To: Debbie Morales, Medicaid Accountable Entity Program Director, Rhode Island Executive Office of Health and Human Services

From: Beth Marootian, Director, Strategy and Business Development

Cc: Nancy R. Hermiz, VP Medicaid; David Burnett, Chief Growth Officer

Re: Response to Public Comment Request: Accountable Entity Program Year 2 Requirements

Date: October 19, 2018

Neighborhood Health Plan of Rhode Island is pleased to respond to the Executive Office of Health and Human Services (EOHHS) Proposed Accountable Entity Program Year 2 (PY2) Requirements.

The following are Neighborhood's recommendations to changes in the PY2 Requirements. We look forward to discussing our comments with EOHHS to answer any questions and clarify our recommendations.

Neighborhood applauds EOHHS for recognizing the need for PY2 consistency in program requirements based on established PY1 requirements. Neighborhood encourages EOHHS to continue program stability, allowing the MCOs and AEs to thoughtfully implement the numerous requirements.

1. **Specialized Accountable Entity**
Neighborhood looks forward to partnering with EOHHS on the development of the Pre-eligibles concept. This is a topic of interest to the MCO as it's particularly aligned with the EOHHS-CMS-Neighborhood Medicare-Medicaid Plan demonstration.

2. **Attachment L 1: Accountable Entity Total Cost of Care Requirements – Program Year Two Requirements**
Neighborhood agrees with EOHHS' approach to allow for stability of the TCOC model in PY2. We encourage EOHHS to continue the model without change throughout HSTP program period. Model stability is important for program consistency and reliability of outcomes, it is also essential to creating program efficiency and oversight for both the MCO and AE.

Rising Pharmacy Costs
Comment: Neighborhood is concerned that the cost saving gains that could be achieved by the AEs will be netted against the ongoing increases in medication costs.

Recommendation: Neighborhood encourages EOHHS to join with other states to develop a response to the rising price of pharmaceuticals. Pharmacy cost increases experienced in the performance period will not be accurately predicted in the current model because those cost increases are relatively new.

Meaningful Risk
Comment: Neighborhood does not endorse EOHHS approach to allow the health plans with the AE to determine the appropriate level of assumed risk. Neighborhood is concerned with the requirement to create shared or full-risk arrangements within 3-5 years. The role of DBR in overseeing these new risk-bearing entities has not been defined and the regulatory framework is unexplored.
Recommendation: Neighborhood encourages EOHHS and DBR to engage in an open rule-making process to determine whether existing statutory authorities are adequate to support the establishment of AE risk-bearing entities. Before any new risk-bearing entities are promoted, EOHHS and DBR need to follow a public and perhaps legislative process for developing this new regulatory framework.

Insufficient Trend
Comment: The EOHHS required annual trend used in the TCOC benchmark is based on historical experience which lacks sensitivity to incorporate more recent changes in health care costs. The trend experienced by Neighborhood is significantly greater in part due to explosive increases in (brand and generic) pharmaceutical costs. The depressed trend raises concern of actuarially soundness of both the Neighborhood rate and AE TCOC benchmark.
Recommendation: Align trend with current provider rate-setting practice in the commercial health insurance sector as required under OHIC Regulation 2. OHIC requires insurers to apply urban consumer price index plus a factor to all population-based provider contracts. Alternatively, consider adding more recent experience to the actuarial rate setting process, at a minimum capturing pharmacy costs.

3. **Attachment A: Quality Framework and Methodology for Comprehensive Accountable Entities**
Neighborhood's comments encompass both PY1 and PY2. The following is based on EOHHS most recent August 2018 PY1 Memo.

We encourage EOHHS to engage the Quality SME as soon as possible. We encourage EOHHS to rely on and benefit from to the expertise of both the MCOs and AEs with decades of collective experience measuring and improving quality. The MCO stakeholders and AEs are national leaders in quality, patient centered medical home and Medicare Next Generation ACO, and through collaboration we can support the overall AE program.

Neighborhood's comments solely represent the health plan but, are informed by discussion at an ongoing collaborative workgroup convened by the MCO inclusive of United Healthcare Community Plan, Tufts and each AE.

Quality Framework PY1 and PY2

The clinical data base that will be established through the EMR extract work is considered a cutting-edge initiative in the health care industry. As such, we are learning it may take time for the MCOs to build the infrastructure necessary to aggregate the clinical data across providers.

System/IT solutions have only recently come forward in the industry that can aggregate clinical EMR data across multiple EMR systems and provider groups. Given this innovative position, it will likely take time before reliable clinical data is available for accurate measurement of both HEDIS and non-HEDIS measures. As such, Neighborhood reiterates recommendations shared with EOHHS on s a two-phase approach to create the infrastructure necessary to collect these measures based on the following phases:

1. **Development Period** (PY1/SFY19) during which the Accountable Entities will work with the MCOs to design and implement a data system based on EMR extracts from the AEs that is needed for ongoing reporting according to the specifications in the EOHHS Quality Framework and Methodology.
   - Neighborhood does not recommend "measuring" the AEs on the submission of self-reported data because self-reported data lacks checks for consistency and validation.
   - PY1 self-reported data cannot be used to establish baseline for subsequent years because it will likely lack methodological consistency with data as measured using the EMR extract data system.

