AEs participated in the AE Pilot as a way to prepare for and access the benefits of the full AE Program under HSTP. During the AE Pilot period, the state crafted modifications to its demonstration project under Social Security Act §1115 and created HSTP. The Centers for Medicare & Medicaid Services (CMS) approved the demonstration project in October 2016. HSTP included $129.8 million in federal matching funds over a five-year period (Oct. 2016 – Dec. 2020); $76.8 million of this funding was directed toward AE Program incentives.[9] EOHHS intended these incentive funds to encourage and enable investments in AE infrastructure and capacity. Exhibit 1 outlines key program attributes of the full AE Program under HSTP.

Exhibit 1: Program Design Elements of Comprehensive AE Pilot and Full AE Program under HSTP

Attribute	Comprehensive AE Pilot	Full AE Program under HSTP
Timeframe	January 2016 – June 2018	July 2018 – June 2019
MCO Contracting Requirements	MCOs must contract with three or more AEs or two AEs serving at least 20,000 beneficiaries total.	MCOs must contract with three or more AEs, or two AEs serving at least 20,000 beneficiaries total.
Covered Populations	All Medicaid beneficiaries enrolled in managed care	All Medicaid beneficiaries enrolled in managed care.
Attribution Methodology	Program originally did not dictate attribution model, but was subsequently adjusted effective on January 1, 2016 to reflect the two-step attribution process in the Full Program under HSTP.	Two-step attribution process: • Members are assigned to an AE if they belong to an IHH that is a part of a comprehensive AE. • PCP assignment by the MCO.[10]
Scope of Services	All Medicaid-covered services that are included in EOHHS' contracts with MCOs.	All Medicaid-covered services included in EOHHS' contracts with MCOs except for: • Long-term care in an intermediate or skilled facility in excess of 30 days; • Organ transplants; • Early intervention services in excess of $5,000 for an individual; and • Hepatitis C pharmacy costs.
Minimum Beneficiary Requirement	"Guideline" of 5,000 Medicaid beneficiaries	AEs must have at least 5,000 attributed Medicaid members, and 2,000 Medicaid beneficiaries per contract.
Incentive Funds	Not available	Medicaid Infrastructure Incentive Program will begin distribution of funds in program year 1. Share of incentive funds is tied to EOHHS-defined program outcome metrics in year 2 and beyond.
Payment Model	Total cost of care-based shared savings model to be negotiated between MCOs and AEs, within guidelines established by EOHHS.	Total cost of care-based shared savings model provides upside-only risk in year 1 of program, and incorporates downside risk in year 3. Specific details will be negotiated between MCOs and AEs, within guidelines established by EOHHS. • AEs may be eligible to retain up to 50% of the Shared Savings Pool. • AEs assuming downside risk may be eligible for up to 60% of the Shared Savings Pool, and up to 60% of the Shared Loss Pool.
Impact of Quality on Distributions	Requires MCOs and AEs to negotiate an appropriate comprehensive quality score factor that must be applied to any shared savings pool to determine the actual amount of the pool eligible for distribution. Specific quality measures are not defined.	Defines Comprehensive AE Common Measure Slate, which consists of 11 measures. AE Contracts must use these metrics, but may also include up to four additional measures from the SIM Menu Measure Set or the Medicaid Child and/or Adult Core Quality Measure Set.[11] State guidance requires the use of a specific algorithm for developing the quality multiplier.
Historical Baseline	An AE specific historical base must be used to develop the AE TCOC benchmark unless specifically approved by OHHS. Risk adjustment shall not be applied while calculating an AE's historical baseline costs, though changes in an attributed population's risk profile may be considered when projecting historical costs forward into the performance year. An exception was granted to this rule in Pilot year 2.	MCOs must make two Required Adjustments to the Historical Base to prospectively establish an AE's TCOC Expenditure Target: (1) an Adjustment for Prior Year Savings; and (2) an Adjustment for Historically Low-Cost AEs, both of which must not exceed 2% of the unadjusted TCOC Expenditure Target. Additional adjustments may be made with EOHHS approval. Risk adjustment shall not be applied while calculating an AE's historical baseline costs, though changes in an attributed population's risk profile may be considered when projecting historical costs forward into the performance year.

Preliminary Performance of the AE Pilot

Five of the six certified pilot AEs entered into contractual arrangements with MCOs, and a total of seven AE-MCO contracts were active, with both participating MCOs holding contracts with the two hospital-based AEs. By

September 2017, 51 percent of Medicaid members enrolled in Medicaid managed care were attributed to an AE. From July 2016 to June 2017, AEs generated approximately $3.2 million in savings.

AEs participated voluntarily in the pilot program and though they had the opportunity to share in savings, no HSTP incentive funding was available during the pilot. The promise of future incentive funding available through the fully-implemented HSTP program, however, was a major catalyst for AEs to sign onto the pilot.

In its interview with CHCS, EOHHS noted several encouraging accomplishments during the short ramp-up to and operation of the AE Pilot. In particular, the EOHHS noted the following, commenting on the progress made by AEs and MCOs:

