Rhode Island Executive Office of Health and Human Services (EOHHS)
Response to Comments on Accountable Entity Roadmap 10/30/2019

II. Rhode Island's Vision, Goals and Objectives			
Comment			**EOHHS Response**
Prospect Health Services RI, INC	**Social Determinants of Health**	The AE initiative would benefit greatly from a common IT platform for managing all activities and functions related to SODH Screening, Referral, Navigation, and Closing-the-Loop. With a single referral and SDOH management platform in place, CBOs will be more likely to engage with the AEs knowing they will not face the challenge of navigating different systems implemented by each AE. AEs, MCOs, EOHHS, and other stakeholders would also benefit from having a single source of aggregated data regarding SDOH needs and the success/gaps in addressing those. The Housing Resources Commission, the state's Office of Community Development, and Rhode Island Housing (RI's FHA) would be valuable additions as AEs endeavor to respond to the housing and supportive housing needs of their patients. Community development corporations (CDCs) would also be a valuable addition to the efforts of the AE program to address SDOH– either select individuals CDCs or sectoral representation. Other potential additions to the assist the AE program in addressing ADOH include education, corrections, DCYF, human services, veterans' affairs, labor & training (beyond the current engagement around healthcare sector employment), and municipalities (consider prioritizing the urban core). The state could also play a catalytic role encouraging and fostering innovative investments to address the social needs of AE patients.	EOHHS is open to exploring ways that centralized investments could support partnerships between the AEs and the CBOs. Before doing so, EOHHS is planning to do an analysis of what the CBOs need in order to support the healthcare transformation activities of AEs.
III. Our Approach			
Comment			**EOHHS Response**

Coastal Medical	**Attribution**	We would advocate that EOHHS develop a process with the MCOs and AEs to fix the attribution issues in PY3 to ensure a more accurate and timely process.	EOHHS will be increasing its oversight of the MCOs' PCP assignment and AE attribution to ensure better accuracy and will encourage the MCOs to work with their AEs to reduce the percentage of non-engaged members. If necessary, EOHHS will convene a meeting to discuss this with the MCOs and the AEs.
Integrated Healthcare Partners	**Attribution**	IHP encourages EOHHS to have a session with the AE's and the MCO's in relation to attribution.	
Neighborhood Health Plan of RI	**Specialized AEs**	Leverage Health System Transformation Program funding to support LTSS provider infrastructure for 3 purposes: promote rebalancing, further quality measurement, and prepare for APM/AE partnerships. Promote opportunities for primary care and LTSS to work together. Consider future MMP/APM Pilot to create shared savings program with Medicare and Medicaid revenue using AE program as the foundation. Current AE providers are highly engaged and understand clinical transformation needed to benefit from shared savings but, MMP financial and utilization experience is still evolving and needs careful assessment prior to engaging in shared savings.	EOHHS appreciates this input and will take it into consideration in its planning processes for the Specialized AE and dual eligible strategy development.
Tufts Health Plan	**Specialized AEs**	While we believe in the value of provider accountability in improving care for these exceptionally vulnerable individuals, we highlight that compared with the comprehensive AE model for the general Medicaid population which features a PCP-centered model; dually-eligible members must be supported by an integrated approach that covers a much broader care continuum that could be best led by MCOs. We encourage EOHHS to take this [An MCO-lead integrated care continuum for the Dual Eligible population] into its design consideration when developing payment models over the coming years.	EOHHS agrees that dual-eligible members must be supported by an integrated approach.
United Healthcare	**Specialized AEs**	To avoid cost shifting between programs: Align state-based quality metrics to CMS Star quality measures, where possible.	During the implementation of this program, EOHHS will make efforts to align with CMS wherever possible.
IV. AE Program Structure			
Comment			**EOHHS Response**

