

**Integrated Healthcare Partners**  
**Feedback on PY3 Requirement Documents**  
**November 8, 2019**

Integrated Healthcare Partners is once again appreciative for the ability to offer feedback on Rhode Island Accountable Entity requirements to the Executive Office for Health and Human services. We look forward to further progression in the program and in our anticipated participation in the upcoming years.

**General Comment**

In an earlier meeting, it was suggested that a definition of terms be included as part of the document set utilized by EOHHS to advise interested parties regarding the AE Program would be helpful. For example, there is not a clear definition of the term provider and how it is used in various components of the documentation. This should be part of a *definition of terms* document.

**Attachment H – Certification Standards**

- Page 8: *Social determinants capacity*: It is good to see Housing Insecurity and Food Insecurity identified as priority domains.
- Section 2 *Corporate Structure and Governance*
  - Page 11: The frame of reference in this section is for new entities and the language should reflect both new and established organizations, such as is done in other sections of the other attachments. For example, the first paragraph of this section: “A fundamental EOHHS objective is to develop a new type of organization in RI Medicaid to promote....” could include principles for new and established AE organizations.
  - Page 12, Section 2.1.5: Reference to Consumer Advisory Committee (CAC). IHP was granted the option to create a Consumer Advisory Initiative in lieu of a CAC. This approach allows the practice of IHP leadership to visit with consumer groups at locations and times that the consumer groups may have as regular meetings and/or events. More details can be provided on this initiative as needed.
  - Page 13, Section 2.2.2.2: This wording is not clear regarding minimal representation requirements or are these examples of categories that could meet requirements?
  - Pages 15-16, Section 4.1 – In light of the recent consultation services underway with Brilljent, it remains unclear how many resources should be devoted to CurrentCare enrollment and interfacing until Brilljent’s statewide HIT roadmap is completed and assessed by stakeholders. Equally unclear is the how the roles of CurrentCare and IMAT, both of which receive identical C-CDA extracts, are distinguished. There are apparently some issues with NCQA certification for standard data that can impact this section of the requirements that may need to be considered.
  - Pages 23-24, Section 7 –IHP believes the requirements in this section should be relaxed. As the current TCOC model is challenged, we are not convinced there are enough funds to prompt investment in new technologies for home monitoring through devices or “cognitive gaming.” , nor would it be the most impactful area for us to focus our resources on at the current time. Financial barriers notwithstanding, there are simply too many competing priorities in program direction (i.e. clinical data exchange, creating

viable referral networks, improving quality and outcome measures, addressing systemically poor housing and food insecurity) to begin embracing such concepts. The level of adoption of such technology among the Medicaid population is also very suspect. Through its continued participation in the Patient Engagement Workgroup, IHP demonstrates its recognition of the need to foster patient engagement, but the requirements set in this section should be considered an add-on.

