A. Respondent Information

Prospect Health Services, RI, Inc. (PHSRI) is pleased to submit our comments on the RI Medicaid Accountable Entity PY3 Guidance Documents.

1. Contact Information

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2. Organization/Organizations Represented by this response

Prospect Health Services RI, Inc. (PHSRI)

B. Comments on Accountable Entity PY3 Guidance Documents

Overview

We would like to thank EOHHS for the robust engagement of AEs and other stakeholders in developing the PY3 Guidance Documents. We believe these guidelines make significant improvements to the AE program, most notably in the area of risk.

The AE Open Discussions have been a particularly welcome addition to the process this year. These meetings provided a forum for the free exchange of information and ideas on how to improve the design and implementation of the AE program. We encourage EOHHS to host similar meetings that convene all stakeholders outside the process of soliciting comments on guidance documents.

On October 9, EOHHS distributed the following DRAFT Program Year 3 Guidance Documents for review and comment:

- Attachment_H_AE_Certification_Standards_PY3_Draft_9-October-19
- Attachment_J_AE_TCOC_REQUIREMENTS_PY3_Draft_9-Oct-19
- Attachment_K_Incentive_Program_Requirements_PY3_Draft_9-Oct-19
- Attachment_M_AE_Attribution_Guidance_PY3_Draft_9-Oct-19

EOHHS solicited comments on the four PY3 Guidance Documents, with comments due November 9th.

ATTACHMENT H - Accountable Entities Certification Standards – Comprehensive AE

Section 1: Breadth & Characteristics of Participating Providers

- *AEs serving individuals 16 years of age and older adults at risk for or diagnosed with an opioid use disorder must make available community-based treatment utilizing all federally approved Medication*

Assisted Therapies (methadone, buprenorphine, and naltrexone), Opioid Treatment Program (OTP) Health Homes and American Society of Addiction Medicine (ASAM) levels 3.1, 3.3, 3.5 and 3.7 of SUD residential treatment. **[Page 7]**

It is not clear why this is an AE responsibility and why it is defined in this way. The language does not require AEs to include providers of all MAT therapies within the AE, or to even include them as affiliates or partners. An AE would meet this standard by ensuring providers make referrals to all MAT programs as appropriate for their patients.

If this interpretation is correct, this proposal requires nothing more than adherence to standard referral practices for MAT – something that should not require such explicit regulatory language. If, however, this language does – or seeks to require – something more than this, we recommend that EOHHS clarify that and explain the issue they are seeking to address/ameliorate with this very prescriptive language.

- *AEs serving individuals with or at risk for having a serious mental illness (SMI) or serious and persistent mental illness (SPMI) must ensure that Assertive Community Treatment (ACT) and Integrated Health Home (IHH) services are available to their members directly or through a Provider Partnership with a Community Mental Health Center (CMHC). CMHCs are licensed by BHDDH.* **[Page 7]**

  This is another requirement for AEs where the need and goal are not clear. This new requirement appears to be tied to the proposed elimination of attribution via IHH/ACT providers in PY3. As currently proposed, all attribution will now be via PCP beginning in PY3. (We discuss this in greater detail below.)

  However, as we understand this proposed change, current IHH/ACT patients will remain with the CMHC that currently serves them – assuming the client does not affirmatively change IHH/ACT provider and/or the CMHC does not discharge that client. Additionally, the proposed change in the attribution methodology will not, in any way, alter the existing practice by which PCPs/AEs refer patients who newly present as SMI/SPMI to an IHH/ACT provider for assessment and potential "enrollment."

  Such referrals do not currently require any formal agreement, partnership, etc. between the PCP/AE and the CMHC. This should not change under the new attribution policy. Additionally, AEs will likely need to work with all IHH/ACT providers. SMI/SPMI patients make an IHH selection based on an array of criteria– geography, convenience, past experience, word of mouth, scope/nature of services etc. For these reasons, this requirement seems unnecessary – in that we can refer patients for IHH/ACT services without a partnership – and narrow – in that PHSRI-AE patients will likely enroll with several IHH/ACT providers.

  We recognize the need to establish closer working relationships with the CMHCs that serve our patients, but, based on the proposed requirements, a formal partnership is not a prerequisite for that kind of close collaboration.

If other goals and/or concerns are motivating this requirement, it would be helpful for EOHHS to explain this so that AEs can be sure to address them.