Providence Community Health Centers	**Risk-Based Arrangements**	PCHC believes Risk Adjustment should have a geographical component. By employing a multi-region element to the Risk Adjustment, the AE's will have a more equitable and objective basis for their calculated results.	EOHHS is considering additional criteria for risk adjustment but any new criteria will not be implemented in Program Year 3.
Providence Community Health Centers	**Risk-Based Arrangements**	PCHC recommends recalibrating/re-bucketing members into their risk-based category ideally on a monthly basis, yet at a minimum on a quarterly basis.	EOHHS appreciates this input but does not feel that there is a need to recalibrate member's risk on such a frequent basis. In PY 3, EOHHS will not be requiring that there be a recalibration of member's risk on a monthly or quarterly basis.
Providence Community Health Centers	**Risk-Based Arrangements**	PCHC final recommendation is for transparency with the sharing of and access to RI EOHHS Medicaid rate books between EOHHS, MCOs and AE's.	Rate books contain proprietary information that EOHHS is not authorized to share. EOHHS will continue to make efforts to be as transparent as is feasible under current restrictions.
V. AE Certification Requirements			
		Comment	**EOHHS Response**
Coastal Medical	**AE Certification and AE/MCO Collaboration**	We are concerned that including the MCO's in the certification process while being excluded from monthly meeting with EOHHS and the MCOs will increase the administrative burden to the Accountable Entities rather than reduce that burden. We recommend that the AE's are included in this process [Monthly Meetings between EOHHS, MCOs] in order to meet EOHHS's stated goal "to foster strong and clearly defined roles and expectations for both the AE and MCO in transforming the delivery of care." In the absence of direct guidance and structure around these joint applications the inclusion of the MCO may delay the certification process.	EOHHS will continue to independently certify the AEs. There will be questions in the revised AE Application regarding how the AEs plan to collaborate with the MCOs. Revisions were made to the final AE Roadmap to clarify this.
Integra	**AE Certification and AE/MCO Collaboration**	We strongly recommend that if the goal is standardization, EOHHS should be specific and prescriptive about the form, content, and standards for a single AE certification and HSTP submission to eliminate unnecessary administrative burden.	
Prospect Health Services RI, INC	**AE Certification and AE/MCO Collaboration**	We support the goal of EOHHS to reduce the administrative complexity of the AE program, however, some of the mechanisms proposed may not achieve this intended goal. The most efficient way to manage this process is for AEs to	

		apply to EOHHS, with any issues or gaps, resolved between the AEs and EOHHS directly. Inserting a layer of MCO review and approval would result in AE certification applications reflecting differing interpretations of the respective MCOs and not the state of the AEs as they present themselves vis-à-vis the Certification standards.	
Prospect Health Services RI, INC	**AE Certification and AE/MCO Collaboration**	We support the idea that AEs can pursue a single HSTP Plan covering all attributed patients. The proposal that AEs develop and submit HSTP plans in partnership with each MCO, however, would not necessarily advance/support this. It would merely move the opportunity for variation in the HSTP to an earlier stage in the process. What is needed is a single, unified review and approval process.	EOHHS's intent through modification to PY 3 processes is to create a single unified review and approval process. This will be done by integrating the HSTP project plan into the certification process done by EOHHS.
Prospect Health Services RI, INC	**AE Certification and AE/MCO Collaboration**	A core challenge to the AE initiative lies in the "delegated" and "divided" authority under the program. The most valuable contribution EOHHS could make to resolving this would be to take steps to decrease the variation in administration by MCOs. As was discussed in the Open Discussion meetings, this could include more forums where AEs, MCOs, and EOHHS together review significant documents, policies, and issues and resolve any differences in interpretation or implementation in an efficient manner.	EOHHS appreciates this feedback. As discussed at the AE Open Discussion meetings, as this program must be administered by the MCOs, there is a certain level of flexibility that EOHHS would like to continue to provide to the MCOs in order for them to be innovative in their implementation approaches.
Tufts Health Plan	**Attribution**	EOHHS should develop concrete guidance to operationalize the member assignment policy, which would require tight collaboration among EOHHS, the AE and the affected MCOs.	EOHHS will impacted stakeholders when operationalizing the member assignment policy.
Integra	**OHIC RBPO Certification Application**	Integra would like to better understand the PY 3 requirement for the OHIC RBPO Certification Application.	Additional detail regarding the requirement for the OHIC RBPO Certification Application will be included in Total Cost of Care PY 3 Requirements document.
VII. Alternative Payment Methodologies			
		Comment	**EOHHS Response**
Coastal Medical	**Risk-Based Arrangements**	Downside risk should be a percentage of fee-for-service revenue rather than TCOC, at least for those organizations that do not include a hospital in their ACO.	In acknowledgement of the varied composition of AEs, the PY3 requirements will include a required downside risk of the lesser of 1% of TCOC or 3% of provider revenue.
Integra	**Risk-Based Arrangements**	Integra does not believe that the program is mature enough to support taking on downside risk in PY3 and encourages	EOHHS strongly believes that PY 3 must be the inflection point of the AE program during