Exhibit 2: AE Pilot Accomplishments

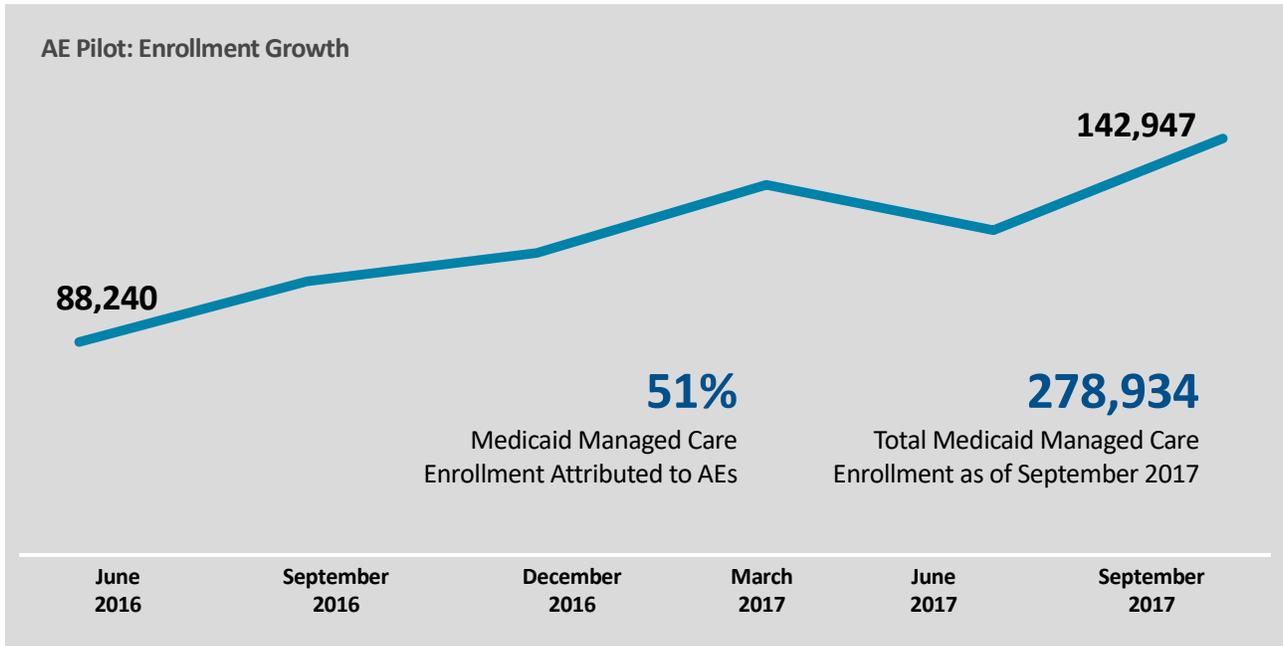| AE Accomplishments |
|---|
| 1. **Met requirements of AE certification.** *AEs responded to state requirements for capacity and capabilities to support an attributed population, and participated as active stakeholders in the review and development process. This resulted in six AEs becoming certified.* |
| 2. **Quickly executed shared savings contracts with partner MCOs.** *AEs were willing to enter into shared savings contacts and invest time and resources into executing contracts for programs quickly.* |
| 3. **Established organizational authority to support Medicaid AE Program.** *AEs adapted their board structures and governance models to address program requirements.* |
| 4. **Committed resources to the program.** *Without any new infrastructure funds and limited initial shared savings opportunity, AEs hired new staff/consultants and established new committees.* |
| 5. **Began to build structure for integrated physical and behavioral health, and social services.** *AEs created new partnerships and organizational structures for integrating behavioral health and social services to address social determinants of health (SDOH), some of which offered an opportunity for shared savings across entities.* |

Exhibit 3: MCO Accomplishments

MCO Accomplishments
1. **Quickly executed shared savings contracts with participating AEs.** *Within about six months of AEs' certification, there were seven contracts in place between MCOs and AEs.*
2. **Set up shared governance models.** *Both MCOs quickly set up a process and structure for AE/MCO partnership, review of key data, and discussion of performance.*
3. **Established key program implementation processes.** *MCOs established processes for member attribution, developed and implemented a financial model for AE TCOC, and established and implemented quality standards.*
4. **Applied new reporting requirements.** *MCOs implemented new state reporting requirements regarding quality metrics, AE shared savings, and alternative payment models.*

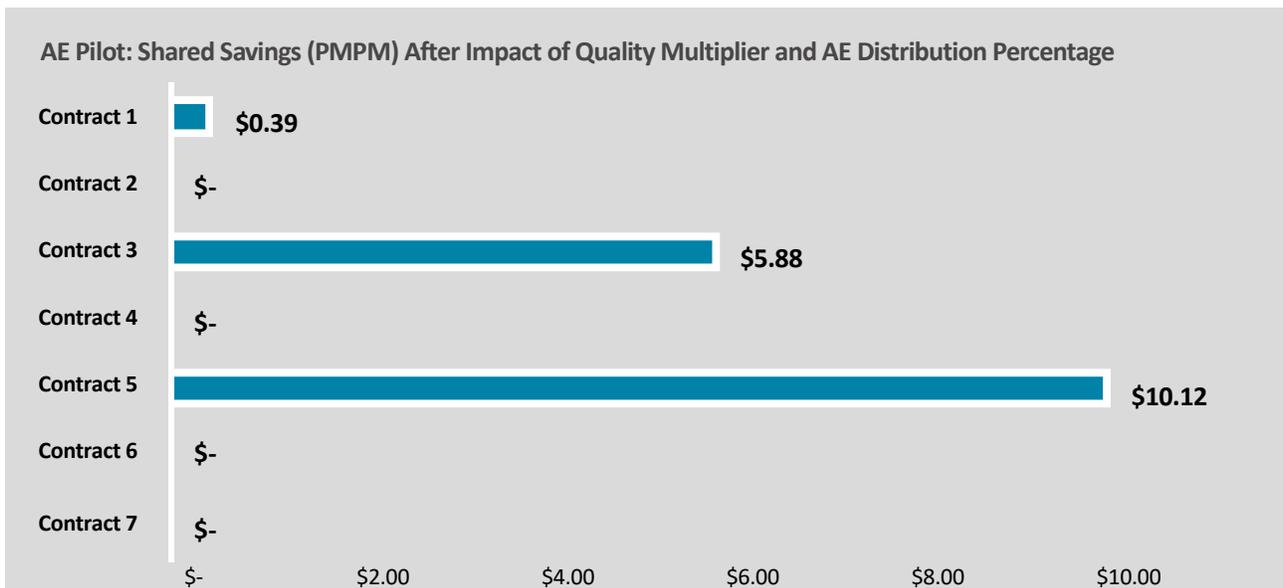## Preliminary Findings on AE Cost and Quality Performance

While only limited information is available at this time, Years 1 and 2 of the AE Pilot have yielded some positive results. The AE Pilot served a significant and growing number of patients from June 2016 to September 2017; the number of attributed lives increased from 88,240 to 142,947 (Exhibit 4). This is not only a 62 percent increase in attributed lives over the first year of the AE Pilot, but also encompasses 51 percent of Medicaid managed care enrollees in the state.

Exhibit 4: AE Pilot Enrollment

AE Pilot: Enrollment Growth

88,240

142,947

51%
Medicaid Managed Care
Enrollment Attributed to AEs

278,934
Total Medicaid Managed Care
Enrollment as of September 2017

| June 2016 | September 2016 | December 2016 | March 2017 | June 2017 | September 2017 |

In addition to the AE Pilot's increase in attributed lives, of the seven contracts between AEs and MCOs, three experienced shared savings.