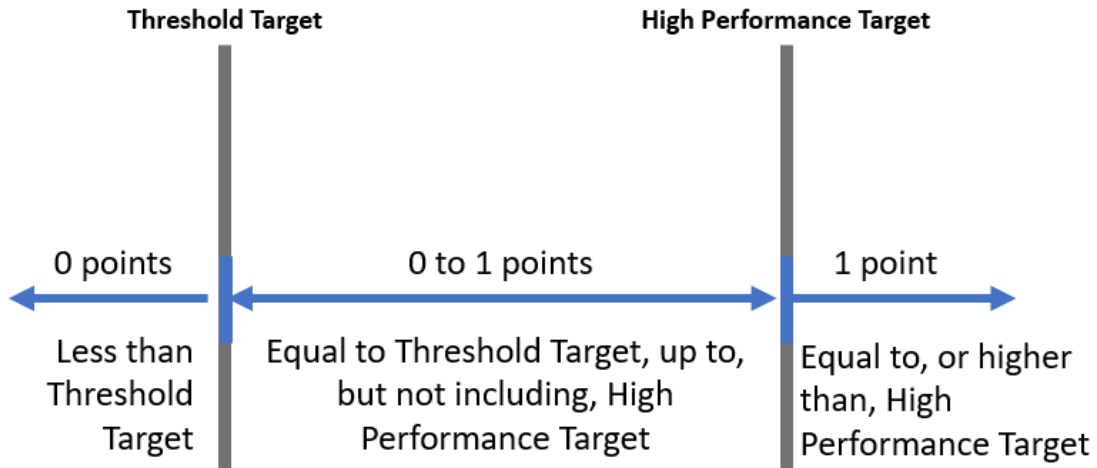
### **Attachment J and Attachment M**

#### **Total Cost of Care, General Comments**

These attachments have a lack of clarity on the relationship between Attribution and the TCOC calculations. One concern is the quarterly updates identified in Attachment M, page 3, Section 3.3 and the last paragraph (same attachment) Page 5: If the attribution is expected to be reviewed and updated quarterly, why do the AEs bear the full cost for the whole performance year of attributed members who are only attributed in the last quarter of the performance year?

#### **Attachment J, Accountable Entity Total Cost of Care Requirements (PY3)**

- Page 3, Section C.2: "...the State/MCO contract provisions regarding Medical Expense calculation...." IHP requests clarification on what this is
- Page 3 Section C.5: IHP disagrees with this approach. The members costs should be with the AE only for the month the member was enrolled in that AE program.
- Page 3, Section D.1.b: IHP continues to request that drugs for Medication Assisted Therapy and HIV care be excluded from the cost of care calculations
- Page 3, Section D.1.c: please define this "changing" risk file and its components
- Page 3, Section D.1.d: IHP requests that the source of the data that will be used to determine these factors is included.
- Page 3, Section D.1, last sentence: IHP requests that EOHHS adds "in collaboration with the AEs and the MCOs"
- Page 4, Section D.3.a: IHP requests that the information in the table be refreshed since the original source is from 2012.
- Page 10, Attachment A of Attachment J, Section D.1.a.ii.1: IHP requests that the language be modified such that performance equal to the threshold target is eligible to earn partial achievement points (reference below diagram).
- Page 10, Attachment A of Attachment J, Section D.1.a.ii.3: We IHP requests that the language be modified such that performance equal to the High Performance Target earns one achievement point, since performing the specified calculation results in this outcome (reference below diagram).



- Page 10, Attachment A of Attachment J, Section D.1.b.ii: Footnote 3 is missing
- Page 11, Attachment A of Attachment J, Section E: Footnote 4 is missing
- Page 12, Attachment A of Attachment J, Section F, *Comprehensive AE Common Measure Slate*: As we are limited in what data we can see for our attributed patients with mental illness, IHP once again, recommends that this measure not be included as a pay for performance measure and that an initiative to handle the systemic data related issue be led by EOHHS. In addition, IHP understands that there has been a recent modification to the HEDIS specification for the *Follow-Up after Hospitalization for Mental Illness* measure, which requires a change in billing practices regarding the rendering provider. As we understand, the CMHCs have commonly used the facility when billing, but now they must specify the exact provider that rendered the service in order to qualify for a visit to meet the measure. Based on this change, comparisons to previous year's results cannot be done. As a result, we request that this measure be 'pay for reporting' in PY3.

**Attachment K, Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities**

- Page 6, first paragraph of Section V: Spelling error, "proposer" should be "proposed"
- Page 7, *Required Performance Areas and Milestones*
  - First row: It appears that the MCOs will be required to have an agreement with social services provider. Please provide more insight as to what is expected in the agreement? Is this payment for certain services?
  - Second row: IHP continues to believe that, with the 42CFR rules and the lack of data sharing related to substance use and some mental health services, the "*ED Utilization Among Members with Mental Illness*" is an unfair outcome measure to include as pay for performance.
- Page 8, Section VI, last part of the last bullet: "... in combination with timely performance on a subsequent related metric." IHP requires clarification of this reference to a subsequent related metric.

- Page 8, Section VI: This section needs to be clearer regarding the reference to *no payment for partial fulfillment* and statements that indicate the AEs will have up to one year to complete the work to receive payment.
- Section VII, pages 9-10, *Allowable and Disallowable use of AEIP Funds*
  - This section has items that are disallowable that will create challenges in fund management. For example, credit cards are a standard in conducting business with vendors, and the prohibition of credit card payments is unacceptable without more clarification.
  - To pay for costs incurred in the process of responding to the EOHHS AE Application, or during contract negotiations with Medicaid MCOs is unclear, and in its current wording, too restrictive. Staff employed by the AE are costs, and for obvious reasons this is unacceptable without more clarification.
  - Not allowing “...and other education expenses” is unacceptable without more clarification.
  - Not allowing “...Gift Cards” is unacceptable without more clarification. Food gift cards to local markets is an effective strategy to address one of EOHHS’ priorities for food insecurity.
  - Insurance is a requirement for certification and MCO contracts and the prohibition for payment is unacceptable without more clarification.
- Page 11: IHP commends the state for specifying that the format of the MCO / AE agreement be an amendment to the contract, and not a new full contract.

