TUFTS Health Plan

75 Fountain Street Floor 1
Providence, RI 02903-1852
tuftshealthplan.com

November 8, 2019

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

Re: Comments on Accountable Entity Program Year 3 Documents

Dear Ms. DelGiudice,

Tufts Health Public Plans ("THPP") appreciates the opportunity to provide comments on the draft Accountable Entity ("AE") Program Year 3 ("PY3") changes and the open and collaborative process that the Executive Office of Health and Human Services ("EOHHS") has undertaken in making program design decisions.

We share the goals of care delivery transformation, promotion of value-based payment models and an enhancement of the beneficiary experience. We welcome EOHHS's efforts to engage the market in making design decisions that help move the program towards long-term success.

As a new entrant to the Rhode Island Medicaid market, THPP is excited about the opportunity to contribute to this historical movement in the State, while leveraging our experience with a similar program transformation in Massachusetts.

Below is a prioritized set of comments and recommendations based on the PY3 documents available for public comment.

**Assumption of Downside Risk**
*Attachment J – Accountable Entity Total Cost of Care Requirements – Section C*

It is clear, from the Accountable Entity Advisory Committee public comments, that the progression to taking downside risk for providers has strong support and opposition. We have several perspectives on this topic rooted in national industry trends as well as our own experience on other markets.

We agree with EOHHS' stated objective of implementing downside risk as a key element for increasing the level of accountability for total cost of care and deepening engagement in population health management.

We acknowledge that movement to downside risk is not a binary decision – the transition can and should be progressive, dependent upon the AE's readiness to assume risk. In transitioning to downside risk, it is important to provide an opportunity for full participation for all AEs, including FQHC-based AEs. Enclosed are references to approaches taken by other states to achieve full

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participation (Reference 1 and Reference 2).

THPP would like to also highlight the protective mechanisms, such as risk adjustment, risk corridors and reinsurance that can be applied to mitigate unwarranted risk that is beyond the provider's ability to affect. Risk adjustment was introduced into MCO capitation development in State Fiscal Year 2020 and we recommend applying a similar, uniform risk adjustment methodology to AE TCOC development. Risk corridors are another important mechanism that should be appropriately calibrated for MCOs and AEs; existing protections exist which carve out the majority of NICU costs and claim cost in excess of $100,000. Finally, we agree with the proposal to establish reinsurance or similar safeguards through OHIC's pre-qualification process for risk-bearing provider organizations.

We also promote symmetry in the gain and risk sharing as a mechanism for shared responsibility between MCO and AE. It is worth noting that the PY3 requirements do not achieve the degree of symmetry we believe is important due to the fee for service cap proposed.

Given the valid imperatives both supporting and discouraging the immediate implementation of mandated downside risk in PY3, we recommend an alternative approach that incentivizes, *but does not require*, AE/MCO partnerships with demonstrated readiness and expressed interest for managing downside risk. The PY3 requirements make strides in affording AEs flexibility in determining their readiness to assume downside risk and incentivizing that strategic decision. Specifically, they allow for an opportunity for entities that choose to *not* assume downside risk to receive shared savings of up to 50% percent, with an additional incentive for 60% or more of shared savings for entities that *do* choose to assume downside risk. THHP notes that this type of incentivized structure is a critical first step but does not yet achieve symmetrical sharing in the event of a deficit.

An additional incentive we recommend is an increased allocation of HSTP funding for downside risk arrangements. Such approach has been successful implemented in the Massachusetts Delivery System Reform Incentive Payment Program.

**Downside Risk Certification**
*Attachment J – Accountable Entity Total Cost of Care Requirements – Section F*

We acknowledge the crucial role and expertise that OHIC brings, in collaboration with EOHHS, to the process of ensuring that AEs assuming downside risk have the financial wherewithal to do so.

We believe AEs and MCOs should have a thorough understanding and input into the standards by which OHIC will evaluate downside risk readiness.

In addition, we ask consideration for grandfathered or expedited approval of TCOC risk arrangements that have been executed prior to the final approval date of PY3 changes which includes flexibility with respect to OHIC review. A similar expedited approval process should be considered for entities with demonstrated ability and financial infrastructure for downside risk in other lines of business such as Medicare.

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**TCOC Target Methodology**
*Attachment J – Accountable Entity Total Cost of Care Requirements – Section D*

PY3 requirements indicate that "EOHHS will further define the methodology for establishing TCOC targets and anticipates completion of this process no later than November 30, 2019." Upon release of the final methodology, we expect to provide additional input.

Due to our lack of historical claims data for contracted AEs, we are using the medical portion of the capitation as the TCOC target for the first four years. This approach is based upon the need for three years of claim data with run out of six months.

Having the TCOC target uniformly developed to align with MCO capitation, we believe, is an approach that merits program-wide implementation, not just afforded to newly established plans such as Tufts Health Plan. This approach offers a degree of simplification and transparency for TCOC target development. We also suggest that EOHHS use a third party (e.g., CHCS) to inventory TCOC approaches for Managed Medicaid around the country in order to capitalize on best practices and criteria.

**Attribution**
*Attachment M- Accountable Entity – Attribution Guidance*

We believe an expansion of the Member Assignment Related to Accountable Entities Policy Statement may be necessary to accommodate new AE arrangements, while at the same time honoring the provider-patient relationship. We further believe that this policy should expand and evolve to meet Rhode Island's AE goals and move the program towards long term success.

**Quality Multiplier for Downside Risk**
*Attachment K – Infrastructure Incentive Program*

As written, the quality multiplier only impacts shared savings. We suggest that a reciprocal approach be used for downside risk whereby a poor quality score would increase the AE deficit share and a good score would decrease it.

We appreciate the opportunity to provide comments on PY3 changes and we look forward to a continued dialogue as the changes are refined and finalized.

Sincerely,

Kristin Lewis

Kristin Lewis
Senior Vice President, Chief Public Affairs Officer