Section 4 IT Infrastructure – Data Analytic Capacity and Deployment

- **4.1. Core Data Infrastructure and Provider and Patient Portals**

  The final language in this section should reflect the current status of the work recently begun by Briljent to define the statewide HIT roadmap. Given that this work has just begun, the current language may be overly specific and prescriptive. Additionally, EOHHS might want to reserve some flexibility to allow for adjustment based on the experience in the forthcoming year related to electronic clinical data transmission.

  We suggest that EOHHS provide more time to finalize these requirements. This would allow EOHHS – in collaboration with AEs and MCOs – to incorporate the work of Briljent and the impact of, and lessons learned from, clinical data transmission.

Section 5. Commitment to Population Health and System Transformation

- **5.2. Social Determinants of Health** *(Excerpts)*

  5.2.2 Evaluate the social needs of their members and take actions to maximize the degree that Attributed Members receive appropriate care and follow-up based on their identified social needs.
  5.2.2.3. Evaluate Attributed Members' SDOH screening needs through regular analysis of available claims, encounter, & clinical data on diagnoses and patterns of care, in partnership with participating MCOs;
  5.2.2.4. Develop reporting or claiming mechanism to allow social needs diagnostic codes to be provided to MCO.
  5.2.3. Tracking and Follow-up Referrals. Ensure that Attributed Members receive warm-transfers for appropriate care and follow-up based on their identified SDOH needs. May be done in direct coordination with MCOs.
  5.2.3.1. Develop a standard protocol for referral for social needs using evidence and experience-based learning and for tracking referrals and follow-up.
  5.2.3.2. AE should have a documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include:
  - *Standardized protocol for referral to social service provider*
  - *Methods for tracking referrals*
  - *Development of metrics to define a successful referral*
  - *Development of reporting of metrics and referral information to MCO* **[Pages 18-20]**

  In this section EOHHS lays out very ambitious SDOH expectations for the AEs. Given the impact of health-related social needs on patient well-being – for the Medicaid population, in particular – this is an understandable priority. The PHSRI-AE shares this priority and is therefore actively working to build our capacity to identify, address, and ameliorate social determinants of health and document and track our work in this area.

  This is some of the most important, and most complex, work the AEs will undertake. Because of that, we encourage EOHHS to consider phasing in some of the performance expectations in this

section. A phase-in would lessen the burden imposed on AEs and, perhaps even more significantly, it will ease the burden on the community-based organizations.

We encourage EOHHS to consider ways it could support and promote the development of a robust partnership between all AEs and community-based organizations. Building a truly effective system that unites clinical and community resources will require more than prescribing partnerships and contracts. It will require more than data collection, sharing, and reporting.

To that end, we recommend EOHHS consider recruiting a trusted community organization – such as the United Way – to serve as an intermediary to provide a single, streamlined system for CBO/AE collaboration. The United Way has existing relationships with many – if not all – CBOs in the state and is well-positioned to help bridge the gaps – operational, financial, cultural, etc. – between clinical sites and community-serving organizations.

Additionally, achieving the goals enumerated in this section will require new IT platforms and data sharing protocols. EOHHS could significantly advance this effort by playing a leadership role identifying, supporting, and financing a common SDOH platform that would serve all AEs, AE members, and provide CBOs a single system with which to engage healthcare systems.

In the current language, it is not clear to what degree AEs will be granted the latitude to tailor their approach to their capacity – which will evolve and grow over time – and the needs of their population. Will AEs be able to set the criteria for which levels of assistance patients get? Will AEs be required to provide a "warm handoff" to any AE patient who tests positive for a social determinant, or can AEs define which patients receive this level of service?

Requiring AEs to provide "warm handoffs" and to track referrals for all patients with social needs will likely over burden AEs. This policy would also likely generate more referrals than CBOs are prepared to meet. For these reasons, we recommend EOHHS allow AEs to define and adjust their service parameters, and to do so collaboratively with CBOs.

We believe the requirement that AEs adopt "social needs diagnostic codes" is overly prescriptive at this point. We recognize the importance of tracking SDOH needs in a uniform, data-friendly way, however we suggest that EOHHS set the goal and not predetermine the method for collecting and tabulating this data. The ramifications of including health-related social needs within patient records via diagnostic codes should also be thoroughly evaluated before a requirement will be adopted.

