Memo

To:	Debbie Correia Morales, Senior Consulting Manager, Conduent/EOHHS
From:	Patrice Cooper, CEO, UnitedHealthcare Community Plan of Rhode Island
CC:	Renee Rulin, MD; Leslie Percy, UHC
Date:	September 18, 2017
RE:	EOHHS Incentive Program Guidance for the AE program dated August 18, 2017

UnitedHealthcare (UHC) believes that a Provider Incentive Program designed to stimulate and support practice transformation, providing necessary funds to MCOs and AEs, is vital to the overall success of the AE program. The total level of funding, in aggregate, outlined in the guidance should be sufficient to enable MCOs and AEs to establish tools and resources that will create sustainability of the program. UHC believes that the funding should be weighted more towards program year one, slowly scaling back funding over the four program years as AEs are able to rely more on tools and processes that will need to be implemented up front. UHC also recommends that EOHHS pay close attention to how the various AE program components – attribution, TCOC calculation, Quality performance, and Incentive program - align to create a cohesive program focused on the Triple Aim.

AE Program Advisory Committee: UHC believes that an advisory committee will be able to drive consistency in approach and share best practices across AEs and MCOs in Rhode Island. UHC is hopeful that EOHHS will allow MCOs and AEs enough flexibility in their contractual arrangements to focus on incentive programs that will be meaningful and measurable for the MCO/AE specific population. This committee is the oversight committee and could serve as forum for EOHHS to review and approve any program submissions. Timely responses will be key to keeping overall program on track to achieve its goals.

Total Incentive Pool: AE incentive program funding suggested in the guidance document should provide sufficient cash flow to AEs to invest heavily in practice transformation. However, UHC believes that AEs are in need of initial funding to jump-start this effort, allowing for measurement and target setting once the AEs have hired staff and invested in technology (3 - 6 months after initial funding). The MCO funding level, on the other hand, does not seem sufficient to support the additional resources necessary in order to hire and deploy clinical transformation teams to work with and support the AEs in practice transformation. Additionally, while UHC understands the desire to reward MCOs for contracting a greater number of AEs, consideration must be given to the membership thresholds and other requirements that may be put in place that will prohibit MCOs from contracting with all approved AEs.

AE Specific Incentive Pools: The UHC Provider Incentive Program accounts for membership changes month by month, supporting AEs with funding that reflect the number of members under their care. We have seen membership grow and decrease over time within individual AEs – UHC believes that setting the membership level PMPM based on membership only at the beginning of the program year may either over or under-fund AEs. Program Year one should reflect a higher base incentive pool as a percentage of total incentive, which should be paid up front to the AE to allow for investment in the tools and resources needed to build the program.

Health System Transformation Project Plans: UHC believes that partnering with individual AEs in creating project plans to transform the way care is delivered is an important driver of success. Not only does this ensure AE engagement but it also allows for common goals to be developed between the entities. While UHC understands that this is not a grant program, it is important to set reasonable goals and measures to allow for the necessary funding in the early stages of the program. UHC has found that without initial investment both from the MCO and the AE, the program will not be able to get off the ground.

1. **Specifications:** UHC believes that data analysis is able to uncover population specific opportunities within AEs that may be specific to each AE. This analysis should be done on a routine basis and discussed between the clinical teams of the MCO and AE in order to drive reductions in total cost of care, regardless of whether or not the specific opportunity is defined within a PMPM incentive program. UHC has found that consistency in measures across AEs has the ability to dramatically impact outcomes and reduce drivers

of total cost of care, without creating a significant administrative burden. UHC feels that if projects are required to be unique by AE and MCO, focus on each project will wane as resources are being pulled in multiple directions. On the other hand, finding high level drivers of cost and creating projects that can be consistent across MCOs and AEs will improve the success of achieving positive outcomes.

2. **MCO Review Committee:** UHC will ensure that the project plans align with EOHHS' goals and priority areas. However, UHC does not believe that detailed oversight by EOHHS on an MCO committee is needed in order to ensure state engagement. UHC will participate and collaborate actively in the Advisory Committee described above.
3. **Required Structure for Implementation:** It is UHC's intention to build the incentive program requirements into the underlying AE agreement. However, if active contracts with an existing AE already exist, UHC would need to amend the current AE agreement to incorporate the terms of the incentive program. The UHC contract paper has been approved by the Department of Health – UHC believes that requiring additional approval on an amendment to incorporate the terms of an incentive program defined by EOHHS is duplicative and will slow the speed to implementation.
4. **Reconciliation**: UHC requests more time to turn around the payment to the AEs after receipt from EOHHS. Our standard payment terms allow for the incentive payment to be paid by the last business day of the month following the applicable (measured) month.
5. **Project Plan Modifications**: It is UHC's intention to build, implement and monitor the project plan and goals attached to this. Requiring additional oversight and approval will create an additional level of administrative burden that will slow down the process and inhibit the ability to make changes as they may be needed.

EOHHS Priorities: One of the core drivers of the AE program and any ACO program is to improve quality, reduce costs and increase member engagement and satisfaction with the health system. These goals are not listed within the document as priority measures.

Allowable Areas of Expenditure and Required Performance Areas and Milestones: UHC fully supports transitioning from readiness domains to system transformation domains over time. As previously mentioned, funding will need to be provided to AEs in order to allow for investment in technology and staff to build the infrastructure for care transformation. That said, the first part of program year 1 (3 – 6 months) should be specifically focused on the readiness domains and developmental milestones, allowing sufficient time for the AE to receive the funding necessary to be measured on metrics and outcomes.

UHC believes that the MCOs should be given the ability to set measureable milestones and targets as part of the project plan. The Advisory Committee should give guidance on necessary parameters – the MCOs need to ensure that they have the ability to operationalize the measurements. Additionally, payment tied to capacity to take on risk in program year one is not realistic for most AEs.

Attribution: Although not addressed in this document, it is UHC's understanding that EOHHS is reevaluating the 5,000 enrollee minimum /AE requirement. UHC has implemented TCOC models for <5,000 enrollees however there is an increased risk of variability. The 5,000 enrollee minimum for a population is assuming all the contract terms, thresholds, risk levels, etc. are equal/equivalent. When the 5,000 is split 3 ways, the terms of the measurement changes and are not equivalent between the 3 AE-MCO contracts. The small sample risk still exists within the individual AE-MCO contract and is not mitigated; it is only mitigated when the whole population is above 5,000 enrollees in total. Operationally, each MCO is blind to the other MCO-AE contract relationships to accommodate any adjustment for the larger population. For these reasons MCO contracts with AEs with <5,000 enrollees may not make sense for either party.