



Date: September 30, 2019  
To: Rhode Island Executive Office of Health and Human Services  
From: Integrated Healthcare Partners  
Re: Rhode Island Executive Office of Health and Human Services (EOHHS)  
*Medicaid Program Accountable Entity Roadmap Document*

Integrated Healthcare Partners (IHP) applauds the Rhode Island Executive Office of Health and Human Services for the collaborative work on this initiative and appreciates the ability to offer feedback for consideration. After our review of the file named AE\_Roadmap\_2019 received from Leah Delgiudice on 9/6/19 we offer the following feedback for consideration.

Section V AE Certification Requirement -

- IHP is concerned about a joint MCO AE application. Currently we must go through a recertification process with EOHHS. This recertification process is streamlined and does not require a large amount of administrative effort. Including the term application in this language raised a concern over the effort required to apply. The first application process was tedious and quite time consuming. In the public session, the AE's voiced concern related to a possible need to accomplish different things for each MCO arrangement. Currently the HSTP process is streamlined with the MCO's and this seems to take some of that simplification away.

Section 9 # 1 - Program Monitoring, Reporting, & Evaluation

- MCO Required Reports - AEIP Milestone Performance Report – AE's may not know what this is, assuming this is already in effect with the MCO. This sounds like an additional administrative item for the AE's. IHP would encourage EOHHS to limit additional administrative activities.

Section 9 # 1 - Program Monitoring, Reporting, & Evaluation- Section 4 Evaluation Plan

- Required Evaluation plan – IHP would ask for more clarification on what this entails, the impact to the AE, the MCO's and a timing for this activity.

There have been some recent meetings to discuss these requirements in further detail. Not stated in the AE Roadmap document, but discussed in some of the public meeting EOHHS held, IHP wants to reiterate the following pieces of feedback:

- Attribution logic may change back to PCP attribution only(?)– As there has not been a session related to Attribution, IHP encourages EOHHS to have a session with the AE's and the MCO's in relation to this topic. Additionally, we encourage EOHHS to share with us the recommendations that have come out of the work group to look at this, and

to include some AE representation on that committee. IHP certainly hopes there are recommendations that can be taken within the UHIP processing system to assist in PCP assignment.

- FQHCs will obtain a lower incentive PMPM by 25%. IHP recommends EOHHS choose a percentage that is much lower than 25%. The FQHC's in RI are the safety net providers of RI Medicaid members.
- The % of incentive dollars for outcome measures recommended by EOHHS to be at 50%. IHP believes that this percentage is too high. Reasons being, this is the first year of placing targets on utilization-based measures, additionally the data that created the baseline and targets for the AE's has not been shared with the AE's
- The percent of incentive dollars for the HSTP plan was recommended to be 25% - IHP believes that this percentage is too low.
- All HSTP activities must be measure driven in order to prove achievement - IHP concurs with the feedback from the meeting, that this would mean, all incentive finds would be measure based. This would mean that all incentive dollars would be earned at the end of the Program year. This could cause cashflow issues for the AE's as those dollars would not be coming in throughout the course of the year. Additionally, this may lead to too many measures for a given AE to manage.
- Change in the method of the PPS payments – IHP understands that EOHHS is changing its method for PPS payments. If so, we are concerned that the FQHC's could be adversely impacted. We understand that currently the PPS is not included in the MCO/Claims/TCOC model. We believe this may change in that, EOHHS will include additional dollars in the capitation payments to the MCO to cover the PPS and that the payment will flow through claims. If EOHHS increases the premium capitation and does not adjust the medical portion of the rates, the FQHC's PMPM will be diluted, because the PMPM sent to the MCO's is based upon prior FQHC payments divided by the full Medicaid population. Therefore, the PMPM would be diluted for each FQHC when we compare it to our actual expense. This would be disadvantageous to the RI Safety net providers taking care of the majority of Medicaid lives in the AE.