Section 7 Member Engagement

- **7.2. Implementation, Use of New technologies for Member Engagement, Health Status Monitoring, and Health Promotion** (Excerpts)
  Demonstrated use of Products that support monitoring and management of an individual's physiological status and mental health (e.g. vital sign monitors, activity/sleep monitors, mobile PERS with GPS) … (Fall detection technologies, environmental sensors, video monitoring) … Technologies, products that support both informal and formal caregivers providing timely, effective assistance… Social media applications to promote adherence to treatment … technologies that

enable vulnerable adults to stay socially connected (Social communication/PC mobile apps for remote caregivers, cognitive gaming & training, social contribution) **[Page 27]**

Interactive technology is an increasingly important tool for monitoring and managing patient health, however this requirement, as currently written, may be unrealistic for AEs at this time. Requiring significant implementation of such technologies in PY3 will strain the limited financial and operational resources of AEs. We encourage EOHHS to reserve these requirements for future program years.

ATTACHMENT J - Accountable Entity Total Cost of Care Requirements

- **Section C, Part D**
  We believe that AEs should only bear the cost of attributed members for the time following attribution. The financial exposure for AEs, under the proposed model, is particularly acute in the fourth quarter of the year a point at which an AE has little to no opportunity to manage newly attributed patients.
  There is a related impact that results from retrospective attribution. AE assignment changes every month. This can result in an AE effectively "losing" the benefit of any investment they have made in a patient – quality measures, improved utilization, savings – and taking on the "cost" for the experience of the patient for the period prior to their assignment to that AE. This is particularly relevant as the AEs, MCOs, and EOHHS work to better define our goals for "patient engagement." The monthly churn in AE enrollment is a major disincentive to sustained member engagement initiatives. Patient turnover also hinders the ability of AEs to develop action plans based on reliable data. We encourage EOHHS to engage AEs and MCOs in ways to address these issues.
- **Section D, Part 1.a**
  Please provide more detail regarding TCOC target adjustments for "changes in covered services." It is not clear what is included in this and what, if any, role AEs will have in considering/evaluating such changes.
- **Section D 1. D**
  Including the pattern of utilization in computing the benchmark is challenges the ability of AEs to have meaningful shared shaving in future years. With every year, with focused care management programs, AEs will be striving to reduce utilization, and if benchmark dollars continue to be reduced, there will be limited incentive for AEs to either participate or to put resources into care management. We encourage EOHHS to consider the unintended consequences of this proposal.

Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk (pages 14-19)

- We support EOHHS' encouragement of MCOs and AEs to enter into APMs that replace the inefficient and fragmented fee for service reimbursement method. We also understand EOHHS' desire and need to protect the Rhode Island's Medicaid beneficiaries and the State from those AEs that are unable to manage the contractual risk they assume. It appears that EOHHS has removed the Year 2 requirement that AEs pursuing 10% downside risk must meet MCO reserve requirement and be subject to RI Department of Business Regulation (DBR) oversight. However, we are concerned that the proposed Year 3 guidance outlined in this section will have unintended consequences, which we discuss in greater detail below. Further, we also provide our

recommendations to avoid the unintended consequences and at the same time adequately protect Medicaid beneficiaries.

- The guidance requires AEs who enter into "full risk" arrangements to "maintain secured liquid assets that, at a minimum, constitute sufficient capitalization to cover two months of claims" as part of the Office of the Health Insurance Commissioner (OHIC) pre-qualification requirements. We believe that this level of financial reserve requirement is excessive. This proposed requirement equates to requiring ~17% of annual medical expenses to be held in reserve at all times. This is very high bar, and a significant challenge for all AEs and will have significant and unintended consequences as follow:
  - **The requirements duplicate the financial reserves required of MCOs for the protection of beneficiaries and will increase the cost of health care for Rhode Island and its beneficiaries.** Under this requirement, not only will the State's premium paid to MCOs need to cover the reserve formation of the MCO, but it will now have to cover the additional reserves required of the AE. As an example, if 5% of the current Medicaid premium is required for the MCOs risk formation, this requirement would require the State to add another 5% for the AE's risk formation. At a time when the State's budget is challenged and we are trying to use the AEs to bend the cost curve, this requirement would add new and unnecessary cost;
  - **The MCOs must reserve for insurance risk, whereas the AEs must have the financial wherewithal to manage contractual risk which is far less than insurance risk.** MCOs do not provide care—they contract with providers and pay claims. The greatest insurance risk for MCOs is for incurred but not reported claims (IBNR). The risk of variation in the cost of care beyond the historically established IBNR is substantial due to the lag between the delivery of care and when the claim for service is submitted and then paid. Literally, 100% of the MCOs' medical costs are subject to this variability and insurance risk. On the other hand, a capitated AE provides care to beneficiaries in its own facilities and offices and can easily match the expense of that delivery for 50-70% of the care provided to its population under management. This eliminates most of the time lag of claims and only exposes the AE to the variable cost of its services. In addition, as providers, the AE has a much closer connection with patient than does the MCO. Due to that relationship, the AE is better able to manage the care and the cost of the care of the patient who is treated by a non-owned provider than the MCO. Therefore, the insurance risk for an AE is only 15-30% of the MCO and so requiring similar reserves of an AE in unduly excessive and cost increasing;
  - **Requiring excessive reserves will exclude many providers from moving to Category 4 APMs.** The only APM that replaces the fee for service system is Category 4 "full risk global capitation" Population-Based Payment. All others continue to rely on the fee for service chassis that rewards volume over value. The declining reimbursement or reimbursement that does not keep pace with increasing medical costs, particularly for Medicaid and Medicare, means that providers have fewer margins than in the past. The excess reserves required of AEs by the current guidance to match MCO reserve requirements will keep most providers, if not all, in Rhode Island from being able to move to Category 4 APMs—and unnecessarily. Additionally, low cost providers are rewarded in Category 4 APMs—and are significantly disadvantaged in the current Rhode Island fee for service system. This hardly seems consistent with State's and

