UnitedHealthcare COMMUNITY & STATE

Memo to: Lauretta Converse, Health System Transformation Project Director, EOHHS

From: Patrice Cooper, CEO, UnitedHealthcare Community Plan of Rhode Island
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CC: January Angeles, Deputy Medicaid Director, EOHHS; Deborah Morales, Accountable Entity Director, EOHHS; Kristin Sousa, Managed Care Director, EOHHS; Barry Fabius, MD, CMO UHCRI; Debbie Rainha, Quality Director, UHCRI

Date: October 17, 2018

RE: Program Year 2 Public Stakeholder AE Requirements Documents

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UnitedHealthcare (UHC) is committed to work towards the success of the EOHHS Accountable Entity program. UHC has reviewed the EOHHS updates to the AE Program Requirement documents and has developed comments for consideration.

Attachment L1: Total Cost of Care Requirements:

Comments on transition to downside risk:

- The table in #6, AE Share of Savings/(Loss) Pool indicates a 5% maximum cap for the AE on shared losses, however the table in #7, Required Progression to Risk Based Arrangements indicates the cap in years 3 – 5 is 'no more than 10%'. Should #6 be deleted as PY1 will be complete, or is it intended to refer to years post PY1? UHC agrees the cap for both upside and downside risk should be consistent across the MCO/AE.
- UHC agrees that a phased in approach to transitioning to downside risk is a preferred method (i.e. requiring the AE be responsible for a smaller percentage of downside risk in the early years, larger as the years progress).
- Withhold: UHC is systematically not able to administer a withhold at this time. Additionally, the guidance indicates "the withhold must capture 75 percent of the maximum shared loss pool". 75% of 10% of the TCOC would be a significant portion, if not all, of the FFS payments to the underlying providers. For downside risk arrangements, UHC would require a security reserve, or a letter of credit that would be established prior to the start of the measurement period that includes downside risk.

TCOC Development Approval and Reporting Process:

- #5, Treatment of State Budgetary Savings Assumptions: The UHC contract passes through any state 'assumed savings' for the AE program directly through our revenue calculation (i.e. the rates have been reduced by EOHHS). The current contracts approved by EOHHS, and executed effective 7/1/18, runs through 6/30/20 (PY2) and does not specifically describe how the per AE adjustment is calculated, however it is calculated based on the assigned/attributed lives per AE.
- Required ongoing reporting: PY1 began 7/1/18, however the table included in the guidance starts 6 months prior to PY1 (Jan 1).

ATTACHMENT A: Quality Framework

- Document references 11 core measures, however, given that guidance on the Weight Assessment & Counseling Children and Adolescent measure uses HEDIS as the Measures Steward, this one measure becomes three, making 13 core AE measures.
- EOHHS has approved an alternative methodology for quality scoring that equally weighs all measures and sets negotiated targets for each of the measures. These targets will need to be met or exceeded prior to the AE earning 'credit' for that measure, therefore increasing the percentage of shared savings. UHC understands that our contracts for PY2 may need to be amended in order to incorporate any future requirements, to be defined by EOHHS after consult from the subject

matter expert, as referenced in the guidance. That being said, UHC would like to see alignment between quality performance requirements of the AEs with the quality performance requirements of the MCOs under our contract with EOHHS.

- F. Comprehensive AE Common Measure Slate. The first sentence in the second paragraph indicates all mandatory measures, with the exception of SDOH Screen and Self-assessment/rating of health status, will be pay for performance in PY2. UHC does not intend to use any optional measures in PY2.
- In alignment with other MCOs and the AEs, UHC is in agreement to remove Sections D and E from the Quality Framework pending review of the third party quality vendor.

Attachment L2: Incentive Program Requirements:

Calculating AE-Specific Incentive Pools:

- UHC executed two year agreements with AEs, running through PY2. UHC believes that these already executed contracts would count as meeting the execution requirement deadline of 7/1/2019. Any new AE contract to start PY2 would need to be executed prior to 7/1/19 in order to achieve the MCO-IMP associated with those. Will the potential inclusion of an additional AE, making the total number of RI AE's 6, change the dollar amounts in the funding table?

VII.A. AEIP:

- Quarterly Reporting on Outcome Metrics. UHC notes the addition of a 4th required quarterly outcome metric, Ambulatory Case Sensitive ED Visits. UHC will need to review the specifications to ensure we are able to administer this measurement for PY2.
- There is reference to an 'AE Outcome Metrics Meeting', however, that is not defined. Is the intention that the discussion on the outcome metrics be included in the Joint Operating Committee meetings between the MCO and AE?
- The 'AE Outcome Performance Plan' is not defined. Is the intention that this be a plan to improve should the AE not meet the outcome metric targets? What entity needs to submit the outcome measure performance plan (the AE to the MCO, or the MCO to EOHHS, or both)?
- Although the proposal is to shift from a required minimum of 5 outcome metrics (3 defined and at least 2 MCO specific) to 6 outcome metrics (4 defined and at least 2 MCO specific), the PY2 funding weighing has shifted down from 20% to 15%. UHC would propose that the weighting for the outcome measures remain at 20%, and move the HSTP project plan weighting from 65% to 60%.

VII.B. MCO-IMP:

- In the AEIP Program Development portion of the grid, Contractor Review Committee is capitalized although not defined. Is the intention that this is the MCO Review Committee or the HSTP Advisory Committee? In the same section, 'established specific incentive provisions for the AEIP contract' referring to the milestones/projects that are part of the HSTP Project Plan?
- Provision of Monthly Attribution Rosters within ten calendar days of the start of the month. UHC requests this timeline be extended to 15 calendar days of the start of the month as that is the timeline of our automatic file transfer to the FSTP sites.
- Quarterly Report on results of monitoring of member access to care – is this a defined monitoring method?