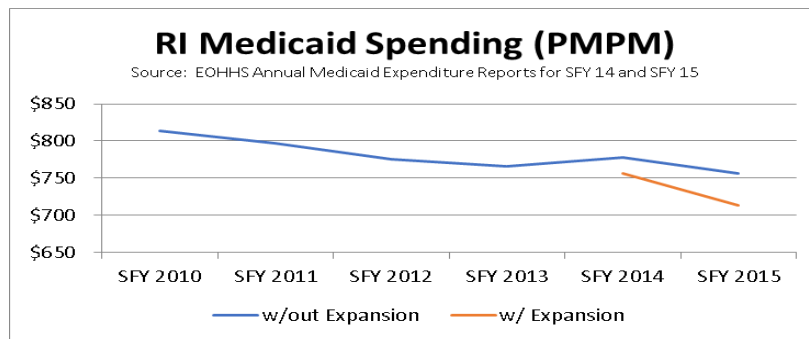


EOHHS Accountable Entity Project Team

August 17, 2017

Dear EOHHS Accountable Entity Team:

Thank you for the opportunity to comment on draft Total Cost of Care (TCOC) guidance and the draft Quality Framework addendum. A lot of hard work and serious consideration clearly went into both documents. Any analysis of the Accountable Entity (AE) program must start from the baseline acknowledgement that RI’s Medicaid program has experienced per-member-per-month (PMPM) cost reductions in four of the past five State fiscal years. Average PMPM costs were 7% lower in SFY 2015 than they had been in SFY 2010. To be successful and sustainable, the AE program must look beyond cost trends and focus financial incentives on bona fide improvements in quality, outcomes, and the patient experience of care.



RIPIN is supportive of a transition away from fee-for-service towards payment methodologies that promote coordination amongst providers, lower costs for payers, and incent better quality, outcomes, and satisfaction for patients. Any such transition, however, must be mindful of the risks created by new financial incentives, and must place appropriate financial emphasis on improved quality, outcomes, and patient experience. RIPIN also appreciates that the AE program is being built in partnership with our State’s high-performing Managed Care Organizations (MCOs), and that MCO networks are being leveraged to ensure patient access to care.

RIPIN has concerns about two aspects of the draft guidance:

1. Quality, Outcomes, and Patient Experience of Care – Though the Quality Framework has many strengths, the TCOC model must still place stronger financial emphasis on bona fide improvements to quality, outcomes, and patient experience of care.
2. Financial Risk – EOHHS must closely monitor to ensure that AEs do not assume undue financial risks.

Quality, Outcomes, and Patient Experience of Care

As currently constituted, the TCOC model places more financial emphasis on cost reductions than on improvements to quality, outcomes, and patient experience (hereinafter generally referred to as “quality”). For example, AEs that beat cost projections can receive shared savings bonuses even if they merely maintain quality or, in some cases, even if quality decreases (depending on the AE’s quality tier). An AE with costs in line with projections, however, cannot receive any bonus even if the AE shows significant quality improvements and/or is a historical high-quality provider. RIPIN believes that these types of imbalances should be mitigated to the greatest extent possible. The following changes, for example would help to achieve this goal:

1. RIPIN strongly recommends that the model incorporate bonuses to quality high performers (and/or those showing strong improvements) regardless of cost performance. Money to finance these bonuses can be garnered from the savings pool of AEs that are not eligible for full shared savings distributions based on their own quality scores. (It is difficult to tell from the Quality Framework, but it appears that many AEs will not be eligible for 100% of their savings pools based on quality scores.)
2. No AE that shows statistically significant decreases on a quality measure should receive a passing score for that measure. The State should not reward cost reductions achieved at the expense of quality, even for historically high-quality AEs.
3. Shared loss risks should be scaled based on quality measures, just as shared savings are. An AE that overshoots its cost projections but also shows significant improvements in quality should not face the same fiscal penalties as an AE that overshoots on costs but fails to improve quality.

RIPIN also strongly encourages EOHHS to report AE quality measures publicly on a regular basis, whether as part of the EOHHS Medicaid Expenditure Report or in some other document.

RIPIN also strongly supports many aspects of the draft Quality Framework, including (i) the use of a unified State-controlled measure set, (ii) the Framework’s thoughtful consideration of how both to reward historical high performers and also reward improvements by others, (iii) the use of cross-MCO reporting for AEs contracting with multiple MCOs, (iv) the measure set’s alignment with SIM, and (v) the inclusion of a measure designed to highlight the importance of social determinants of health.

Financial Risk

Nobody wants an AE to go bankrupt. The draft guidance, however, requires progression to “meaningful downside risk” without creating any effective State agency oversight of the risks being assumed by AEs that follow the State’s proposed risk progression schedule. EOHHS is also yet to specify, in AE certification guidelines or elsewhere, the fiscal and risk capacity standards that it will apply to AEs. The draft TCOC guidance nonetheless proposes specific risk levels that AEs must be willing to bear, and asks stakeholders to comment. It is very difficult to

determine if those risk levels are reasonable without understanding the AEs' risk capacity. This approach – laying out proscriptive risk requirements for AEs before nailing down risk capacity guidelines – feels imprudent.

The risks being proposed are substantial, far more so than the draft guidance seems to indicate. For a primary care based AE (of which there are many), 1% of TCOC will equal about 10% of the AE's own revenue under the contract. The table on page 8 of the guidance also shows risk levels based on the minimum risks required, not the maximum levels allowed. In year 3, for example (year 1 of risk), an entity would be allowed to bear 50% (or even more) marginal risk, up to a cap of 5% of TCOC. That would create a "total risk" of 2.5% of TCOC, which would be about 25% of contracted revenues for a primary care based AE. Can RI's AEs bear that level of risk?

RI Medicaid's negative cost trends also exacerbate this risk. If TCOC targets are based on projecting costs with negative trends, then even an AE with level costs can be at financial risk.

When discussing a similar topic at OHIC's APM committee, several ACO leaders, including Integra and Coastal, expressed serious concerns about their ability to bear risk at similar levels. In the Medicaid context, with many community health center AEs, the concern about financial capacity to assume risk is even greater.

This is not also an area where industry should be policing itself. Beyond the obvious risk of disruptions to patients, workers, and the healthcare system if a provider goes broke, providers facing large financial risks may be more likely to mitigate those risks by restricting patient access to care. A long history of insurance and banking regulation shows that industry players themselves are not always the best protectors of the public's interest, and also that the risks and rewards of the industry and public are not always perfectly aligned. A publicly-accountable entity should have a role in protecting the public against these risks.

RIPIN strongly recommends that EOHHS or some other State entity take more responsibility for ensuring that risk-bearing providers have the financial and operational wherewithal to manage the risks they are assuming. The risk-monitoring model employed for ACOs in Massachusetts should be studied as a starting point.¹

¹ See MGL Ch. 176T and 211 CMR § 155.00

Conclusion

Thank you again for the opportunity to comment on the draft TCOC guidance and draft Quality Framework. It is clear that a great amount of work and thought went into both documents. With an appropriate financial focus on quality and acknowledgement of the new risks being created, the AE program has the potential to promote coordination amongst providers, lower costs for payers, and incent better quality, outcomes, and satisfaction for patients.

Also attached to this document is a mark-up of the TCOC guidance (in pdf) with some comments on wording and the like. If you have any questions, please do not hesitate to contact me.

Sincerely,

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