Exhibit 5: AE Pilot Shared Savings across AE-MCO Contracts

AE Pilot: Shared Savings (PMPM) After Impact of Quality Multiplier and AE Distribution Percentage

Contract	Shared Savings (PMPM)
Contract 1	$0.39
Contract 2	$-
Contract 3	$5.88
Contract 4	$-
Contract 5	$10.12
Contract 6	$-
Contract 7	$-

Under their FY 2017 shared savings arrangements with an MCO, five contracts between AEs and MCOs resulted in the AEs meeting their quality threshold. However, only three AEs generated savings, and could therefore, only those three AEs earned a shared savings distribution.

Methodology

CHCS used the Working Group's final report as an organizational and comparative framework for this report. CHCS reviewed interviewees' assessment of the following aspects of the AE Pilot, listed in Exhibit 6 below:

*Exhibit 6: **Vision of a Reinvented Medicaid***

Accountable Entities
(1) **Care Management and Integration**
(2) **Accountability for Cost and Quality**
(3) **Accountability for an Attributed Population**
(4) **The AE Pilot as a "Fast-Track Path"**
(5) **The AE Pilot as a Learning Opportunity**
Next Generation MCOs: New Competencies
(6) **Data to Support AE Functions**
(7) **VBP Strategies**

This report summarizes participants' assessments of the AE Pilot and draws on those assessments to develop recommendations for the state. The summaries included in the "Discussion" section do not attempt to provide objective facts about performance and program design, but rather paint a general overview of reactions to, and opinions of, the AE Pilot. While this report focuses on the AE Pilot, it is intended to be forward-looking and present opportunities for better state, AE, and MCO processes moving forward.

Because only partial quantitative data on pilot AE cost and quality performance are currently available, this report relies primarily on qualitative data, including: (1) publicly available documents relating to the AE Pilot; (2) interviewees' stated experience with the AE Pilot; and (3) documents submitted to the state that summarize reactions to the AE Pilot and the full AE Program under HSTP. A quantitative evaluation of the AE Pilot will be conducted in the future. To the extent that high-level information from state FY 2017 is available, this report includes aggregate information on AE cost and quality performance during the AE Pilot.

In addition to its initial interview with EOHHS leadership and program staff, CHCS conducted 15 interviews in May and June 2018, targeting individuals who either participated in, or influenced the development of, the AE Pilot. CHCS conducted six interviews in person and 10 telephonically. Interviewees included all six entities certified as Type 1 AEs during the AE Pilot, including the two Type 2 AEs; all three MCOs participating in Rhode Island's Medicaid program; and representatives from six other stakeholders, listed below:

Exhibit 7: AE Pilot Stakeholder Interviews

Type	Interviewees
EOHHS	1. AE Program Staff and Members of EOHHS Leadership
AEs	1. Blackstone Valley Community Health Center; 2. Coastal Medical, Inc. (Coastal); 3. Community Health Center Accountable Care Organization; 4. Integra Community Care Network, LLC (Integra); 5. Prospect Health Services Rhode Island, Inc.; and 6. Providence Community Health Centers, Inc.'s Providence ChoiceCare AE.
MCOs	1. Neighborhood Health Plan of Rhode Island (NHPRI); 2. Tufts Health Plan (Tufts); and 3. UnitedHealthcare.
Other Stakeholders	1. Jane Hayward, President and CEO, Rhode Island Health Center Association; 2. Linda Katz, Co-Founder and Policy Director, Economic Progress Rhode Island; 3. Marti Rosenberg, Director, Rhode Island State Innovation Model (SIM) Test Grant; 4. Sam Salganik, Attorney, Rhode Island Parent Information Network; 5. Susan Storti, President and CEO, The Substance Use and Mental Health Leadership Council; and 6. Anya Rader Wallack, former State Medicaid Director and Acting EOHHS Secretary, now Associate Director at the Center for Evidence Synthesis in Health, School of Public Health, Brown University

Pilot AEs included two hospital-based entities, one multi-specialty group practice, and three federally qualified health center (FQHC)-based entities. One AE, Coastal, did not contract with an MCO during the AE Pilot period. Tufts is a new MCO entrant into the Rhode Island Medicaid market, and did not participate in the AE Pilot, but was interviewed for its perspective on the full AE Program under HSTP and future development.

With input from the state, CHCS developed an interview guide tailored to each type of entity or stakeholder. This guide provided a general structure for the interviews, but CHCS encouraged interviewees to speak candidly about the AE Pilot and introduce their own topics for discussion.

Discussion

Through its interviews, CHCS identified the following findings within the themes of the Vision of a Reinvented Medicaid (Exhibit 6):

(1) 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.

(2) 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.

(3) **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.

(4) **The 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.

(5) **The 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.

(6) **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.

(7) **VBP Strategies** —While five of six 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.

Accountable Entities

The Working Group's final report defined AEs as "integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population."[12] This next section describes how interviewees' assessments of the AE Pilot compared to this articulated vision for AEs.

AEs: Care Management and Integration

According to the Working Group's final report, payment models for AEs should support "the full integration of primary and behavioral healthcare and care management services," as well as activities and partnerships that address SDOH.[13] In its program description and application for the AE Pilot Program, EOHHS evoked the Working Group's vision; the state noted that AEs should demonstrate "certain characteristics and capabilities to achieve meaningful improvements in [Rhode Island's] system of care," including a "a multi-disciplinary capacity with a strong foundation in high performing primary care practices" and the "ability to manage the full continuum of care, including 'social determinants.'"[14]

> **FINDING 1: 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.**

In interviews, AEs generally expressed pride in their patient satisfaction levels, quality performance, and cost efficiency. AEs also expressed a commitment to quality improvement, team-based care, and population health management, and in many instances, the AE pilot reinforced care management and data initiatives that were already underway prior to the pilot. Many AEs described the AE Pilot bolstering efforts to develop data analytics capacity and to use community health workers, medical assistants, and dedicated care coordinators to support care management functions.

EOHHS designed the AE Pilot to encourage providers to form unique partnerships across provider organizations and adopt VBP arrangements and has generally been impressed by the AEs' progress in this regard. In some cases, provider organizations formed a single-entity AE or used existing organizational structures that enabled participation in other VBP arrangements, such as the Medicare Shared Savings Program (MSSP). However, other provider organizations came together to form new multiple-entity AEs. For example, one AE includes six FQHCs,

as well as community action programs (CAPs) and community mental health centers (CMHCs). While some organizations had pre-existing VBP arrangements, the AE Pilot was some AEs' first introduction to a shared savings program. All AEs expressed a willingness to add additional organizations to their AE in the future, and many highlighted the potential to work with behavioral health providers and CBOs. EOHHS also noted that it expects the AEs to build on their initial model to include such organizations and improve care coordination among these entities.