		EOHHS to move judiciously towards adding risk to the program.	which the AEs begin taking on downside risk. The amount of downside risk that AEs will be required to take on in PY 3 will be minimal, and will increase gradually in the future, in order to allow the AEs time to fully prepare for entering into contracts that have more material amounts of downside risk.
Neighborhood Health Plan of RI	**Risk-Based Arrangements**	To ensure the future success of the AE program, please consider allowing changes to an MCO's shared savings model. Specifically, consider allowing the use of EOHHS-established MCO risk-adjusted rates to be used to establish performance targets.	EOHHS is considering the use of MCO rates in the establishment of TCOC targets and will be working with stakeholders in the coming weeks to refine the methodology.
Neighborhood Health Plan of RI	**Risk-Based Arrangements**	Neighborhood does not concur with EOHHS's recommendation to require AEs to assume meaningful downside shared risk or full risk. If any AE opts to assume down-side risk, an actuarial review of the AE's financial readiness to assume risk needs to be conducted. EOHHS needs to ensure any risk arrangement does not jeopardize RI's Medicaid primary care infrastructure comprised of both FQHCs and non-FQHCs.	AEs assuming downside risk in PY3 will be required to obtain certification from OHIC as a risk-bearing provider organization.
Prospect Health Services RI, INC	**Risk-Based Arrangements**	Prospect supports moving away from traditional fee-for-service payment in favor of alternative payment methods however accommodating those AEs that wish to proceed slowly should not delay those that are prepared to move more quickly toward downside risk and capitation.	The AE program provides that AEs that want to assume additional risk beyond program minimums are able to do so with approval from EOHHS and with the otherwise-required RBPO certification from OHIC.
Tufts Health Plan	**Risk-Based Arrangements**	We encourage EOHHS to develop policies that support robust risk mitigation to help delineate insurance risk from performance variation, so that AE providers are accountable for what they can control and influence. One of the key mechanisms is risk adjustment, which has been launched for MCO capitation rates starting in FY2020. While the state does not prescribe the risk adjustment methodology applied to TCOC targets in MCO-AE contracts, from a practical standpoint it is highly compelling for the market to apply the same risk adjustment methodology for TCOC to ensure incentive alignment between AEs and MCOs, not to mention the vast benefit of simplification and consistency. To support this effort, we ask that EOHHS maximize transparency of the	EOHHS appreciates this input and will take it into consideration in its standardization of the TCOC methodology.

		risk adjustment program, sharing with not only the model name/version, but also any unique adjustments made by the state and normalization calculations. EOHHS should consider CMS's approach to risk adjustment transparency in the Medicare Advantage and ACA small and non-group programs as a best practice and benchmark.	
Providence Community Health Centers	**Methodology/Standardization**	PCHC recommends EOHHS standardizes a methodology for the MCO's to follow when calculating the TCOC to account for this disparity.	In Program Year 3, EOHHS will be standardizing and setting the TCOC benchmarks.

VIII. Medicaid Infrastructure Incentive Program (MIIP)

		Comment	EOHHS Response
Coastal Medical	**Performance Measures**	Coastal agrees with and recommends lowering the percentage for the outcome measure set to 25%, increasing the joint project-based performance measures to higher percentage and adding a provision for quarterly milestone payments. Coastal recommends adding an additional category that would allow the AE's access to a percentage of the incentive money earlier in the performance year so that the AE's can continue to fund the work of their care teams and collaborations which aim to address the utilization and behavioral health needs of their patient populations.	The AE PY 3 Incentive Program Requirements document will delineate in further detail the allocation of the Incentive Pool funds. EOHHS encourages the AEs and MCOs to work together to establish arrangements for more frequent payment of these funds if needed, specifically as it relates to the variable allocation of incentive funds project-based measures.
Coastal Medical	**Performance Measures**	Coastal recommends maintaining flexibility in determining the joint performance measures and allowing for overlap between the outcome measures and the project performance measures.	EOHHS will not be allowing overlap between the outcome measures and the performance measures.
Providence Community Health Centers	**Performance Measures**	PCHC recommends keeping a level playing field between the RBPO's and Non-RBPO's by not making any changes incentive pool calculations.	The AE PY 3 Incentive Program Requirements document will delineate in further detail the allocation of the Incentive Pool funds. Contained within those requirements are opportunities for the Non-RBPO AEs to receive 100% of the Incentive Pool funds.

IX. Program Monitoring, Reporting, & Evaluation Plan

		Comment	EOHHS Response
Integrated Healthcare Partners	**Administrative Burden**	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.	The AEIP milestone report is a report that enables EOHHS to monitor and track MCO determination of AE achievement of milestones, metrics, and payment earned and made by program year. This adds no administrative burden to the AE.