EOHHS' policy intention to move AEs to greater levels of provider accountability to replace the fee for service system and to reward lower cost, high quality providers.

- **Providers who can meet Category 4 reserve requirements and be subject to pre-qualification by OHIC would likely conclude that there is no reason not to become an MCO.** Some providers have moved into becoming MCOs themselves. But many of us do not want to become MCOs, unless forced to do so due to MCOs unwillingness to move to Category 4 APMs. Having to meet proposed reserve requirements and becoming subject to oversight by DBR removes nearly all the impediments to becoming an MCO. While this could be an objective of EOHHS in establishing the proposed financial reserve requirement, it is our understanding that EOHHS has always been clear that it wanted to work through its partner MCOs and move the market to greater risk APMs with AEs rather than stimulate more competition to the existing MCOs.

Given these unintended consequences, PHSRI asks that EOHHS consider the following principles in establishing reserve requirements which will encourage AEs to move to greater risk forms of APMs and at the same time provide adequate financial protection to the State and its Medicaid beneficiaries:

1. AEs who demonstrate their experience, capability and expertise to assume and manage accountability for the quality and cost should be encouraged to do so immediately as a positive example to the rest of the provider community and reserve requirements should not be a barrier to that accountability.
2. Supporting and encouraging all AEs to assume and manage greater accountability for quality and cost of care early is necessary to achieve the State's goal of sustainability after five years, when development and implementation funding will end and AEs are expected to be self-sustaining based on their successful performance.
3. Risk based capital requirements for AEs should only be tied to the portion of TCOC that the AE is under contract to manage with an MCO and only those uncovered expenditures which are not capitated and paid on a fee for service basis in non-owned facilities.
4. Since AEs do not hold IBNR underwriting risk, a substantial discount factor to reserve requirements should be applied to reflect that the AE is not an insurer. Unlike insurers, AEs do not price and cover policies on an annual basis but provide and manage the care of their patients.

In order to achieve these principles, we recommend that the AE who assumes global risk on a percentage of premiums must demonstrate to its contracting MCO that it has the minimum of the following in financial reserves:

- A minimum of $500,000; or
- 6% of the annualized health care expenditures, except those paid on a capitated basis.

The financial reserves must be evidenced by a restricted account; a letter of credit; a surety bond; or a combination of the three.

ATTACHMENT K – Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities

- **Section II, Determining Maximum Incentive Pool Funds Part 2**
  We encourage EOHHS to consider including a "material increase" adjustment to balance the "material reduction" adjustment. Just as it is reasonable to make an adjustment should an AE experience a significant decrease in population, AEs should be protected from a potential spike in attribution. In a dynamic and small healthcare landscape, such an adjustment would help protect AEs from market changes that could otherwise destabilize them.