**Attachment M – Accountable Entity - Attribution Guidance (PY3 Draft)**

**General Comments**

IHP continues to receive deceased members in the monthly attribution files from both MCOs. In some cases, the date of death goes back two years. IHP would recommend the state and the MCOs look at this process flow for efficiencies. Additionally, we receive members with addresses that are out of state. What are the requirements around what states our members may live in?

**Page 3, Section 3.3**

- Section 3.3 has subsections that are numbered beginning with 1. IHP requests that these sections be re-labeled starting with 3.3.1 to facilitate unique references to section numbers in this document.
- Page 3, Section 3.3: IHP requests clarification from the state regarding the provider lists that are required on a monthly basis. Currently one of the two MCOs submits the PCP provider files directly to EOHHS on IHPs behalf and the other MCO requires IHP to provide a provider roster on a monthly basis. They then submit it to EOHHS. Is there a standard process that should be followed by the MCOs and the AEs on this topic? How are the MCOs expected to use these files? What does EOHHS do with the files upon receipt? What is the correlation of this to attribution?

Page 3, Section 3.3 & Attachment A to Attachment M

- AEs need more effort from the MCOs on initial outreach and engagement with members related to PCP selection, releases of information for the disclosure of ALL PHI (especially 42 CFR Part 2 protected data) and the need to engage with PCPs for primary care.
- IHP requests a flow chart and timeline for the assignment and change process for member attribution.
- IHP continues to request the documented PCP auto-assignment algorithm.
- IHP asks, once again, that information be shared with the AE's regarding the process the MCOs follow to obtain a PCP choice from an enrollee before auto assignment of a PCP is executed. In other words, is the member allowed to pick a PCP upon registration with the MCO? In addition, what is the process if the member does not pick one, what is the process of they do pick one, etc.? It currently seems to yield little benefit, perhaps some funding to enhance this process might be in order.
- IHP requests that the MCOs share their current policies for assignment of PCP for those members who did not pick one upon registration. Additionally, we suggest that a task force that includes the State enrollment team, the MCO's, and AE representation look at these for efficiencies.
- Page 3, Section 3.3 & Page 5, 1<sup>st</sup> paragraph: IHP believes that if a member calls the MCO or processes a change form to change their PCP that the change should be processed with an immediate effective date, not an effective date of the beginning of next quarter. - In Section 3.3, it appears that a PCP change would take effect quarterly, IHP believes it should take effect immediately and not be done only quarterly. The members cost should change based on the new effective data as well. At the end of Section 2.05.07 (Attachment A, Page 6), it states it is EOHHS' preference it is done the next business day. Suggest this be the requirement, or within 3 business days. This is contradictory in the document.
- Page 5, last paragraph: IHP does not agree that a member's costs for the entire year should be allocated to the AE they are assigned to at the end of the year. We recommend that the state reconsider this approach and allocate only the costs associated with the period of time that member is associated to that (or each) AE.
- Page 6, Attachment A of Attachment M, Section 2.05.07, last paragraph: IHP would like to better understand how the MCO defines an appropriate patient panel size? An MCO will not know what the provider's panel size is since it can include uninsured patients, and patients from outside that MCO. The provider facility is the only source for this information. This section needs more clarity on the MCO and EOHHS requirements and expectations for the enrollment and PCP selection.
- Page 6, Attachment A of Attachment M: In the last paragraph, should "member panel size" read "provider panel size"?

