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I am writing to offer comments on behalf of Coastal Medical on the Medicaid Program Accountable Entity Roadmap draft document dated August 30th, 2019. We appreciate the opportunity to provide comments on this document and are committed to the goals and objectives of the Accountable Entity program and ensuring that best practices and lessons learned through implementation are leveraged and incorporated into the State's overall vision of delivery system reform.

Alternative Payment Methodologies

EOHHS has stated that AE's and MCOs will progress to assuming downside risk as part of a qualified TCOC based contractual arrangement. In the September 13th AE Strategy Meeting, it was proposed that AE's take on downside risk of 2% of TCOC beginning in PY3. Coastal is unique amongst AE's in being a physician-led primary care ACO. Two percent of TCOC represents a financial risk that is excessive for an organization such are Coastal and does not sufficiently recognize the investment risk that the AE has to take to build the infrastructure required for this patient population. The OHIC policy on meaningful downside risk (in the 2019 APM plan) expresses that risk as a percentage of TCOC for ACO's that include hospital systems and as a percentage of FFS revenue for physician led ACO's. Track 1+ of the MSSP also expresses downside risk as a percentage of FFS revenue for qualifying ACO's (including Coastal) and now Track E Basic of the MSSP does the same. As such, we feel that downside risk should be a percentage of fee-for-service revenue rather than TCOC, at least for those organizations that do not include a hospital in their ACO.

Attribution

Attribution continues to remain a concern for AE's given the many issues regarding PCP assignment, auto-assignment of patients to a PCP, and the reported 40% or higher non-engagement rates of patients with PCPs. Enrollment of new patients continues to lack the ability to track a patient-identified PCP and the systems used by EOHHS are unable to identify when a patient switches from one MCO to another to ensure continuity of care. The impact of erroneous attribution is borne fully by the AE's and the financial model here is tenuous enough that attribution errors could determine shared savings success or failure on their own. We would advocate that EOHHS develop a process with the MCOs and AEs to fix the attribution issues in PY3 to ensure a more accurate and timely process.

Medicaid Infrastructure Incentive Program

At the September 13th AE Advisory Committee meeting, EOHHS proposed changes to the incentive pool determination based on performance in several categories including:

- 25% for RBPO contract
- 50% for quality outcome measures
- 25% for joint project-based performance measures achievement.

The majority of the incentive funding will not be earned by an AE until after the end of PY3. AE's have made significant investments in infrastructure and the current funding proposal does not provide a mechanism for pre-funding some of these expenses which are necessary to produce the outcomes EOHHS

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access to a percentage of the incentive money earlier in the performance year so that the AE's can continue to fund the work of their care teams and collaborations which aim to address the utilization and behavioral health needs of their patient populations.

Based on the discussion at the September 19th meeting, Coastal agrees with and recommends lowering the percentage for the outcome measure set to 25%, increasing the joint project based performance measures to higher percentage and adding a provision for quarterly milestone payments. In addition, Coastal recommends maintaining flexibility in determining the joint performance measures and allowing for overlap between the outcome measures and the project performance measures.

AE Certification Requirements and Program Monitoring, Reporting, and Evaluation Plan

EOHHS supports a closer partnership between the AE's and the MCOs as to foster meaningful change in the healthcare delivery system and to accelerate the progression towards value based arrangements to improve the quality and health of the Medicaid population. Coastal believes that building and maintaining a strong partnership with EOHHS and the MCOs are important elements in realizing the vision and goals of the AE program.

EOHHS proposes to meet with MCOs on a monthly basis to provide an opportunity to review program performance. EOHHS has emphasized the importance of AE's and MCO's working together to review the financial, operational and quality performance of the program. Coastal is concerned that meetings between the MCO and EOHHS without the AE present would undermine the effectiveness of such collaboration by limiting the dialog between the three parties. We recommend that the AE's are included in this process in order to meet EOHHS's stated goal "to foster strong and clearly defined roles and expectations for both the AE and MCO in transforming the delivery of care."

We are concerned that including the MCO's in the certification process while being excluded from monthly meeting with EOHHS and the MCOs will increase the administrative burden to the Accountable Entities rather than reduce that burden. Further, in the absence of direct guidance and structure around these joint applications the inclusion of the MCO may delay the certification process. As such we feel that a joint AE Certification requirement should also include a joint program monitoring, reporting and evaluation plan that includes all three parties: the AE, MCO, and EOHHS. We feel that this structure will enhance transparency, clearly set expectations of the AE and MCO, and will provide the greatest opportunity to achieve the goals and objectives of the AE program. If the AE's are unable to participate in the monthly MCO/EOHHS meetings, then a joint application does not make sense from the AE perspective.

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Conclusion

We are grateful for the work of EOHHS in transforming the delivery system for Medicaid patients. We appreciate the opportunity to participate in the AE Advisory Committee and to provide our written feedback.

Sarah Thompson, PharmD, MBA, MHL

Vice President, Clinical Operations and Pharmacy