- **Section V, Accountable Entity Incentive Pool (AEIP) & Managed Care Organization Incentive Pool (MCO IP) Required Performance Areas and Milestones**
- We are encouraged by the support EOHHS provides regarding movement toward risk. We recognize that this policy change has been met with resistance and skepticism. We continue to believe that risk and capitation are the best route toward realizing the ambitious goals of the AE program.
- In addition to tying funding to risk-based contracts, these documents call for a significant increase in the payment tied to Outcome Measure reporting. We are concerned that tying 45% of AE incentive funds to annual outcome reporting, will pose a financial strain on AEs. AEs are using these funds to finance staff, services, capacity, and infrastructure. We encourage EOHHS to develop ways these funds could be disbursed over the course of the program year.
- We also encourage EOHHS to consider granting latitude to AEs and MCOs to negotiate the allocation of incentive funds between performance milestones and outcomes reporting. We believe contract negotiation, and the AE/MCO partnership, is the best place for reaching a common, shared understanding around these important decisions.

ATTACHMENT M - Accountable Entity- Attribution Guidance

Section 3. Comprehensive AE Attribution

- *3.3 Hierarchy of Attribution for Comprehensive AEs*
  1. *Attribution to the AE will be based on PCP assignment of record within the MCO.*
  2. *Attribution based on actual primary care utilization* **[Pages 3-4]**

  This section contains one of the most significant proposed changes to the AE program: Eliminating attribution via IHH/ACT providers, in favor of all attribution through primary care providers.

  Based on the initial analysis conducted by EOHHS, the PHSRI-AE is predicted to see an increase of more than 140 SMI/SPMI patients. While this represents a small percentage of our attributed population, c. 1%, this population comprises high utilizing patients who are among the most complex, and most resistant to management.

  We understand that, with this change, EOHHS is seeking to realize better coordination of medical and behavioral care. The original attribution model was based on the belief that CMHCs were best positioned to perform care coordination as they were, effectively, the "medical home" for SMI/SPMI clients. BHDDH contracts with IHH/ACT providers also clearly define the care coordination responsibilities of CMHCs. Care management in IHH/ACT programs includes coordinating medical care. It is not limited to behavioral health and substance use services.

The original attribution model provided TCOC incentives to the entity "closest" to the SMI/SPMI and aligned those incentives with the underlying obligations of the BHDDH contract.

This will no longer be the case.

The new policy transfers TCOC risk to the AE of the SMI/SPMI client's primary care provider. In order to achieve the goals motivating this change, we urge the state to consider the following:

- We believe this success of this policy change would benefit from a clear and frank explanation regarding why and how the original attribution model did not meet expectations. Without a thorough understanding of what preceded and precipitated this change, AEs will not be able to meet the expectations of EOHHS and.
- AEs would benefit as well from detailed guidance regarding what the state aims to achieve and correct with the new attribution model. In addition to providing clear guidance to the AEs on what is expected of them, we believe this policy change would also benefit from the state setting clear expectations for IHH/ACT providers, including the continued responsibility CMHCs have for care coordination.
- The challenges posed by *42 CFR Part 2* have been a frequent topic of discussion at AE meetings, forums, and public hearings. EOHHS has acknowledged the ways *42 CFR Part 2* constrains the ability of AEs to provide timely comprehensive care management to some of their neediest members. We appreciate the commitment the state has made to working on solutions to these barriers. This policy change will likely further the highlight the need to find ways to share information while abiding by the requirements of this federal regulation. Perhaps the state could take the lead in developing a uniform understanding, across all providers and stakeholders, regarding *42 CFR Part 2*. Ideally, this would result in a common set of rules and procedures for sharing information and coordinating care. Without timely and complete information, AEs are seriously challenged to coordinate care, meet quality targets, achieve outcomes measures, and reduce total cost of care for affected members.
- We encourage the state to work with CMHCs to develop effective patient engagement programs so IHH/ACC clients understand the benefits of allowing IHH/ACT providers and AE-affiliated primary care providers to coordinate care and share information.
  While patient consent, in the form of signed authorizations, cannot be required, the state should help CMHCs achieve high authorization rates.
- We urge the state to identify a process by which AEs will be notified when an IHH/ACT patient has been discharged/disenrolled from IHH/ACT services, for any reason.
  As stated above, TCOC risk will be transferred under this policy. It is reasonable for an AE to assume that SMI/SPMI clients enrolled in IHH/ACT, are receive those services. Given that, an AE should be informed immediately when/if a client is discharged/disenrolled so they can engage their patient and ensure that patient is reconnected with the appropriate level of service as quickly as possible.
  Without such notification, an AE would likely identify this situation after a decline in patient health and a spike in patient utilization.