



May 30, 2019

Medicaid Director, Patrick Tigue
c/o Christine Dadali
Medicaid Policy Office
RI Executive Office of Health and Human Services
Three West Road
Cranston, RI 02920

Dear Director Tigue:

Providence Community Health Center (PCHC) appreciates the opportunity to collaborate with the RI EOHHS on the future direction of the Medicaid Accountable Entity Program. Our mission "To improve the well-being of the communities we serve by providing high quality, accessible, patient-centered care regardless of cultural background, social barriers, or ability to pay" aligns with the State's mission to provide access to high quality and cost effective services that foster the health, safety, and independence of all Rhode Islanders. In an effort to promote the mission of both the State and PCHC, we have identified some concerns and/or recommendations about the fiscal underpinnings of Accountable Entities (AE's) in Rhode Island as well as opportunities for the State to bridge gaps, creating a sustainable health care system within the healthcare industry.

First, PCHC has concerns regarding the application of AE-Specific Historic Cost Data (P.5) as currently defined. Specifically, the concern deals with the transition of prior Rhody Health Option members to active Rhody Health Partners. These member's historical cost data need to transfer along with the member. As future programs are developed and members are transitioned between programs, their historical cost should also transfer and be part of the Total Cost of Care (TCOC) Target, facilitating an equitable comparison.

Additionally, PCHC would request a review of the Mitigation of Impact of Outliers: Claims threshold for high cost claims (P. 5) policy. We recommend excluding the 10% annualized spending per member add-back. A majority of cases above the \$100k threshold are beyond the impact of the AE. Typically, these cases (transplants, extended hospital stays, nursing home residents) are managed at the MCO level, not the AE level. The AE's do not have delegated authority to make an impact on these types of cases.

Further, PCHC believes greater transparency is needed with Cost Trend Assumptions. In Historical Base with Required Cost Trend Assumptions (P. 6) section, we believe the AE requires the right to inspect any trend assumption, to secure a better understanding of "the medical component of capitation rates



being paid to MCOs by EOHHS”. Inspection of the rate books would promote a higher level of transparency between AE, MCO and RI EOHHS.

Finally, Providence Community Health Center has 3 recommendations for consideration:

1. PCHC recommends redefining the “Total Cost of Care” (TCOC) to be exclusive of AE claim payments. The one of the admirable goals of the AE program is to “**Incorporate quality metrics related to increased access and improved member outcomes**”. Currently, including the AE’s claims cost in the TCOC calculation, the AE will be incurring an increase to its TCOC. As such, the AE is being penalized by increasing access to the member. If the AE’s claims cost are removed from the TCOC calculation, the AE would be incentivized to increase access to the member while also “**creating greater financial incentives for being inside the AE program than for being outside**”. Metrics around engagement could be as simple as logging mail, text, email, call or other means of directly attempting to engage attributed but unseen patients 2-4 times a year. In the event that a patient ‘opted out’ they would be removed from the future contact efforts that calendar year.
2. AE’s should share in any capitation paid from RI EOHHS to the MCO’s for administrative cost related to primary care, in order to cover the additional cost incurred by the AE.
3. AE’s should share proportionally in any capitation paid from RI EOHHS to the MCO’s for any built in profit margin, understanding the need to build a sustainable infrastructure for the AE Program.

Providence Community Health Center has been part of the Rhode Island landscape for over 50 years and believes in the State’s efforts to promote access to high quality and cost-effective care. Our focus is on the well-being of the communities we serve and we are confident our concerns recommendations will be heard and considered.

PCHC encourages EOHHS to formally foster relationships across IHH member organizations and AEs with the specific goal of generating a standardized Unified 42CFR Part 2 consent form (or language to be included in a consent to treat form) to address both ADT, HIE information (CCDA) and standard (paper/fax) release of information. Specifically, getting to an *opt-out language for ADT level information* would solve the vast majority of the AEs needs to manage behavioral health patients using the same programs that are available to patients with other chronic medical conditions. This is critical to reliably impact 7 day follow up of inpatient mental health care, and represents a codified healthcare disparity for patients with mental health who cannot be effectively offered the same level of timely service as other chronic medical conditions. PCHC recommends engaging the same legal consultant who has provided clear and actionable insight to Blue Cross in these matters, Thomas D. Bixby Law



Office LLC, P.O. Box 5646, Madison, WI 53705, (608) 661-4310, tbixby@tbixbylaw.com to facilitate such a venture with EOHHS, MCOs, BHDDH, and BH facilities (at least Butler Hospital, The Providence Center, and CODAC – with others on EOHHS’ and BHDDH’s recommendation).