MCOs expressed skepticism around the transfer of care coordination and data analysis functions to AEs. One MCO representative noted that AEs were at different levels of readiness for the AE Pilot, noting that despite widespread participation in the Care Transformation Collaborative and certification as a patient-centered medical home, AEs were generally not prepared for population health management at the outset of the program. During implementation of the AE Pilot, one MCO met monthly and sometimes weekly with AEs to introduce basic concepts of care coordination, risk assessment, patient stratification, and care management for high-risk and rising-risk populations.

Some AEs explained how the AE Pilot nudged them to do things that they would not otherwise have prioritized. One AE noted that it changed its processes in response to the "follow-up after a hospital discharge" quality measure integrated into its AE shared savings agreement. In addition, several AEs stated that, in response to program requirements, they have explored relationships with CBOs to address SDOH. However, many AEs are unsure of how to formalize these relationships, noting that CBOs often do not have sophisticated patient intake or data systems, and some have none at all. One AE noted that it may be beneficial to pool AE and MCO resources for certain SDOH interventions, serving local communities without regard to MCO enrollment, AE affiliation, or health insurance status.

AEs: Accountability for Cost and Quality

In the Working Group's "Vision of a Reinvented Medicaid," AEs are "responsible for the total cost of care and healthcare quality and outcomes of an attributed population."[15] To achieve this goal, payments to AEs "may begin as fee-for-service with shared savings and transition over time to capitated payments with opportunities for reward based on overall quality and cost performance."[16] The Working Group's report notes that a "flexible funding stream,"[17] such as shared savings payments, can be used to invest in the necessary infrastructure and interventions to adequately coordinate care and improve health outcomes, such as addressing SDOH and building partnerships with CBOs. This next section describes how the payment model under the AE Pilot aligned with these general goals, as communicated by interviewees.

> **FINDING 2:** AEs expressed dissatisfaction with the amount of shared savings payments they received, or expected to receive, from MCOs under the AE Pilot Program. Some interviewees suggested that state budget cuts may have contributed to these low payments.

EOHHS designed the AE Pilot as a shared savings program, which gives providers the financial incentive to reduce the volume of services and enhance the value of services. It also allows providers to "share" a portion of any cost savings generated with MCOs. In order to ensure that patient outcomes do not suffer and that providers do not withhold care to achieve cost benchmarks, these shared savings payments are contingent on quality performance.

EOHHS established broad program requirements, such as TCOC guidance, and attribution methodologies, but left it to the MCOs and AEs to negotiate specific terms. EOHHS intended to balance flexibility and innovation with transparency and consistency, and adjusted that balance throughout the AE Pilot period. For example, EOHHS allowed one MCO to risk adjust its benchmarks—an approach technically inconsistent with general guidelines for the AE Pilot—to adequately reward historically low-cost providers. EOHHS tightened imposed limits on this risk adjustment methodology in the second year of the AE Pilot Program. Responding to variability

in quality measures across MCOs, EOHHS also introduced a standard set of quality measures for use in the full AE Program under HSTP.

Of the seven AE-MCO contracts in effect from July 2016 to September 2017, AEs achieved savings under three contracts, with those three shared savings pools totaling approximately $3.2 million. Of the three AEs that achieved savings, two AEs achieved a quality multiplier of .75, and one AE achieved the full quality multiplier of 1. Earned shared savings payments ranged from $0.39 to $10.12 per member per month.

Five of the six AEs, as well as other stakeholders expressed concern with the amount of shared savings payments under the AE Pilot. They noted that they either received underwhelming shared savings payments or did not achieve savings at all, and largely attributed this result not to individual cost and quality performance, but to problematic payment methodology and related budgetary expectations. Interviewees noted that payment methodologies changed often throughout the program period, making it difficult for AEs to engage in strategic planning. Several AEs commented that the benchmarks for quality performance were set too high, and some also noted the cost benchmark was rebased too often, and that that the trend rate for TCOC (which reflected historical trends) was too low. While having about half of the contracts receiving shared savings is consistent with performance of MSSP ACOs[18] and state-based Medicaid ACO programs in their first year, the quality thresholds established via MCO-AE contracts do seem more challenging than the vast majority of ACO models.

Many interviewees described the AE Pilot as, first and foremost, a state budget initiative. The interviewees generally observed that state budget decisions impacted AEs' abilities to meaningfully share in savings. The interviewees described a process by which the state reduced MCOs' capitation rates upfront, in anticipation of the expected future savings of the AE Pilot. According to AEs, this reduction in capitation rates encouraged MCOs to recoup some of those lost funds by including challenging quality and cost benchmarks for AEs, which allowed the MCOs to retain a larger share of realized savings. One interviewee noted that this reduced earning potential in the program impacts AEs' ability to invest in infrastructure that would improve performance in the AE Program over time.

MCOs corroborated the impact of the state's budgetary decision on AEs' capacity to realize shared savings. One MCO conceded that it was very difficult for AEs to earn shared savings under the AE Pilot, but noted that the state's budgetary decision resulted in less revenue for all parties involved, including MCOs. EOHHS similarly acknowledged that accomplishing shared savings in the Medicaid arena can be particularly challenging, given the difference in budgetary trend rates and health care cost growth over years. EOHHS also noted that it has incorporated additional mechanisms to support AE opportunities for shared savings in this challenging budgetary environment.

AEs comprised of FQHCs particularly expressed frustration with low or nonexistent shared savings payouts under the AE Pilot and characterized this low level of funding as inconsistent with the state's and MCOs' projections. Some health centers, as well as one MCO, said the AE payment methodology targeted and favored hospital-based AEs, and did not appropriately reward historically low-cost, efficient providers like FQHCs. These FQHCs suggested incentive payments under NHPRI's legacy incentive program were a more dependable source of funding than shared savings payments under the AE Pilot. FQHCs also noted that they agreed to participate in the AE Pilot with the understanding that other incentive funds would be available to them. These incentive funds were available for the first year of the AE Pilot, but not in the second year.

EOHHS noted that it was challenging to implement a payment model that: (1) creates meaningful opportunities for historically low-cost providers; and (2) is consistent across all participating providers. In order to drive more meaningful changes to care delivery, however, EOHHS intentionally favored the AE Pilot over NHPRI's legacy incentive programs, which it believes had notable structural and strategic limitations.

