Lifespan

Delivering health with care

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November 8, 2019

Leah DelGiudice
Executive Office of Health and Human Services
3 West Road
Cranston, RI 02920

RE: Lifespan's Comments: AE Guidance Documents J, K and M for Program Year 3

Dear Ms. DelGiudice:

Lifespan values the opportunity to comment on the Executive Office of Health and Human Services' (EOHHS) Proposed AE Guidance Documents J, K and M.

As Lifespan embraces the transition to value-based care, we have been reluctant to consider a Medicaid accountable care arrangement due to the administrative complexities and regulatory requirements that have been assigned to the program to date.

Lifespan was encouraged by Medicaid's release in April 2019 of the *"Member Assignment Related to Accountable Entities Policy Statement"*. We believe this Policy statement will serve to improve the Accountable Entity program and its beneficiaries. Lifespan anticipates entering into accountable arrangement(s) should this vision as outlined in the Policy statement come to fruition. With that said, please accept our comments related to the Proposed PY3 Documents:

AE Attribution Guidance-PY 3- Attachment M

EOHHS regarding Attribution: EOHHS proposes that attribution will be by assignment by the MCO at the point of entry into the MCO. Attribution to the AE will be based on PCP assignment of record within the MCO.

Lifespan's Comments: Lifespan recommends structuring beneficiary assignment such that beneficiaries with a PCP participating in an AE arrangement with an MCO will, by default be assigned to that MCO (one or more) holding the AE Contract(s) with the ability to opt out. Lifespan's reasoning for this proposal is as follows:

1. It demonstrates that the patient/provider relationship is paramount and protected;
2. It will be easier to align performance expectations;

3. It will facilitate operational decisions;
4. It ensures that beneficiary choice is preserved with the ability to choose a MCO preserved;
5. It will consolidate resources for more efficient and meaningful agreements;
6. PCPs in multispecialty group practices or part of a hospital clinic will not be forced to terminate their groups' contracts with the other MCO to funnel their patient to the AE;
7. Multispecialty primary care practices and hospitals in the AE's system of care will be able to maintain contracts with MCOs outside the AE/MCO Contract;
8. It ensures that investments made through HSTP funding is afforded to all Medicaid beneficiaries in a primary care practice and not just those enrolled with an MCO under and AE arrangement.

AE Total Cost of Care-PY 3-Attachment J

A.

EOHHS regarding Historical Base: Establishing the correct baseline target for total cost of care is a critical aspect of an effective program. For PY 3, EOHHS proposes to establish a standard methodology for establishing targets and the methodology will include historical cost of care for all services included in EOHHS's contract with MCOs.

Lifespan's Comments: Lifespan agrees that the use of a historical baseline COC as referenced above is necessary, however, Lifespan does not have historical baseline data and thus financial projections cannot be made with any accuracy. Lifespan is not able to develop a robust financial model as the AE Application requires without historical trends. Furthermore, Lifespan (or any other AE) cannot be expected to assume any amount of financial risk without an accurate historic baseline calculated and adjusted accordingly. Access to historical claims data for patients attributed to Lifespan's PCPs (and other entities with similar issues) must be provided should this proposal be adopted.
After receipt of thes data, Lifespan will work with EOHHS to validate PCP assignment and attribution. Finally, Lifespan recommends EOHHS require all MCOs to send EOHHS historical claims data for the beneficiaries attributed to certified AEs.

B.

EOHHS regarding Downside Risk: MCO/AE contracts in PY3 must include the assumption by AEs of a minimum level of downside risk.

Lifespan's Comments: Current AE program requirements do not distinguish between existing and new AEs, which means that all AEs are expected to enter Program Year 3 in 2020.

Historically, existing AEs have been afforded two years of performance analysis prior to their entry into the AE downside risk requirement as well as indemnification from any downside risk for those two (2) years. Lifespan shares EOHHS' goal of value-based contracting moving toward downside risk, but Lifespan and any new AEs will have neither immediate insight into claims data nor an understanding of the drivers impacting quality and cost. Accordingly, we believe that separate rules be established for any newly certified AEs in 2020 and beyond. We recommend that EOHHS afford any new AE the same "grace period" afforded existing AEs before having to assume risk.

C.

EOHHS regarding OHIC: The proposal grants to OHIC, on behalf of EOHHS, to require a financial review of AEs anticipating taking down-side risk to participate in: *Pre-Qualification of Accountable Entities Bearing Financial Risk* (Attachment B). The AE will be required to take adequate steps to cover the risk using: a) secured assets b) a reinsurance policy and/or c) delegation of risk.
OHIC's review will include whether the AE has sufficient financial resources as well as a review of the AEs current and/or planned process for ongoing monitoring.

Lifespan's Comments: Lifespan appreciates EOHHS's concerns that AEs assuming downside risk in their contracts with MCOs should be financially prepared to do so but Lifespan's concerns center on the choice of the proposed mechanism to determine financial viability. As we have stated previously, in the absence of legislative authority, Lifespan views this proposed review process by OHIC as an overreach of authority.

Putting the issue of authority aside, Lifespan believes that those hospital-based AEs should automatically be considered financially viable to take on risk and not be financially scrutinized. Hospital-based systems are organizations with significant financial mechanisms including liquid assets, stop-loss insurance, working capital and reserves. These mechanisms are available to protect the interests of attributed Medicaid patients in the event of losses with downside risk. Such an amendment would then exempt hospital-based AEs from the OHIC pre-qualification and on-going monitoring process.

D.

EOHHS regarding Data and the TCOC Methodology and Establishing Targets: PY3 institutes a standard methodology for establishing targets with associated quality and reporting requirements. Components for the methodology include historical cost of care and adjustments for the changing risk profile of the population.

Lifespan's Comments: Newly-formed AEs entering in PY3 will have no prior experience in order to enable fulfilling the quality and reporting requirements immediately.
Lifespan recommends that newly-formed AEs be granted time to asses and /or establish capabilities regarding PY3 Guidance and the Implementation Manual for the *TCOC and Outcome Measures and Associated Incentive Methodologies for Comprehensive AE* s, which pertain to baseline measurement, outcome measures, and data reporting/exchange, including SDOH and the Common Measure Slate.

AE Infrastructure Incentive Program-PY 3-Attachment K

A.

EOHHS regarding Infrastructure: AEs certified through the PY3 (1-1-20 to 6-30-21) and in a qualified APM contracts consistent with EOHHS requirements are eligible to participate in the Medicaid AE Incentive Program, however, without being eligible for HSTP funding.

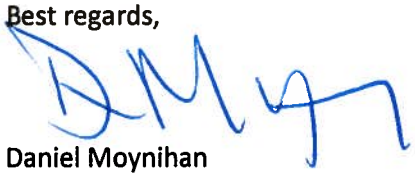
Lifespan's Comments: Lifespan recommends that newly-formed AEs be granted an equal share of HSTP funding without the requirement that AE assume downside risk. This would be similar to AEs who participated in PY1 and PY2 prior to their assuming downside risk.
Furthermore, Lifespan proposes that funding be at a higher level at the outset for the newly-formed AEs in order to catch up to and receive equitable levels of funding afforded other AEs during PY1 and PY2.

B.
EOHHS Regarding the Quality Multiplier: The formula for the quality multiplier is applied to shared savings.

Lifespan's Comments: Participation in the AE Incentive Program specifies the quality multiplier is applied to shared savings. A similar method could be used for entities assuming downside risk where a low-quality score would increase the deficit share and a high score would decrease th share.

Lifespan is appreciative of your consideration of our comments.

Best regards,



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