PCHC further requests that EOHHS require of hospitals both physical access by AE nurse care managers formally attributed to a patient by the AE, and require that a copy of the AE longitudinal plan of care be added to the inpatient chart for reference by the inpatient treatment team at the discretion of the AE Nurse Care Manager or designee. In most, but not all, EMR systems it is possible to require that each provider and nurse viewing the patient chart review such a plan of care once during the admission (such as on chart open, suppressed after attestation of review). EOHHS should empower a state agency to perform regular audits of patients defined as high risk by their MCO who are admitted and discharged and have no evidence of inpatient care managers successfully contacting the AE by one of the following mechanisms: phone, fax to the AE or PCP, ADT notification directly to the AE or RIQI within 24 hours of these two critical events.

PCHC requests that EOHHS require hospitals - where acute illness causes information transparency to be especially critical – to accept ‘carbon copy’ of outpatient lab and imaging results from all free-standing sites within 25 miles of the treating institution by March of 2020. Copies of labs would be sent by the reference lab when the ordering provider indicates this on the order. These labs and radiology should display in the hospital EMR system *in the same manner as those results performed inside the institution* so as not to be missed by treating providers or impede their ability to read the reports in a timely fashion or trend the results in the same manner as hospital-based results. One mechanism to expedite this would be to have the state create an ‘orders clearinghouse’ such as offered by Atlas Medical (<https://atlasmedical.com/products/atlas-labnetworks/>). PCHC in no way is recommending this vendor, and is including it merely as an example of a potential solution.

PHCH requests that BHDDH create a cloud-based solution for collecting and/or tracking 42CFR Part 2 patient consent to share substance abuse related information, allowing access by treating providers and AEs to verify that behavioral health information can be shared. This could potentially be combined with KidsNet such that automated queries are possible. In the absence of this, EOHHS could empower a state agency to conduct regular audits of MCO-defined high risk patients’ discharges and actively discuss with an organization the deleterious effects of not conducting a confirmed handoff when the patient has consented to have this done. Such an audit would seek patients discharged who both signed a consent to share information about substance abuse treatment and where there is no evidence of a transmitted CCDA or fax to the patient’s primary care provider or AE within 24 hours of discharge. Of note, even a real-time notification of discharge with no additional information would dramatically improve our system’s response to these transitions of care (see ADT above).



Finally, PCHC is acutely aware of issues generally out of our control with our EMR's inability to transmit more than 4 ICD-10 codes per CPT code in a provider friendly fashion. This is an inherent burden on the healthcare providers because of the reliance on claims information for risk stratification. PCHC recommends several strategies for acknowledging the complexity of patients care while mitigating the bottleneck of claims information:

- 1) Perform redetermination on member's risk adjusted category on a quarterly basis to reduce PCHC's anticipated penalty and encourage all AEs to actively manage accurate claims processing.
- 2) One step the State could take to level this field vis-a-vis predicted total cost of care would be to allow HCC codes from the previous three years to inform in the predicted TCOC, instead of the last calendar year.
- 3) A second method would be to allow provider video visits to carry a face to face qualifying charge and ICD 10 diagnoses to be used in the predicted TCOC.
- 4) 'January memory loss' is a problem for the claims based approach – taking an annual EMR extract of 'Problem Lists' and at least compare the predicted TCOC with the risk adjustment based on the EMR data that is not making it through the billing stream. Taking an average of this EMR-risk prediction and the claims-based predicted TCOC would mitigate provider burn-out from EMR-billing manipulation, and improve the inherent under-valuing of patient complexity in the claims-based system. This would likely have a modest side-benefit in incentivizing providers and AE's to curate patient's problem lists more closely, which in turn would make CCDA-based information more valuable when exchanged with other institutions.

In the spirit of collaboration and the creation of a sustainable, world-class healthcare system – EOHHS mission is our mission. Please contact me with any questions or clarifications with the comments. I can be reached at (401) 444-0400 or jgates@providencechc.org.

Thank you for your consideration,

Jonathan Gates, MD

Director of Integrated Care Delivery for Providence Community Health Centers Accountable Entity