Tufts Health Plan	**Data Sharing**	Proper two-way data exchange between the AE and MCO is a foundational requirement and that policy-level specifications of how the exchange shall be conducted and supported would be important. For example, a standard model of clinical data access by the MCOs should be established as a component of the AE program design. We ask that EOHHS engage stakeholders on the design of this effort [Proper two-way data exchange between the AE and MCO], to ensure market alignment on key metrics, thresholds, and ultimately the conclusions from the evaluation.	EOHHS agrees that two-way data exchange is a foundational necessary element of the AE program. MCOs are required per their contract with EOHHS to provide AEs with a standard claims data set. EOHHS will convene the MCOs and AEs if needed.
Integrated Healthcare Partners	**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.	HSTP and AE program evaluation has been embedded into the 1115 Waiver Evaluation Plan. This Evaluation Plan is to be conducted by a third party per RI STC's. Once the contract with NORC, the evaluator, is fully executed, EOHHS anticipates providing an overview of the elements specific to HSTP.
United Healthcare	**Monthly Meetings**	Consider one monthly meeting with all MCOs, AEs, and EOHHS to ensure all parties are on the same page with program expectations and have equal representation.	EOHHS appreciates this feedback and will take this into consideration in planning for PY 3. EOHHS anticipates ongoing dialogue as needed with MCOs and AEs on various topics.
United Healthcare	**Monthly Meetings**	We request clarification from EOHHS as to whether the meetings referred to under the In-Person Meetings with MCOs section are the existing EOHHS Oversight monthly meetings with each MCO or if this section refers to a different set of meetings.	The meetings referred to under the In-Person Meetings with the MCOs section refers to the current monthly MCO oversight meetings convened by EOHHS.
Neighborhood Health Plan of RI	**Performance Measures**	Consider adopting input from the MCOs and AEs to use a standard, minimal set of metrics to assess the overall performance of the AE program. Metrics should address an array of domains most relevant to the goals of the program.	In CY2019 EOHHS contracted with Balit Health to develop a simplified standard minimal set of metrics. There will be additional information in the Program Year 3 Incentive Funding.
Neighborhood Health Plan of RI	**Performance Measures**	Consider creating a standard progression to advance new quality, outcome or HSTP metrics based on the following cadence: Time 0 = Introduction of new metrics with discussion and analysis to arrive at EOHHS/AE/MCO adoption consensus – this includes preliminary measurement to assess the measurement feasibility Time 1 = Baseline calculation (test data methodology and validation) Time 2 = Pay for Reporting (test data methodology and validation) Time 3 = P for Performance	EOHHS appreciates this feedback and requests that after review of the PY 3 Incentive Program requirements, the commenter clarify their proposed approach.

United Healthcare	**Repository/Access to Documents**	Create a centralized repository to house all documents related to the AE program to provide participants with a one-stop shop for the most up to date, relevant documents.	EOHHS will continue to work on the development of an online repository of documents supporting the AE program.
United Healthcare	**Required Reports**	Include a comprehensive list of required reports within the Roadmap, including use and expected frequencies of submission. The current list in the revised Roadmap is not a comprehensive list.	The list of required reports included in the revised AE Roadmap contains the reports that are specific to the AE program. The full list of all reports, including those related and unrelated to the AE program, will be included in the MCO reporting calendar, which will be posted with MCO Contract Amendment 3.
Other Comments			
		Comment	**EOHHS Response**
Integrated Healthcare Partners	**PPS Payment Methods**	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.	EOHHS appreciates this input and will take it into consideration in its standardization of the TCOC methodology.
Integrated Healthcare Partners	**FQHC Rates**	FQHCs will obtain a lower incentive PMPM by 25%. IHP recommends EOHHS choose a percentage that is much lower than 25%. 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.	EOHHS appreciates this feedback. The AE PY 3 Incentive Program Requirements document will delineate in further detail the allocation of the Incentive Pool funds.
Prospect Health	**Rule Changes**	We urge EOHHS to impose new/revised rules sparingly. Rather than rule changes, simple[sic] giving more time for all parties involved to achieve our shared goals might be more effective.	EOHHS appreciates this feedback and does not plan to make any changes that are not necessary to this success of the AE Program.

Services RI, INC			
Tufts Health Plan	**Provider Network Design**	We ask EOHHS to consider program options to strengthen members' "AE affinity" as a strategic design feature of the AE program. Within applicable boundaries, EOHHS should consider flexibilities in benefit/network design to reinforce the use of AE providers.	EOHHS encourages AEs to develop innovative strategies to communicate to, and engage with, their patients regarding the benefits of in-network providers. However, EOHHS does not plan to allow AEs to restrict member access to care to the AE network.