AEs: Accountability for an Attributed Population

In the Working Group's Vision, AEs are responsible for an attributed population. The report notes that, eventually, "all Medicaid members will be attributed to an Accountable Entity."[19]

In its AE Pilot description, EOHHS noted that the AE Pilot's attribution method "must seek to preserve existing provider-recipient relationships."[20] To realize this goal, the AE Pilot proposed a specific attribution methodology for patients enrolled in an IHH, a program for individuals with certain behavioral health diagnoses.[21]

FINDING 3: AEs noted that the attribution methodology for a member enrolled in an integrated health home, 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.

One AE acknowledged that an IHH often serves as the primary health provider for many patients with behavioral health diagnoses, and by that standard, the AE Pilot's attribution methodology made sense. However, that AE, in addition to other AEs, noted that the attribution methodology, in combination with a patient's choice of providers, makes accountability for the SPMI population more diffuse. Multiple AEs and advocates noted that members enrolled in an IHH may receive physical health services outside the AE to which he or she is attributed, thus confounding the AEs' attempts at behavioral health integration. One AE noted that it specifically requested the state to reconsider its IHH attribution methodology. However, EOHHS noted that since AEs are not closed networks, and patients have a choice of providers via their MCO network, if patients select providers that are part of different AEs, a different attribution methodology would not fix this issue.

MCOs noted that they would prefer a more straightforward attribution methodology based on primary care providers (PCP). While MCOs noted the value of integrated behavioral health, one MCO noted that an attribution methodology whereby IHH affiliation trumps PCP affiliation forces patient assignment to become a lengthier, less automated process. Under the current process, the MCO needs to manually integrate information from a monthly EOHHS spreadsheet into its system to create AE attribution lists.

Several AEs also noted that they have seen variation in the levels of attributed members, and they sometimes do not understand the logic by which members were or were not assigned to the AE.

AEs: A "Fast-Track Path" and Learning Opportunity

EOHHS developed the AE Pilot quickly. In the same month that the legislature enacted the FY 2016 budget, August 2015, EOHHS published a request for information (RFI). Approximately two months later, in late October 2015, EOHHS published the program description and application process, relying in part on responses to the RFI. According to the state's "AE Roadmap," an exhibit in the state's 1115 demonstration, the pilot was designed as "a fast-track path and an opportunity for early learnings." It also notes that the AE pilot participants "provide three different models of Comprehensive Accountable Care, which will allow significant opportunities for evaluation going forward."[22] The next section examines interview perspectives regarding whether and how the AE Pilot eased participation in, or led improvements in, the full AE Program under HSTP.

FINDING 4: 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.

Given the accelerated timeline for AE Pilot implementation, interviewees said they had little time or opportunity to: (1) contribute to the development of AE Pilot requirements; (2) deliberate on the merits of participation; and (3) build the infrastructure and processes necessary for success. Advocacy groups felt especially strongly about the speed of the process being too fast. One interviewee commented that the state was trying to do in six months what typically takes three to five years.

In its discussions with CHCS, EOHHS applauded the efforts of early adopters and acknowledged the inherent problems with its accelerated timeline. It noted that it established this accelerated timeline in an effort to stand up the Medicaid Infrastructure Incentive Program under HSTP quickly, and get AEs needed funding. Nonetheless, EOHHS released an RFI for feedback and carved out several opportunities for stakeholders to submit comments and guide the AE Pilot and full AE Program under HSTP, including 13 stakeholder meetings.[23]

However, one MCO noted that it was "disheartened" when the state did not consistently seek advice from MCOs during development and refinement of the AE Pilot. The MCO noted that there were few learning or feedback sessions, and that most stakeholder engagement — if conducted — was to scope the AE Program under HSTP, not to refine the AE Pilot.

Another MCO noted that participation in an AE is a "big lift," requiring entities to build information technology infrastructure, care coordination processes, and new leadership and board structures. Additionally, once these organizations form an AE, they need to build a common infrastructure. In many cases, they may not share the same electronic medical record system or common tax identification number. The MCO noted that AEs first need to get to a "base starting point" before engaging in population health management. Because of this need for preparation and strategic planning, AEs could not achieve many improvements in the limited timeframe.

FINDING 5: 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.

AEs and MCOs noted the value of the state's more prescriptive approach in the full AE Program under HSTP. In particular, AEs, MCOs, and other stakeholders all spoke favorably about the selection of 11 core quality measures. AEs felt this standardization was helpful, eased reporting burdens, and was necessary to guide care delivery changes. While it recognized improvements in the state methodology, one MCO maintained that many aspects of the AE model seemed unnecessarily complex and required labor-intensive modifications to existing VBP programs.

In addition, interviewees generally spoke favorably about the availability of incentive funds through the full AE Program under HSTP. Several interviewees noted that these funds will enable investments in AE infrastructure, and are particularly integral to the success of the program in the absence of robust shared savings payments. One advocate noted concerns about sustainability and hopes that AEs use incentive funds to make one-time investments, rather than investments that require yearly support. Some AEs and MCOs expressed doubt about AEs' readiness to comply with the proposed transition to downside risk in future program years, and noted a lack of clarity surrounding this upcoming programmatic change.

AEs and MCOs highlighted areas in which the state could allow flexibility and accommodate more tailored VBP arrangements; however, these recommendations were often advantageous to an AE's or MCO's particular characteristics or position in the market. For example, one AE expressed interest in receiving a capitated rate, taking on full risk, and performing care coordination functions delegated by MCOs. In another example, one MCO noted that the state should consider requiring AEs to contract with all Medicaid MCOs, just as MCOs are required to contract with at least two AEs.

Many interviewees noted that, unlike other pilot programs, the state did not conduct an evaluation of AE Pilot results before implementing the full AE Program under HSTP. However, the embedded timelines in the state's 1115 demonstration made such a delay impossible. Instead, the state negotiated its demonstration project with CMS during the length of the AE Pilot and made modifications to relevant methodologies and program documents throughout the AE Pilot period. Interviewees generally noted the state has improved AE Pilot requirements over time, and many specific modifications to AE methodologies and state requirements were in response to early concerns about the AE Pilot.