2. **Transition Period** (PY2/SFY20) given the effort and commitment of technical resources by the MCO and heavily by the AE provider groups, Neighborhood recommends PY2 as a transition year to continue EMR data infrastructure build and if appropriate establishment of improvement targets and benchmarks.
   - Neighborhood recommends PY2 measurement to be considered a "pay for reporting" pilot. Allowing the MCO and AE to substantiate the completeness and accuracy of the data, allow for adjustments before applying the measurement to the shared savings model.
   - In PY2 baseline performance and improvement targets can be established.

3. **Production Period** (PY3/SFY21) provides for full implementation of valid EMR data sharing and HEDIS mapping.
   - Neighborhood recommends performance based measurement based on CY20 data
   - Performance will be scored based on achievement relative to benchmarks and improvement over baseline.

Neighborhood's goal is partner and support the AEs and if possible align with the other MCOs to create a streamlined, efficient and cost-effective system that supports accurate data reporting. Allowing the time and resources necessary to achieve this goal will support a sufficiently fair process to assure the AEs receive the appropriate share of any medical cost savings they achieve under the program.

Long-term Benefits
By endorsing the recommendations described above, EOHHS will allow for the time necessary to build one of the most innovative quality data collection approaches in the nation. Based on feedback from industry experts we believe RI's Medicaid Managed Care program and the Quality Framework will be seen as a national leader. Rhode Island will continue the benefit of its 25 year investment in Medicaid Managed Care by leveraging the collective experience of the MCOs and the AEs. Complete and accurate HEDIS data collection and quality improvement is only possible when claims data is joined with clinical data and supplemental information to accurately measure and understand the patient experience.

However, the MCOs and AEs need more time put the EMR data collection infrastructure in place. Neighborhood will continue collaboration across MCOs and AEs to develop common data requirements and to create streamlined and consistent processes as much as possible. We invite EOHHS staff to join this ongoing activity.

Quality Framework and Methodology Recommendations
Program Year One
- Remove the self-report requirement given the lack of data validity and ability to use the data for improvement targets or benchmarks. The self-reporting process will also divert resources from both the MCO and AEs necessary to accelerate EMR data exchange.

- OHHS to convene AE and MCO stakeholders prior to years end and regularly in 2019 to provide EOHHS with ongoing input and learning associated with the implementation of the PY1 Quality Framework and planning for PY2 improvements. We invite EOHHS to join the AE Quality Circle workgroup attended by the MCOs and AEs.

Program Year Two
- Allow time for the AEs and MCOs to complete and fully test the EMR data systems.
- PY2 is a pay-for-reporting pilot to substantiate the completeness and accuracy of the data and allow for adjustments to the data system. Neighborhood does not recommend the use of data from PY2 to be used for performance improvement.
- Data collected in PY1 and PY2 will need to pass rigorous tests of completeness and validation as defined by HEDIS before being used to set the baseline and performance targets.
- Establish baseline performance (for measures without available AE baseline for calendar year 2018) and

- Establish benchmarks – consider HEDIS or AE-specific targets to allow for percent improvement over baseline for all measures (except self-reported data).

Program Year Three
- Begin performance measurement based on baseline and improvement targets set in PY2.

Neighborhood's comments are submitted after full consideration of the requirements developed by EOHHS and the capabilities of the MCOs and AEs to meet these requirements. The collective goal is to develop an efficient and cost-effective system that can support data reporting that is sufficiently accurate and timely to assure that the AEs receive the appropriate shares of any medical cost savings they achieve under the program.

4. EOHHS Medicaid Infrastructure Incentive Program
L2: Program Year Two Requirements and Program Year One Feedback

Program Year 1 Feedback
We formally request from EOHHS a consolidated document describing the implementation of PY1 AEIP. The consolidated document would bring together materials distributed at meetings and email. It would also include an understanding of EOHHS' intent and program rules. Neighborhood is also seeking the final AEIP Milestone Template; the last version received is labeled draft.

Program Year 2 Feedback
HSTP AE Advisory Committee
Neighborhood encourages EOHHS to continue with a community-based Co-Chair, ideally seeking candidates from the AE provider community.

AEIP Developmental Milestones
Neighborhood encourages EOHHS to reconsider requiring AEs to execute Value based agreements with SDOH, BH, and/or SUD Provider in accordance with the standards defined by HCP-LAN for a Category 2 APM. Given the diversity of provider types and the likely small number of lives associated with these arrangements it does not seem feasible to accurately measure performance at the AE level.

Quarterly Reporting on Outcome Metrics
Neighborhood encourages EOHHS to reconsider the use of the Outcome Metrics as an AE incentive. These metrics will be developed and reported by the MCOs because the AEs do not have the capability of performing this measurement. EOHHS should consider moving this "pay for reporting" requirement to the MCO and keep "pay for performance" with the AEs.

We look forward to discussing our comments with EOHHS to clarify our recommendations.