

May 31, 2019

Christine Dadali  
Executive Office of Health and Human Services  
3 West Road, Virks Building  
Cranston, RI 02920  
*Submitted via email: Christine.dadali@ohhs.ri.gov*

RE: Accountable Entities (AE) Program Requirements

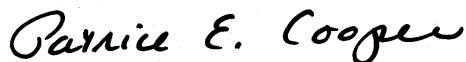
UnitedHealthcare Community Plan of Rhode Island (UnitedHealthcare) welcomes the opportunity to provide feedback on the technical corrections made to the Accountable Entities (AE) program requirements. We appreciate the commitment of the Executive Office of Health and Human Services (EOHHS) to stakeholder engagement as the State continues to refine its approaches to the Accountable Entity Program.

UnitedHealthcare is dedicated to helping individuals live healthier lives and making the health care system work better for everyone. We have served the State in the Medicaid managed care program for over twenty-five years and have seen firsthand the continued improvements EOHHS has brought to this vulnerable population. With the approximately 100,000 Rhode Islanders that we serve in the State today through Medicaid Managed Care, we have a deep appreciation of the unique needs of the population, as well as an in-depth understanding of the provider community serving this population.

Additionally, our experiences with value based payment (VBP) approaches across the country reinforce our belief that these arrangements provide the best path to better health, better care, and lower costs – for our Medicaid members and state partners. Today, approximately 3.5 million of our Medicaid members are seeking care from health professionals who participate in value based arrangements. Our current VBP portfolio includes over 300 Accountable Care Organizations (ACOs), over 4,000 providers in our quality focused VBP programs, and multiple states participating in our Hospital Performance Based Contract program. It is through this lens that we offer comments and recommendations.

We welcome the opportunity to discuss our feedback with you. Should you have any questions or seek additional information, please do not hesitate to contact me by phone at (401) 732-7439 or by email at [pcooper@uhc.com](mailto:pcooper@uhc.com).

Sincerely,



Patrice E. Cooper  
Chief Executive Officer  
UnitedHealthcare Community Plan of Rhode Island

## MEDICAID INFRASTRUCTURE INCENTIVE PROGRAM

UnitedHealthcare supports the overall goals and objectives of the AE program to improve quality and patient satisfaction while decreasing total cost of care (TCOC) by aligning payer and provider interests through risk sharing contracts. Additionally, we support EOHHS' desire to recognize and incentivize AEs that either reach achievement targets or show a specific level of improvement towards these targets when compared to prior performance. This will ensure that all AEs, even those that have not fully hit achievement targets, are recognized and incentivized to make progress towards targets.

We also appreciate that EOHHS recognized and addressed the need to increase the per member per month (PMPM) multiplier for the AE-Specific Incentive Pool to \$8.44. The new PMPM multiplier allows AEs in good standing the opportunity to obtain more incentive dollars for investment in the capabilities needed to manage greater financial risk. We applaud EOHHS for funding AEs working towards building value based infrastructure. As the first MCO to execute an AE contract, we have been a committed partner to the AEs and EOHHS to help guide program development and continue to promote program simplification.

While it is clear that EOHHS is committed to helping AEs improve health outcomes of Medicaid members, the proposed quality gate requirements, as currently structured, may be overly complex and thereby put the non-quality goals of the AE program at risk. Over-emphasizing quality could dilute focus on TCOC and patient satisfaction. Thus, AEs may have a difficult time achieving shared savings if the State implements the proposed changes.

### AE Contract Timeline

We agree with EOHHS that high-quality care is essential to a successful program and improving health outcomes for Medicaid members; however, we caution EOHHS that the timeline for contract execution between MCOs and AEs must be reasonable and attainable. We strongly urge EOHHS to extend the contract deadline for MCOs to finalize contracts with new and current AEs, as the proposed timeline is aggressive. The delays in setting Program Year (PY) 2 quality standards and approving contract templates has significant implications for MCO funding, as MCOs stand to lose 20% of their MCO Incentive Management Pool (MCO-IMP) funding if contracts with AEs are not fully executed by July 1, 2019. While we support the concept of timely contracts, the changing requirements and evolving nature of this program makes it virtually impossible to reach the timeline proposed. We strongly urge EOHHS to grant MCOs and AEs an extension until July 31, 2019, to complete all contracts.

### Clinical Data Exchange

We completely agree with EOHHS that the ability to exchange accurate and timely data is critical to the success of the AE program, but we have significant concerns about the timeline. Given our experiences in other markets, standing up a clinical data exchange by January 1, 2020, will be operationally challenging for both the MCOs and AEs.