Several interviewees supported a more measured approach to health care reform in the state, whereby the state avoids duplication by regularly evaluating and leveraging its existing programs. The interviewees noted that the state has carried out many programmatic changes in recent years, and recommended that it regularly take stock of their health care innovation programs and conduct more thoughtful evaluations of existing programs before rolling out new ones. Interviewees suggested that there may be an opportunity to reduce redundancies and leverage existing programs before investing in new infrastructure. For example, interviewees expressed interest in building on existing programs such as the Comprehensive Primary Care initiative through the state's State Innovation Model (SIM) initiative, as well as opioid treatment health homes. One interviewee commented that creating feedback loops and collaborative learning opportunities in a small state like Rhode Island is an easier undertaking than in other states, and recommended a more robust stakeholder engagement process. In the words of one interviewee, "everyone can get in the same room together."

Next Generation Managed Care: New Competencies

In its final report, the Working Group notes that MCOs should "shift care management and disease management efforts" to AEs and thus, the AEs should gain "new competencies." Accordingly, MCOs should "establish mechanisms to hold [AEs] responsible for care management activities"; excel at "producing, analyzing, and feeding back to accountable providers the data they need to manage their populations"; and "support the [AEs] in their population management efforts."[24] The MCOs should also "innovate in value-based purchasing strategies."

The next section describes how interviewees' assessments of the AE Pilot compared to the Working Group's vision for Medicaid MCOs. Specifically, the section discusses how: (1) the MCOs provided data to support AE functions; and (2) developed VBP strategies for the AE Pilot.

New MCO Competencies: Data to Support AE Functions

The Working Group noted that AEs would need data, and that MCOs would largely be responsible for providing this data. The Working Group's final report also noted one consistent challenge to addressing cost and quality in Medicaid: the "lack of accurate, timely, and actionable data on quality, cost, and utilization."[25] Describing this challenge, the report continued:

> In the current system, even if a provider wished to be accountable for cost and quality of a population, they are hindered by a lack of systematic and consistent sharing of data on cost, quality, and utilization of their populations. Patient follow-up after hospitalization is critical to reducing readmissions, but information transfer from hospitals to outpatient providers is suboptimal. Referral decisions are made without information about the cost or quality of laboratory services, radiology, or specialty services that might alter referral decisions for a provider that was accountable for the total cost of care.

> Medicaid must encourage and support the development and integration of robust systems to share and analyze health care data.[26]

In presenting its "Vision for a Reinvented Medicaid," the report noted that the MCOs would need to "gain new competencies," especially pertaining to providing data to the AEs. Specifically, the report states:

> In particular, as MCOs shift their care management and disease management efforts to the accountable entities, they will need to establish mechanisms to hold them responsible for care management activities. MCOs will need to become expert [sic] at producing, analyzing, and feeding back to accountable providers the data they need to manage their populations. Experience with the Medicare Shared Savings ACOs has shown that without actionable, timely data, providers are unable to effectively engage in activities to control costs and use services more appropriately. This includes data on quality and cost of hospital and specialty care, real time data on hospitalizations and emergency department use, and provider-level measures of

performance on quality, utilization and member experience. Primary care-based accountable entities will need support in data collection, analysis and use, and it is logical for MCOs to develop this competency and support the accountable entities in their population management efforts.[27]

This section discusses interviewees' assessments of MCO data feeds and related support, and how that support helped achieve the Triple Aim—"controlling costs, while improving health and the experience of care."[28]

> **FINDING 6: MCOs have created several care management tools, data feeds, and reports designed to support AE functions. However, most AEs noted they need more complete and actionable data.**

In their interviews with CHCS, MCOs outlined the resources they provide to AEs to support care management as well as cost and quality monitoring. These tools enabled MCOs to support AEs in developing their own care management and patient stratification activities, which are critical to achieving the goals of the AE Pilot and the Full AE Program under HSTP. One MCO described the data tools it provides to AEs, including information on utilization, hospitalization, baseline and interim reports on HEDIS rates, and gap reports. It also provides monthly reports on attribution and high-level cost information that flags high-cost, high-risk members for prioritization by AEs. Furthermore, the MCO developed a tool for AEs that aggregates all claims at the member level. Noting that AEs are at different levels of readiness, this MCO expressed the opinion that because it provides these data and has invested in resources to help AEs manage their populations, AEs do not need to build their own data management infrastructure. Rather, the AEs can utilize the reports that the MCO is providing them.

Another MCO discussed similar data sharing with AEs, including information on the highest-cost, highest-risk patients and rising-risk patients, as well as population-level cost data AEs can use to pinpoint high-cost patients. It shares quality reports at an individual practice level and helps AEs identify areas of improvement. This MCO also provides AEs resources to assist in care management. In particular, it partners clinical transformation consultants with two AEs to focus on follow-up after emergency department visits, primary care visits, and reducing TCOC. The MCO noted it is developing a detailed claims data feed, and provides support from its quality team on how to close gaps in care. These types of activities require a lot of support from the plan, and some of the reports that the MCO is developing go beyond what it has historically shared with provider networks. These activities suggest that MCOs are developing new competencies to support AEs with data and help them enhance care management.

Despite progress toward Next Generation principles, the challenges outlined in the Working Group's report—a lack of accurate, timely, and actionable data on quality, cost, and utilization—persist. All six AEs mentioned that MCOs did not provide claims data with sufficient patient-level cost information, which made it difficult for AEs to determine whether they were successfully managing patient-level TCOC and identify opportunities to reduce costs. If claims data were shared, the data were often limited or delayed. AEs noted, and MCOs confirmed, that MCOs do not provide AEs with paid and allowed claims data. One AE received claims data with a proxy price, a more robust data set than those received by other AEs; however, that AE nonetheless felt it needed a more comprehensive data set with paid and allowed claims data. The interviewed MCOs noted that there are barriers to sharing paid and allowed claims data, such as: (1) concerns about releasing proprietary information and safeguarding competitive advantage; (2) confidentiality restrictions in MCOs' network provider contracts; and (3) inadequate analytic capacity at the AE level. Two of the three MCOs noted they would consider sharing more detailed claims data if the AEs were subject to downside risk, though increasing risk sharing would likely not address the barriers noted above.

Several AEs noted they receive claims data for VBP contracts with other payers, including Medicare and commercial plans. Two AEs mentioned the availability of Medicare claims data under the MSSP as an example, although Medicare fee-for-service methodology is standard across providers and does not involve the same concerns about proprietary pricing information. Because they receive more complete data through other VBP programs, AEs know what level of data sharing is possible, and one AE said that it would not participate in the AE Program in the future if it could not get adequate access to claims data.

