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Dear Ms. Morales:

We thank you for the opportunity to continue to offer comments and suggestions. UnitedHealthcare Community Plan (UHC) supports the goals and objectives of the total cost of care (TCOC) model proposed by EOHHS to promote shared responsibility for costs and quality and to align incentives to support investments in care management and other services that are most likely to meet enrollees' needs in an efficient and effective manner. UHC offers the following suggestions and recommendations to ensure that the goals and objectives of the health reform initiative are met in the most effective manner.

TCOC Methodology

1. **PMPM vs. BCR** – Although the blended PMPM model is a reasonable attempt to align a PMPM and BCR model, UHC would suggest that the differences between the current PMPM and BCR models are modest and do a third, new, methodology may not be neccesary. The BCR model is dynamic and takes into account trend and risk as established by EOHHS. UHC also has a PMPM model that we use for AEs with lower BCRs where we want to assure quality and access is not compromised.

   UHC BCR and PMPM Model comparison provisionally approved by EOHHS

   
   EOHHS Approval Request_PMPM progra

   

   UHC Response to EOHHS questions_PMP

2. **Historical Data** – UnitedHealthcare supports the use of historical data however looking back prior to January 2016 does not take into account the significant programmatic changes (e.g. IHH program) that occurred at or after this date which will impact future trend. Based on the limited historical data from BHDDH, the IHH program historical financial performance cannot be accounted for accurately in a TCOC model.
3. **2% Shared Savings Cap**- UnitedHealthcare agrees with the concept of a cap on savings and risk however, we believe that the cap should be based on the size of the membership assigned to the AE. United recommends a 2% cap for AEs with smaller membership with tiers up to a 5% cap for AEs with larger membership. United believes adjusting the cap based on the size of the population limits exposure for groups with more financial volatility due to the size of the membership base, and a greater incentive for those groups with higher assigned

membership. Depending upon the ultimate membership guidance for the AEs, United suggests the following caps based on membership level:

Size of population	Maximum payout/risk cap based on TCOC
1,000 – 2,499	2.0%
2,500 – 4,999	4.0%
5,000 +	5.0%

4. **Savings assumptions**- UnitedHealthcare reiterates that upfront assumed AE programs savings may create unachievable expectations. Care must be taken to ensure that payment reform is not advanced at a pace that is not sustainable and therefore puts the system at risk for disruption. State aspirational goals must be balanced and informed by AE ability, interest and capability. Savings assumptions implemented too early in the process are likely to compromise the AEs ability to prepare or transform to take on risk. Creation of a phased path to savings shared between the State, the AEs and the MCOs over the course of several years is more likely to ensure long term system transformation and success.

   UnitedHealthcare is committed to driving affordability in the Medicaid program. Both parties should be incentivized to realize savings through fairly constructed shared savings models that benefit the MCO as well as the AE. These shared savings model may shift risk and benefit over time and should be stipulated in the contract between the MCO and the AE.

   The AE model operates with the premise that the MCO share affordability savings with the AEs. Because the AE program is in its infancy, the investments of the MCOs are not rewarded fairly through the current gain share methodology. Moreover the State should ensure the MCOs sufficient flexibility to design an incentive structure with AE's that is subject to the savings assumptions and cap noted above and that ensures a reward structure that incentives and rewards both the MCO and the AE for investments made.

DSRIP Payments/Funds Flow

Timing and flow of payments must be structured to ensure AE fiscal solvency at the outset. To this end it may be appropriate to front load funding – i.e. drive up-front payments to support infrastructure changes and assume a slow transition to self-sufficiency (and lower supplementary payments) over the ensuing years. To assure timely and effective flow of funds we offer the following suggestions:

1. Timeframes must be carefully evaluated to ensure reasonableness. Given that CMS won't issue payment until performance measures are met it is imperative that the measures be structured to allow for sufficient payments at

the outset to ensure fiscal solvency and support the transformational activities needed to achieve longer term savings.

2. To execute contracts, AE's need transparency on the criteria for infrastructure funding that will be paid and timeframes.
3. The overarching timeline must be carefully assessed. The current model suggests that contracts are to be in place by January 1, 2018 with payments from the MCO to the AE beginning in the 1st quarter although could be as late as 2nd quarter 2018.
4. Year 1 and/or 2 measures should be more focused on process or narrowly defined metrics that are reasonable for the provider to accomplish. For example, closure of gaps identified in AE applications may be reasonable Year 1 measures, specifically Domain or Performance Milestone's gap closures. Premising year one measures on process measures that are more likely to be achieved in the short term will ensure early success, and provision of incentive payments needed to support the AE's as they mature.

Attribution Methodology

UnitedHealthcare recommends that **all** members be assigned/attributed to PCPs. Assignment with lock in until open enrollment and/or the member elects to change PCPs, is most likely to achieve desired cost and quality goals through continuity of care. Assuring that assignment models are consistent across populations and programs will create a truly integrated medical and BH AE. In this model the AE would determine internally any shared savings or shared risk distributions. We believe that in these early stages of ACO creation in RI, PCPs have substantially greater experience and expertise in clinical and cost management. The integrated care management approach as envisioned by EOHHS for the IHH program is not fully realized. IHHs can still share savings & risk with the AE but members would be attributed to PCPs. We offer the following slide as an example of complexity of current attribution model.

MMOS				PCP Groups				
IHH's	AE #1	AE #2	AE #3	AE #4	AE #5	AE #6	Non AE	Grand Total
IHH #1	165	92	59	71	54	16	366	823
IHH #2		363	12	289	17	15	285	981
IHH #3	48	43	12	55	33	39	257	487
IHH #4							12	12
IHH #5	60	438	30	278	192	294	882	2,174
IHH #6		54	24			5	310	393
IHH #7		257	24	77	34		117	509
IHH #8	41	50	17	67	43	65	205	488
IHH #9		972	22	230	79	36	409	1,748
IHH #10		326	66	127	37	22	334	912
IHH #11	11	87		27	1	21	57	204
IHH #12	411	1,117	163	563	339	283	1,736	4,612
IHH #13		677	85		12	34	1,015	1,823
IHH #14	10	252	1	93	145	321	585	1,407
IHH #15	2	463	2	134	37	20	254	912
IHH #16		78		40	39	33	150	340
IHH #17	10	503	43	224	391	268	761	2,200
IHH #18		441	28	215	42	35	152	913
IHH #19	307	568	235	556	708	3,917	2,289	8,580
No IHH	22,658	139,982	54,620	201,309	54,184	118,857	414,380	1,005,990
Grand Total	**23,723**	**146,763**	**55,443**	**204,355**	**56,387**	**124,281**	**424,556**	**1,035,508**

Quality Measure Alignment

Alignment and consistency is essential. While core SIM measures will assure alignment, additional optional measures may need to be added to mutually address MCO and AE requirements. A balance between alignment to ensure consistency from the AE and provider perspectives and flexibility to reflect unique MCO/AE arrangements can be achieved in AE contract negotiations.