

Memo to: Leah DelGiudice, RI Executive Office of Health and Human Services

From: Ray Parris, Executive Director, PCHC Accountable Entity

CC: Patrick Tigue, Medicaid Program Director, RI EOHHS; Dr. Jonathan Gates, Medical Director, PCHC AE; Ron Price, Chief Compliance Officer, PCHC; Melody Lawrence, Director of Policy and Delivery Systems, RI EOHHS; Edward Smith, Finance Director, PCHC

Date: November 9, 2019

RE: PCHC Public Comments for State of Rhode Island Medicaid Managed Care Program Year 3 Guidance (ET1)

Providence Community Health Centers (PCHC) is committed to partnering with RI EOHHS and the identified MCOs to produce the highest quality of care at the lowest cost within the Accountable Entity Program (AE). PCHC has reviewed the EOHHS proposed Policy Statements and has developed comments regarding the proposals.

Attachment H: AE Certification Standards PY3:

- The financial impact from the IHH assignment is a known quantity by the MCOs and EOHHS. PCHC is requesting an impact study regarding the change within the MCO's TCOC respective models. Until fully modeled, we are concerned about the long term sustainability of the AE program.
- Moving the financial incentive from the IHHs to the AE's effectively places the IHH into a Fee-For-Service arena while making the AE's accountable for the risks without oversight/management.
- We believe that many services provided by the IHH are duplicative, yet with the IHH having no incentive to reduce cost attributed to PCHC AE, they are functionally at risk of returning to a Fee-For-Service mode.
- PCHC requests the State takes the lead in coordinating a formal relationship between AE's and IHHs.
- PCHC feels EOHHS should develop a plan to incentivize IHHs for high quality and positive TCOC results based performance measures similar to the AE's. The IHHs need to more reliably and effectively bridge the 42 CFR-protected information gaps that currently exist.
- Regarding the pediatric population which requires a full continuum of mental health and substance use services, PCHC AE asks will those members be identified through the IHH program or CEDARs type of program?

Attachment J: AE TCOC Requirements PY3:

B. TCOC Methodology Goals

- PCHC has seen significant utilization increases with substance abuse conditions, and we expect this expansion of services provided to increase our TCOC beyond actuarial trends. We request EOHHS to undertake an analysis to calculate the Opioid Crisis' impact on the AE's TCOC models.
- PCHC is not currently receiving timely and/or complete data files from the MCO's.
- The current AE model does not allow a complete reconciliation between shared claims data and the final settlement number because of 42 CFR Part 2. Our care teams are also finding it difficult to care for our members because of the lack of data transfers.

Establishing TCOC Targets

- With the potential change in membership assignment from the IHH to the primary care basis, prior claims history that built the current target needs to be adjusted for the time of assignment. PCHC believes these members are significantly higher in cost from the average.

E. TCOC Reporting Requirements

- For transparency, PCHC believes any MCO submissions to EOHHS will be shared with the AE

Attachment K: Incentive Program Requirement:

Annual Reporting on Outcome Metrics

- PCHC AE views the heavily weighting "ED Utilization Among Members with Mental Illness (20%)" as a significant and inadequately delineated risk because of the current state of sharing data, and historical barriers to co-locating PCHC AE care managers within the emergency departments/inpatient settings. PCHC AE recommends reducing the significant weighting of this measure, or converting to reporting only, until data can be shared freely and the AE's will have thereby an ability to make an impact on the Mental Health related measures.

Attachment M: AE Attribution Guidance PY3:

2. Attribution based on actual primary care utilization

- Currently, the ending attribution list is the basis for the TCOC. PCHC request using the assignment on a month by month basis. The AEs are focused on our entire Medicaid population and we would not be measured for our full efforts, if the TCOC

is only calculated on the ending membership. The ending membership is subjected to significant impacts TCOC because of churn and State redeterminations efforts.

3.3 Hierarchy of Attribution for Comprehensive AEs

- Any MCO methodology for attribution should be consistent across all AE's. Express Care sites within an AE should not be a consideration for utilization attribution. A disproportionate share of higher utilizing members and their associated cost will be transferred from providers without extended hours to providers who have extended hours.

2.04.01 Changing PCPs

- Changing the assigned PCP process is currently initiated by the member. Frequently, during our outreach efforts, the member informs PCHC that they have a different (external) primary care provider. PCHC is unable to move the member's assignment in the current model. PCHC request to be able to move the member's enrollment to the correct primary care provider or task the MCOs with validating attribution when conflicts arise.