Timeliness of data from plans, including hospital admission, discharge, and transfer data, was also cited as an issue by several AEs as well as other stakeholders. One AE said it receives emergency department data from one MCO on a daily basis, but says it should be receiving more frequent updates—perhaps every 15 minutes. Since many of these data are transmitted after a patient is discharged, this information is not actionable for hard-to-reach members who could be contacted while they are in the hospital if real-time data were used. AEs often described attempts, some more successful than others, to interface with organizations that were unaffiliated with the AE, but served attributed members, and looked to MCOs as a potential partner for this effort.

Several other AEs echoed this sentiment, saying they need more actionable data, and that the data they are receiving are not being shared frequently enough to allow for course-correction. Two AEs said claims data are delayed by three months. Data from one MCO, according to another AE, are only available through the MCO's website, making it inconvenient to access. The same AE said it had not seen TCOC data for more than a year.

New MCO Competencies: VBP Strategies

According to the Working Group's final report, Next Generation Medicaid MCOs should "innovate in value-based purchasing strategies" and find ways to support and monitor AEs. Under its contract with the state, each MCO had to enter into a contract with at least two pilot AEs. However, EOHHS "strongly encourage[d]" MCOs to contract with all pilot AEs.[29] EOHHS stipulated that these contracts should include some variation of a shared savings model, based on: (1) a measurement of TCOC that would allow comparison of actual AE performance against a projected baseline or benchmark; and (2) a quality score factor applied to a shared savings pool.[30]

The AE Pilot description also noted that "the specific terms of the savings and risk transfer between the MCO and the AE are at the discretion of the contracting parties." EOHHS did not "intend to stipulate the terms of these arrangements but [did] reserve the right to review and approve them."[31]

> **FINDING 7:** **While five of six AEs established at least one VBP contract, most AEs noted that they did not actively negotiate their shared savings contracts with MCOs, and both MCOs participating in the AE Pilot said that state requirements did not provide enough flexibility to allow for much negotiation or customization.**

In a document released in January 2016, EOHHS provided guidance to MCOs on TCOC methodology for pilot AEs. That TCOC served as the projected cost for an AE's attributed population based on historical baseline or benchmark cost of care data. The guidance specifically stated the TCOC requirements were intended to "support the goals of the AE Program and Reinventing Medicaid Initiative" and "allow variation in pilot methodology."[32]

EOHHS required MCOs to describe the following elements relating to TCOC: (1) Covered Services; (2) Historical Benchmarking; (3) Performance Time Period; (4) Cost Trend Assumptions; (5) Impact of Quality and Outcomes on Distributions; and (6) Exclusivity of Approved TCOC Methodologies.[33] To "help ensure that any cost savings that are realized are due to improved care and outcomes rather than denial of care," EOHHS required "an appropriate quality score factor [to] be applied to the shared savings pool to determine the actual amount of the pool eligible for distribution."[34] MCOs selected HEDIS quality measures and established benchmarks for the quality score factor.

In general, EOHHS wanted to allow TCOC arrangements between MCOs and AEs during the pilot to be flexible enough to account for heterogeneity between AEs, but were open to requiring more uniformity if there were concerns about program evaluation, fairness, and sustainability. For example, the state initially allowed one MCO to implement a risk adjustment methodology for its cost benchmark that rewarded historically low-cost providers, but tightened imposed limits on this methodology over time.

However, most AEs stated that they had few opportunities to negotiate or tailor payment agreements with MCOs, and that these contracts were presented under "take-it-or-leave-it" terms. AEs often expressed discontent with the terms of these agreements, as well as the quality and cost data integral to their execution. For example, AEs often noted that the MCO's AE performance data provided an inaccurate, inconsistent, or incomplete view of the AEs'

progress or sustained success. Many AEs expressed frustration with and suspicion of MCO partners, and some AEs felt they received unfair contracts with unattainable expectations. AEs questioned what the MCOs and the state discussed behind closed doors and how that impacted them.

MCOs suggested that they had little time or opportunity to allow for that negotiation process given the AE Pilot's accelerated timelines and the specificity of state requirements. While the AE Pilot was intentionally flexible, the state did impose some more prescriptive requirements. For example, EOHHS limited risk adjustment of the cost benchmark and required that the TCOC trend reflect the trend in the medical component of MCO capitation rates—a particularly low figure, as compared to other Medicaid managed care programs. When combined with the rate adjustments made in anticipation of savings created a narrow band of opportunity for AEs and MCOs to meaningfully share savings.

All three Medicaid MCOs noted that, in general, the AE Program is complex and does not allow MCOs to build VBP arrangements in the way they would prefer. One MCO noted that the state aspired to a "grandparent-parent-child" relationship, whereby the MCO — the "parent" — had ultimate authority over its relationship with the AE — the "child"; however, MCOs noted that the state — the "grandparent" — often intervened in the MCO-AE relationship more than expected. Another MCO noted that the AE Pilot has required significant modifications to their existing model and has made consistency across markets difficult to achieve. Two MCOs noted that the inclusive nature of the AE Program approach — and its participants of diverse sizes, types, and affiliations — has also contributed to the complexity of the program.

One MCO felt the AE Program could be improved by simplifying the TCOC measures. In a "Lessons Learned" document produced by the MCO at the state's request, this MCO observed there would likely be increased buy-in from AEs if the TCOC methodology was easier to understand, but still flexible enough to allow for differences in AE readiness.

Recommendations

The AE Pilot has officially ended, and six AEs are certified for participation in the full AE Program under HSTP, which began in July 2018. Based on the qualitative feedback gleaned from stakeholder interviews, CHCS recommends the following for ongoing state support of the AE Program.

1. Ensure AEs Have the Data Necessary to Succeed.

In its final report, the Working Group envisioned a close and evolving relationship between AEs and MCOs. AEs would engage in care coordination and care management, bringing that function closer to the point of care for the member, and Next Generation MCOs would help oversee and facilitate those processes.

While the Working Group recommended that MCOs develop expertise in "producing, analyzing, and feeding back to accountable providers the data they need to manage their populations," AEs clearly expressed that they needed better data to manage their populations. Although information was shared pertaining to quality and utilization, very little, if any, cost data were shared, and even less of that data was timely enough to be actionable. The AEs are on the frontline of this transformation effort, and they should feel empowered to make the necessary delivery system changes to execute the Working Group's vision. While divulging proprietary information around pricing and cost is a legitimate concern for MCOs, the AEs, MCOs, and EOHHS should work together to enable sharing of more timely and actionable data, including appropriate information on cost.