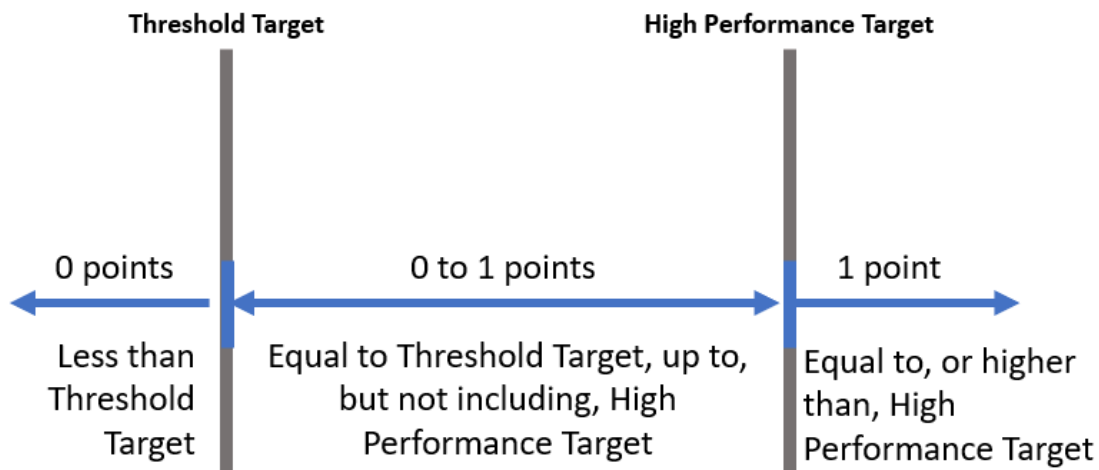
**TCOC Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive AEs: Implementation Manual (PY3, October 10, 2019)**

- Page 7, footnote #2: this footnote appears in the heading "Measures" but is apparently referencing a particular measure: "Attachments L1 for Program Years 1 and 2 included Self-Assessment/Rating of Health Status as developed by EOHHS. This measure is no longer part of

the AE Common Measure Slate for QPY1-3. EOHHS communicated its decision to drop this measure from Program Year 2 in its 4/30/19 amended Attachment L1.”

- Page 7, *Follow-up after Hospitalization for Mental Illness*: As we are limited in what data we can see for our attributed patients with mental illness, IHP once again, recommends that this measure not be included as a pay for performance measure and that an initiative to handle the systemic data related issue be led by EOHHS. In addition, IHP understands that there has been a recent modification to the HEDIS specification for the *Follow-Up after Hospitalization for Mental Illness* measure, which requires a change in billing practices regarding the rendering provider. As we understand, the CMHCs have commonly used the facility when billing, but now they must specify the exact provider that rendered the service in order to qualify for a visit to meet the measure.
- Page 10, P4R Measures: In this section IHP does not agree with the language changes to the original text that make reporting P4R measures MCO defined formats. IHP understands that reporting should be a collaborative approach towards the format of the quality file. We request that the language be changed to “...MCO and AE-agreed upon formats...”
- Page 10, Section 1.a.ii.1: IHP requests that the language be modified such that performance equal to the threshold target is eligible to earn partial achievement points (reference below diagram).

Page 10, Section 1.a.ii.3: IHP requests that the language be modified such that performance equal to the High-Performance Target earns one achievement point, since performing the specified calculation results in this outcome (reference below diagram).



- Page 12, HEDIS and non-HEDIS measures. Overall: IHP recommends that quality measure benchmarks have risk adjustment taken into consideration based on the population
- Page 12, b.ii and b.iii should be b.i and b.ii, respectively
- Page 12, last paragraph (continues to page 13):
  - IHP continues to believe that the TCOC model limits AE ability to attain shared savings and as such should not be further constrained by a quality improvement gate/factor. We believe that an effective goal for an AE would be to **maintain** quality, and that quality improvement efforts exist/remain in the MCOs direct contracts with the member organizations.

