EOHHS Total Cost of Care (TCOC) Guidance
Neighborhood's Comments and Questions

Neighborhood Health Plan of Rhode Island is pleased to have the opportunity to review The Executive Office of Health and Human Services (EOHHS) Total Cost of Care (TCOC) Guidance document of July 7, 2017 to understand the guardrails for the post-pilot model development. The Guidelines are very comprehensive incorporating elements based on statistically advanced methodologies which should prove useful as we move towards progressively higher levels of risk-sharing as the program matures and advances to two-sided risk in the coming years.

1. In the State/MCO Capitation Arrangement section, please explain if "Capitation adjusted for savings/risk" is a continuation of the current approach whereby EOHHS adjusts our rates for "assumed savings"? If so, please submit the underlying data and assumptions to support the assumed savings.

Also, with reference to the "No gain share between the state and MCO" provision in the same section, please note that our current arrangement allows for the entire shared savings pool to be included in risk share calculations. Is this changing? If so, please submit the assumptions used for this change.

2. Neighborhood will continue to use the cost trends at the rates we are receiving in our reimbursements as indicated and detailed in the EOHHS rate books. The trends used to calculate these rates are not reflective of recent experience or prospective performance. As indicated on various occasions and detailed in comments submitted on the Road Map document, Neighborhood believes that the sustainability of the program depends largely on a reasonable cost trend and elimination of, or reduction in, the budgeted savings assumed upfront as discussed in number 1 above.

3. Neighborhood will continue to use Fiscal Year July to June cycles for the benchmark and performance periods consistent with the 2017 Medicaid LOB Contract requirement (section 2.08.02.01). Neighborhood informed EOHHS via email on 6/30/2017 that all assigned members will be included in the post-Pilot phase, starting with the current contract period of 7/1/2017 to 6/30/2018.

4. Neighborhood suggests a more easily intelligible model construct to ensure that all parties feel comfortable with the methodology used to build targets and evaluate performance, recognizing that even within a simpler framework many relatively complex concepts will have to be incorporated. Similarly, a progression from the current Pilot model need not be significantly different since the key goals are already reflected in Pilot methodology albeit using different terminology. In addition the proposed guidelines need to be balanced against the specific experience of the healthcare market under consideration, such as the maturity of the market in establishing value-based care. The following suggestions are in concert with this objective:

> a. There is a large variation in AE memberships' risk profile from period to period in the last few years since risk score measurements became available. Therefore in the first year following the Pilot model adjustment for *change* in the risk profile of AE membership over time should be applied within a limited corridor that can be progressively wider in future versions.

Please provide an example of incorporating a *change* in risk scores over time in both the benchmark and performance years – it is not illustrated in any of the hypothetical examples in the Guidelines document.

b. Adjustment for historically low-cost AEs is already being accomplished in the Pilot methodology via the use of efficiency factors. Historical Performance adjustment in the Guideline examples can be best achieved with the use of efficiency factors, a concept currently used by major predictive models, such as Milliman and DxCG. This adjustment is limited to a 50% weight for efficiency-adjusted costs in the current Neighborhood's Pilot model as approved by EOHHS. To not make a similar historical adjustment for high-cost AEs, even if to a lesser degree, would act as a disincentive in achieving the larger goal of cost-efficiency.

Also, MCO risk-adjusted average PMPM should relate to the AE space. Non-AE space includes high cost duals as well as Exchange (QHP) populations with high co-pays and deductibles which lead to different utilization patterns compared with those of Medicaid population.

c. While the probability of savings by chance based on the Monte Carlo exercise is a statistically sophisticated and valid approach suggesting savings as a result of chance to be between 0 and 27%, it may be best at this stage of the risk-sharing initiative to follow a simpler approach. Neighborhood's contracts already include a provision to limit sharing if savings are in excess of 5% of target for AEs with fewer than 5000 members. Our recommendation is to continue to use this provision. We also recommend retaining potential AE shared savings at the current 50% level instead of moving to a 40% level.

d. Neighborhood's position is to not include infrastructure payments made by MCOs to AEs, including payments such as CTC or PCMH-Kids, in covered services. These payments are more in the nature of infrastructure funding (similar to MIIP funds) and should not be a part of the costs in the risk-sharing model.

e. Neighborhood's position is to regard FQHC reconciliation payments as outside of the TCOC calculations and therefore these will not be factored into the calculations. The TCOC model is based on medical claims incurred by members, not on reimbursements or payments made to the AEs. Our position is to avoid unnecessarily complicating this calculation for changes that will not materially impact results.

f. To also not unnecessarily complicate the TCOC calculation and avoid duplication of adjustment factors, Neighborhood plans to not specifically exclude services that fall under stop-loss provisions between EOHHS and Neighborhood. Also, since these adjustments would be made in the benchmark years as well as in the performance period the impact is likely to be minimal.