2. Foster Open Communication and Trust.

Rhode Island has an established Medicaid managed care program, and its MCOs are consistently given high ratings by the National Committee for Quality Assurance.[35] The introduction of a different type of entity (in this case, AEs) is bound to cause some disruption. However, the accelerated timeline for the AE Pilot seemed to exacerbate the

inevitable frustrations and suspicions that arise during this sort of transition. Both AEs and MCOs expressed frustration with the pace of change during the AE Pilot period and their ability to inform those changes, even if EOHHS was constrained by federal timelines.

But more troubling than the AEs' and MCOs' distrust of the state was their level of distrust with each other. To rebuild trust among AEs, MCOs, and EOHHS, the state should consider taking steps to foster open communication and trust among partners in the full AE Program under HSTP. In this vein, HSTP may benefit from a more structured stakeholder engagement process around programmatic changes from year to year, such as in-person meetings and open comment periods, which could give AEs and MCOs more opportunities to inform program requirements. EOHHS could also conduct periodic listening sessions for AEs, MCOs, or even a broader stakeholder audience, to take suggestions and discuss potential solutions. In addition, communication between the state and its AEs and MCOs could be improved by developing a communications strategy for the full AE Program under HSTP. In addition to state-produced guidance and regulations posted on the EOHHS website, the state could follow the practices of other states, like the New York Delivery System Reform and Incentive Payment Program,[36] which distributes regular updates, guidance, and best practices through a voluntary email listserv and dedicated Twitter account. CHCS' technical assistance program and learning collaborative for AEs, to be developed in Fall 2018, can also serve as a forum for these state updates.

To encourage stronger and more trusting partnerships between MCOs and AEs, EOHHS may also explore ways to increase transparency in MCO-AE negotiations. While it may not be necessary, nor advisable, for EOHHS to actually participate in the negotiations, the state could issue specific guidance on shared savings contract negotiations, such as specific terms of engagement on payment negotiations, a model contract, or a guide that clearly shows what standardization the state requires and what flexibility the state permits.

3. Modify Incentives to Encourage Additional Participation.

EOHHS could also consider ways to enhance the incentives for participation in the full AE Program under HSTP. Most AEs expressed continued support for the goals of HSTP and the full AE Program, despite their frustrations with the AE Pilot Program. Specifically, the AEs expressed approval of the AE incentive program funds that will be available under HSTP, and hoped that these funds would enable investments that the AE Pilot had not.

In the absence of state budget changes, EOHHS may consider implementing changes to the shared savings model that would allow AEs to achieve higher proportions of savings. For example, in addition to attainment of a "High" or "Medium" benchmark, the quality gate for the AE shared savings model may be tied to quality improvement, rather than performance versus peers. Currently, EOHHS's preferred methodology only considers improvement when the AE score is below the defined "Medium" benchmark target, but shows meaningful improvement over the prior year's performance; in this case, a 50 percent measure score is applied. If AEs can receive higher portions of the shared savings pool by demonstrating substantial quality improvement, not just attainment of a static benchmark, AEs may feel more invested in the AE Program. For example, Minnesota's integrated health partnerships[37] program uses a points system to recognize quality improvement in the calculation of shared savings and population-based payments.

4. Strive for Simpler, Streamlined Requirements, but Continue to Provide Some Flexibility.

States designing VBP initiatives consistently wrestle with the tension between flexibility and prescriptiveness. It is difficult to strike a balance, and the state has achieved a commendable balance of both flexibility and standardization in the AE model. While each organization would probably support prescriptiveness in its favor, the AE Pilot's flexibility probably helped achieve stakeholder buy-in — especially in situations where AE and MCO interests were opposed.

While interviewees did seek more flexibility on some aspects of the AE model — for example, those that required substantial changes to existing structures and processes — interviewees often craved more prescriptiveness on other aspects. For example, interviewees consistently listed the 11 standardized quality metrics under HSTP as an

improvement over the AE Pilot. In addition, more novel requirements, such as requirements around SDOH, have pushed entities to explore how best to partner with CBOs and craft SDOH interventions, but left them the latitude to chart their own course on how best to accomplish this goal.

EOHHS may consider conducting an annual reassessment of program regulations and guidance to determine necessary changes based on stakeholder input throughout the year. During this process, the state may focus on modifying the program by: (1) removing non-essential requirements that contribute to the complexity of the model; (2) standardizing aspects of the program where there is broad consensus; and (3) allowing flexibility in areas where differences among AEs are great or innovation should be encouraged.

5. Let Iteration Drive Innovation.

All of the interviewees expressed commitment to VBP and the Triple Aim. HSTP has great potential, and Rhode Island has learned some valuable lessons from the AE Pilot.

As is often the case with VBP and ACO programs, it may take time to realize results. Studies have shown that more experienced MSSP ACOs achieve better results over time,[38] and similarly, Medicaid ACO programs in Minnesota and Oregon have achieved greater cost savings as their programs have progressed.[39] This timeline should not be a surprise, as changing business models from one based on volume to one driven by value requires a learning curve.

In addition, since iteration often drives innovation in Medicaid ACO programs,[40] Rhode Island should continue to build on successful aspects of the AE Pilot and revise its program as needed. A planned quantitative evaluation of the AE Pilot will also provide valuable feedback, from which Rhode Island can innovate its program further.

Next Steps

As the full AE Program begins under HSTP, EOHHS, AEs, and MCOs will need work together to build a program that achieves common goals and, most importantly, improves the quality of care for Medicaid enrollees in Rhode Island. It is clear from the interviews that all stakeholders remain committed to the full AE Program under HSTP and transitioning to VBP, despite issues with the AE Pilot. While transitioning from the AE Pilot to the full AE Program under HSTP will take significant time and effort, EOHHS and stakeholders are consistently looking at ways to improve the program in an iterative way. Along these lines, CHCS will be partnering with EOHHS to support AEs and MCOs through a learning collaborative and technical assistance program. There is a myriad of pressures associated with running a high-performing Medicaid program, but Rhode Island would be well-served to continue to develop its evolving AE Program over time. An evaluative, collaborative approach could allow the AE Program to thrive in Rhode Island for years to come.

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[39] R. Matulis and J. Lloyd. The History, Evolution, and Future of Medicaid Accountable Care Organizations. Center for Health Care Strategies. February 2018. Available at: https://www.chcs.org/media/ACO-Policy-Paper_022718.pdf

[40] Jim Lloyd, CHCS, "Medicaid Accountable Care Organizations Version 2.0 Underway in Minnesota and Colorado." Available at: https://www.chcs.org/medicaid-accountable-care-organizations-version-2-0-underway-minnesota-colorado/