Stakeholder Comments on Accountable Entities Roadmap

The draft roadmap that was posted on December 27, 2016 for comments included both an in-depth discussion of for vision, goals and objectives of Rhode Island under the waiver, as well as appendices that outlined initial details of programmatic guidance for AEs. As such, many of these comments received were more directly related to future anticipated guidance – either APM guidance, Incentive Program Guidance or Attribution guidance, and will be addressed as part of that public input process. There were a number of comments directly related to the roadmap and many provided valuable input to the final roadmap.

The following is a list of respondents and a summary of the comments received by thematic areas. *Comment themes in italics have been incorporated into the roadmap.* All formal comments have been posted on the EOHHS website.

Respondents

Blackstone Valley Community Health Center	Integra	RI Coalition for Children
Carelink	Kids Count	RI Community Action Agencies
Center for Treatment and Recovery	LeadingAge	RI Health Care Association
CHC ACO	Lifespan	RI Health Center Association
Coalition for Children and Families	Neighborhood Health Plan of Rhode Island	State of Rhode Island SIM Team
Coastal Medical	Partnership for Home Care	Substance Use and Mental Health Leadership Council
Disability Law Center	Prospect Health Services of RI	Tufts Health Public Plans
Economic Policy Institute	Providence Community Health Center	UnitedHealthcare

State Policy and Coordination

The following comments will be considered for inclusion in general policy documents, guidance documents and future iterations of the roadmap.

Comment Themes
Consensus support for AE program in general and direction of the roadmap, especially for the non-aged population
State should continue public input and stakeholder process and implement transparent evaluation process

State needs to review licensing and regulatory structures to allow and promote coordination between acute and primary care settings and behavioral health settings
AE program should coordinate with Dept. of Health on data and social determinants issues
Some concerns about the pace of program adoption, especially pace of APM adoption with downside risk
State should consider the creation of a peer-to-peer learning network
State should consider how the transition from pilot AEs to a full program would incorporate learnings
State should consider creating easy to understand materials about program for caregivers & families

Choice and Access

These comments are considered both in the roadmap, and in future program guidance

Comment Themes
State needs to ensure that if an AE member is being treated by a non-AE provider, the AE must have information on the treatment and access for the purposes of care coordination
State needs to ensure that an AE member is not precluded from seeking treatment at a non-AE provider
Oral health is not included in Road Map
Consider new population categories given care needs
Consider requiring an AE to serve all population categories
Specific needs of pediatric patients (both high-risk/high-cost and low-cost patients) need to be protected
Lack of capacity/experience in community-based coordination should be addressed

AE Certification

These issues will be considered in separate AE certification guidance and input process

Comment Themes
Governance structure is too burdensome, redundant, or prescriptive
Financial standards are too burdensome for smaller providers. DBR should have a role for risk bearing entities. Financial contracts are private between payer and provider
Patient access and availability standards are too prescriptive
State should relieve certification renewal burden (move to every 3 years) and not duplicate certification process for different AE types for same AE
Providers in an AE should have integrated data systems, but should not be required to have the same platform
Various comments on details of certification standards • Accreditation entities • Specific capabilities • SA treatment

State needs to ensure effective data transparency on risk, claims and clinical data to allow AE to effectively coordinate care
State should consider including Social Determinants of Health in risk profiling for health needs

Alternative Payment Models

These issues will be considered in separate APM guidance and input process

Comment Themes
Varying opinions on levels of flexibility afforded to AEs and MCOs to develop APMs. Some comments favored broad flexibilities for AEs based on the varying levels of readiness to move to APMs. Others sought a more standardized process to limit variation between payers.
State should set benchmarks and trends so that historically low-cost providers are not penalized
Total Cost of Care calculation should exclude, or account for, certain additional cost (infrastructure, rising pharmacy, social determinants)
Move to downside risk may be too fast / might not allow for full infrastructure investment
APMs for LTSS will need even more time to mature
APM development for specialized AEs should be separate from other APM development

Attribution

These issues will be considered in separate attribution guidance and input process

Comment Themes
Attribution methodology should be transparent to AE, MCO and patient
Type 2 (IHH) attribution policy is split – some wish to stay with IHH, some call for move to PCP
Attribution should follow PCP if PCP moves AE
State should consider patient choice and appeal process for final attribution

Delegation

These issues will be considered both in AE Certification Standards as well as Incentive program guidelines

Comment Themes
Varying opinions on statewide data infrastructure versus MCO data sharing, data feeds from MCOs and MCO analytics vs. AE analytics
Varying opinions on level of activities delegated from MCO to AE as mandated by state (some call for full MCO freedom, other identify necessary delegable activities) • Care Coordination • Basic Needs Management • High risk population identification • Network Development

AE Incentive Program

These issues will be considered in the Incentive Program Guidelines

Comment Themes
Concern that structuring payments as reimbursements is unworkable
Incentive payments should include investment in LTSS to support the move to APM
Varying opinions on whether payments should flow through MCOs or directly from EOHHS to AEs
If MCOs administer payments, varying opinions on standardizing method to determining amount and payment schedule
Performance milestones to receive payment should move from process to outcome, and should be uniform for all AEs
Various suggestions for targeted uses of incentive payments • HIT • LTSS housing needs • Community Health Teams • Person-centered training • Gaps in pre-conception and pre-natal care • Young adult transitions

Quality Scorecard

These issues will be addressed in separate Quality Scorecard as part of the APM Guidance and input process

Comment Themes
Clarity is needed in role of the scorecard (menu vs. standardized metrics)
Scorecard metrics should be the same for incentive program and for TCoC APM program
Scorecard performance should be based on improvement to benchmark, not just performance
Scorecard should be a multiplier of savings, not a gate to participation
Scorecard should be more directly linked to SIM
Utilization measures will be captured in TCoC
Social determinant, community-based services, patient-centered and children's health measures should be included
Certain proposed measures have collection, validation, redundancy or statistical significance issues: • SNF measures • Schizophrenia measure • ADHD measure

Reporting

These issues will be considered in future program guidance

Comment Themes
Consensus that reporting methods and formats should be standardized
MCO reporting on AE performance should be standard, regular and actionable for AEs
Reporting should include measures of patient choice and provider accessibility

Social Service Integration

These issues will be addressed as part of the AE Application/Certification standards

Comment Themes
Integrator capacity is already in existence in most provider settings
Community-based services may not exist in all geographic locations
Consider co-location for social service integration
Some social issues are not always included in social determinants of health, so capacity for connection should be wide-ranging
Integrated behavioral health models need specific attention in social service coordination
Funding for social service integration should be included in AE payment, and funding for services themselves should be braided into TCoC in future years

Specialized AE Pilot

These issues will be considered in the creation of program policy and materials for Specialized AEs.

Comment Themes
Ongoing implementation of ICI poses a challenge for Specialized AE (SAE) implementation and financial benchmarking
Delegation of authority to SAEs for service approval is unclear
Patient and family choice must be considered in SAE model
State should conduct study of nursing home capacity in state to inform move to full SAE program for LTSS
LTSS and Pre-Medicaid should be a single AE model
Quality Scorecard for SAEs may need to be different than for Comprehensive AE
Allow Comprehensive AEs to also certify as SAEs
Role of home care in SAE needs more clarity
Role of behavioral health in SAE needs more clarity
State should consider nursing home bed buy-back or streamlined bed transition to support multiple care settings