- IHP recommends a possible solution to quality limitation on TCOC, the MCO and AE share 50% of any shared savings as a base. Then apply quality performance to 50% of that shared savings base (or 25% of the 50%), adding a percentage for each measure passed. This may diminish some concerns raised over TCOC attainability and apply the quality the state is looking for.
- Page 13, last sentence of first paragraph: IHP requests, that anytime EOHHS is creating or modifying benchmarks, AE and MCO participation be included in the process.
- Page 16, IHP believes that there was not sufficient time invested in collaborative discussion around Outcome measures. We recommend a collaborative deep dive of the specifications be undertaken before a Pay for Reporting date be determined. We have learned that the devil is in the detail and it is always best not to make the same mistake twice. We believe that a deep dive on the outcome measures at this time may not be operationally feasible for all participants, with the fast approaching deadlines for CDE.
- Page 16- All-Cause Readmissions. IHP advocates some level of accountability be placed on hospitals by tying this measure to inappropriate hospital discharges. There remains risk of hospitals prematurely discharging patients in order to meet their incentive requirements, and in doing so worse outcomes are more likely to be realized by patients, including readmission likelihood. Hospital discharges are outside the control of AEs lacking formal affiliation with a hospital. IHP requests EOHHS place requirements on hospitals to work directly with all AEs to help control these practices as well as to integrate Care Management services within the hospital settings.
- Page 17: The first two measures indicate that they are not included for OPY3. IHP commends EOHHS for removing these measures, however, on page 18, in “Section of P4P Measures,” it states that “All Outcome Measure Slate measures” are P4P. IHP requests this note should be corrected on page 18.
- Page 17: IHP continues to believe that, with the 42CFR rules and the lack of data sharing related to substance use and some mental health services, the “*ED Utilization Among Members with Mental Illness*” is an unfair outcome measure to include as pay for performance. It is also unfair for those AE’s without hospital affiliations.
- Page 18, *OPY3 Measure Weights*: IHP continues to believe that 45% of the AEIP funds for either the MCO or the AE is too high for Outcome Measure performance, as this is the first year that the measurements were developed, and the AE’s have no insight as to how the baseline rates were calculated were developed. We recommend this rate drop to 25% and be broken down as follows: 10% for the first two measures and 5% for the last measure.
- Page 19, *Outcome Measures Data Collection Responsibilities*
  - Data Validation: will the outcome measure data created by EOHHS also have data validation requirements?
  - Additionally, IHP recommends that the MCOs continue to generate Outcome Measure results for each AE, versus introducing a new reporting system into the mix by having EOHHS generate them. If the state decides to move forward as documented in this manual, then we recommend that the MCOs and EOHHS use the same reporting specifications so that an AE is not taken by surprise seeing regular data from the MCO that is far off from the EOHHS rates generated at the end of the year.
- Page 19, *Outcome Measure Targets for OPY3*, last paragraph

- Although the approach sounds logical for QPY3 outcome measure target development that you recommend for *Potentially Avoidable ED visits* and *ED Utilization Among members with Mental Illness*, we recommend a slower approach towards this being a Pay for Performance measure:
  - NHPRI only recently began to report on *Potentially Avoidable ED Visits*
  - UnitedHealthcare reports on *Potentially Avoidable ED Visits*, but uses a different algorithm
  - Neither MCO has reported on *ED Utilization Among members with Mental Illness*, and even if they did, we do not expect that the AEs would receive comprehensive data because of 42CFR
  - These are measures for which providers have not been previously held accountable. Once data is received by the AE from the MCO or the state using the EOHHS recommended logic (and it is unknown when that will be), the providers will need time to assess, build and roll out new workflows.
  - IHP would like to see what data was used for generating our baseline, and what baseline was used to create our target.
  - To seek consistency in targets across the AE's, has EOHHS considered using, for example, a 1% over baseline increase as a target?
  - If EOHHS was to continue with different targets per AE, we recommend that EOHHS provide transparency in the target algorithms and that the difference in targets be based upon the results of a population assessment.
- Overall comment related to the ED based outcome measures: ED visit counts can fluctuate from year to year due to a number of reasons/conditions, i.e., the flu factor. How will this be taken into consideration in the setting of these targets? We recommend this fluctuation be taken into consideration.
- Page 30 last row of the SDOH infrastructure Table – does not contain the exclusions of patients in hospice and if patients refuse
- Pages 37-38, Data Validation: IHP recommends the addition of member-matching logic to the validation activities and for the guidelines to be included in the manual inclusive of retroactive review and adjustment.

Overall Recommendation: IHP recommends that QPY3 Quality measurement either become quality maintenance or be similar to QPY2, having a few measures that are Pay for Performance with the balance Pay for Reporting or consider decreasing the number of measures included and the complexity of their calculations.