Data sharing across integrated healthcare partners is often difficult, as these entities' systems do not typically interface or "communicate" with one another. In some cases, providers may have extremely limited or no health information technology infrastructure to facilitate communication. AEs differ in the readiness, willingness, and ability to seamlessly exchange clinical data with MCOs, meaning some AEs will require significant time and resources to get to the functional levels desired by EOHHS. The type of data, such as behavioral health data, being shared can also be limited by regulations specific to different entities. It is important that EOHHS consider these variations when developing their approach to clinical data exchange.

EOHHS's proposed program design for the clinical data exchange will require MCOs and AEs to build multiple data connections to meet data exchange requirements. AEs that use a number of different electronic medical record (EMR) platforms, which many currently do, will require separate connections to be built for each as each EMR connection is unique between the AE and MCO. Connections must be built and then potentially altered following testing, making the allotted six months ambitious and dangerous to the success of the program. Finally, MCOs must have methods for harmonizing multi-source, heterogeneous data from dozens of clinical systems, which all use a mix of standards and proprietary formats.

Based on our experience with data sharing in other markets, we recommend EOHHS consider delaying electronic clinical data requirements until PY3 or PY4 to allow MCOs and AEs to develop usable connections and validation plans. Creation of a phased in approach between the State, the AEs, and the MCOs over the course of the next few years is more likely to ensure long-term system transformation and success.

If EOHHS is intent on beginning this process sooner, another alternative is to have MCOs begin with a pilot project with a single AE to refine their approach before instituting it across all AEs. Data exchange between AEs and MCOs will lead to improved health outcomes, but only if done with an eye towards long-term sustainability and complete data integrity.

## **TOTAL COST OF CARE**

AEs were instituted with the overall goal to improve quality, decrease TCOC, and delegate risk to providers. The concerns addressed in this document stem from EOHHS placing greater emphasis on quality, which has the potential to eclipse any focus on decreasing TCOC. The complexity of the quality requirements will force AEs to divert their attention away from TCOC initiatives to meet them. AEs will also be unprepared to take on risk if they are overly burdened by understanding and meeting quality requirements as currently set forth by EOHHS. We recommend that EOHHS simplify quality requirements and support AEs to also focus on TCOC initiatives to create a sustainable program.

Additionally, the proposed quality methodology would likely not be well received by the AEs as added quality requirements may undermine cost efficiency initiatives. Accountable care programs need to be as simple as possible, from an administrative standpoint, so that care providers can focus on the underlying clinical work and not the intricacies of the incentive program.

## Risk Adjustments

The number of risk adjustments that EOHHS expects MCOs to manage is excessive and will prove difficult, if not impossible, to ensure that risk arrangements are applied appropriately to the AEs, MCOs, and EOHHS. We request EOHHS provide a numerical example of how the multiple risk adjustments (AE-MCO) and (MCO-EOHHS) will work in terms of timing and withholds. This will allow us to understand better the expectations going into PY3 when the requirement takes effect. In addition, the movement to EOHHS risk adjusted rates requires a re-baselining of historical years. Because of the AE Program attribution methodology, all calculations are manual and non-standard.

## Attribution

Attribution is of critical importance, especially as reimbursement evolves to total cost of care. In addition, while we certainly agree that the contributions of the Integrated Health Homes (IHHs) are significant to achieving program goals, especially for integrated behavioral health, we have concerns about the current attribution methodology. We encourage EOHHS to reevaluate their approach to attribution to align with industry standard ACO attribution. This will be an important consideration in PY3 as the AEs begin to take on risk.

## Reporting

The TCOC reporting timeline proposed by EOHHS concerns us. Once MCOs receive a minimum of three months of claims run out, they must calculate, confirm, and develop reports prior to sending to AEs for review. As proposed, EOHHS's timeline will not provide AEs with sufficient opportunity to provide feedback or recommendations before the reports are due to EOHHS.

Consequently, we encourage EOHHS to consider the timing it takes to develop and validate these reports, and how AEs should have the opportunity to review before they are submitted to EOHHS. We recommend minimally 165 days after the close of a quarter to allow for 3 months of claims run out and 45 days to calculate, confirm, and complete the report and meet with the AEs to review the outcomes.

## CONCLUSION

We at UnitedHealthcare are dedicated to helping people live healthier lives, and this commitment extends to all of our members in Rhode Island. We believe that our recommendations will support EOHHS in achieving its goals of improving care while managing costs and improving system efficiencies.

We appreciate your thoughtful consideration of our comments. We welcome the opportunity to discuss our feedback with you. Additionally, we are happy to provide additional information or clarification to any of the recommendations that we have provided.