

MEMO

Date: May 31st, 2019
To: Rhode Island Executive Office of Human and Health Services
From: Blackstone Valley Community Health Care Accountable Entity Program
Re: Accountable Entity Program Year 2 Attachments L1 & L2 Comments

After careful review of Attachments L1: Total Cost of Care Requirements and L2: Incentive Program Requirements drafts issued April 30th, 2019 for Accountable Entity (AE) Program Year 2 (PY2), Blackstone Valley Community Health Care (BVCHC) offers the following comments on existing and proposed program framework initiatives for use in the Executive Office of Human and Health Services' (EOHHS) evaluation of program efficacy and long-term sustainability.

Attachment L1: Total Cost of Care Requirements

1. Adjusting for a Changing Risk Profile

Page 6 states, "MCOs [Managed Care Organizations] may apply a clinical risk adjustment software. Under such an approach, risk calculations and any adjustments shall be applied at the total population and not the EOHHS rate cell level. The TCOC methodology must describe the MCO's risk-adjustment method including underlying software parameters set by the MCO. Such information shall also be disclosed to contracting AEs." BVCHC believes it would be helpful if the clinical risk adjustment methodology was defined and standardized such that all AEs are subject to the same adjustment. It would also be helpful if either the MCO's risk adjustment methodology including underlying software parameters set by the MCOs was disclosed to the contracting AEs or, if opting for Rate Cell Adjustments, the calculations were shared with the AEs.

Additionally, BVCHC hopes to receive clarification regarding the application of risk adjustment to actual costs as opposed to top-line revenue. It remains unclear as to why this application was implemented given that risk adjustment factors are traditionally applied to top-line revenue in order to accommodate patients' acuity.

2. Adjustment for Historically Low-Cost AEs

The benefit of the Adjustment for Historically Low-Cost AEs is split 50/50 with the MCO. This adjustment should be made directly to the AE and not become comingled with the shared savings generated in any subsequent performance year. The TCOC model proposed by EOHHS is distinct in identifying the upward adjustments and could therefore be easily separated from a current performance year's shared savings pool and paid to the AE. Some MCO TCOC models obfuscate the presence of these adjustments that make them difficult to identify for payment to the AEs. Furthermore, placing a cap as low as 2% on the AE's cost efficiency will severely constrain historically low cost AEs from assuming risk.

3. Required Progression to Risk-Based Arrangements

BVCHC is not of the conviction that constituent AEs will be sufficiently prepared to assume risk for PY3. The minimum requirement of withholding at least 75% of the maximum shared loss pool in combination with a 10% maximum cap of shared losses is not commensurate to the minimized shared savings potentially realized due to constraints established in the current total cost of care (TCOC) methodology. Furthermore, the withhold timing, presumed to occur monthly, creates a cash flow misalignment given that AE shared savings payout occurs annually. Lastly, there are concerns that FQHC PPS regulations do not permit withholds.

4. Hybrid Measure Generation

Page 16 does not specify EOHHS' acceptance of self-reporting for hybrid clinical quality measures. BVCHC recommends that PY2 hybrid measures continue to be reported using self-reporting means as agreed upon between the AE and MCO.

5. Program Sustainability

Although not specifically mentioned in the L1 document, BVCHC wishes to take this opportunity to reflect on the overall program sustainability, particular regarding the quality framework proposed in the PY2 L1 document as it pertains to the continuance into PY3 currently managed in a separate process through third party consulting. BVCHC remains concerned that PY2 is ultimately feeding into a PY3 that contributes to an overall program volatility both AEs and MCOs cannot fairly manage. BVCHC shares EOHHS' vision of a sustainable value-based program and commends EOHHS for the enormous undertaking in instituting the AE program. However, there is a degree of change management necessary for such an undertaking that has not been fully realized:

- a. Certain HSTP needs (i.e. partnership formation with community-based organizations) are intensive tasks that have been subject to difficult parameters;
- b. The quality framework continues to undergo numerous transformations;
- c. All activities remain subject to ongoing technical integration.

The lack of continuity in measure setting limits the ability to produce meaningful outcomes and benchmarks, particularly for quality measurement. The rigorous change management activities running alongside the progression into the working PY3 methodology for both clinical quality and utilization outcome measures is detrimental to policy-setting, performance improvement, and provider acceptance.

Along these same lines, BVCHC believes that the proposed timetable for clinical data exchange is unrealistically aggressive. Validation of quality measures, particularly for multi-practice AEs, is a process whose intensity cannot be overemphasized. Furthermore, the decision to recalculate PY2 measures on the same date of PY3 completion is very alarming, stripping AEs of workable targets in favor of retrospective targets subject to the hasty validation necessary to meet the aggressive timeline.

BVCHC strongly urges EOHHS to consider maintaining some level of PY2's status quo into PY3 (i.e. maintaining benchmark-/measure weight-setting between AEs and MCOs, pay-for-reporting outcome measures) to help trend the AE program's impact on population health as well as allow for sufficient time for AEs and MCOs to institute the operational changes necessary for this ground-breaking health care transformation. BVCHC is not opposed to

graduation into more intensive, performance-based program requirements, but hopes EOHHS will opt to stagger this progression in a more feasible manner. Otherwise, BVCHC believes the program runs a severe risk of disenfranchising constituents out of sheer confusion.

Attachment L2: Incentive Program Requirements

1. AE Incentive Pools

Page 8 states that a “material reduction” in attributed lives warrants a reduction in Accountable Entity Incentive Pool (AEIP) funding commensurate to the reduction. The document then continues to read, “The AEIP will not be increased if there is a growth in the attributed lives so as to not exceed the HSTP funds available to EOHHS for this initiative.” It seems wholly inappropriate that development funds, which are prescribed as early as within 60 days of contract execution (an aggressive goal that limits the viability of MCO project plan review; see pp. 15-16), be at risk for reduction in response to attribution mechanisms beyond the AE’s control (i.e. EOHHS requirement that MCOs have a higher proportion of high cost/high risk members assigned to the AEs than exist in the rest of the MCO population by 4th quarter of the fiscal year) without any opportunity for an increase in funds necessary for covering added lives. BVCHC recommends either allowing the potential for additional funds or striking this clause completely.

2. Failure to Meet Milestones

While BVCHC recognizes the need to maintain adequate incentive to complete milestones prescribed by the HSTP plan, the decision on page 11 to wholly withhold all funds associated with the timely completion of a milestone is unnecessarily detrimental to the efforts required to implement the complex objectives necessary for a viable AE. These efforts are the result of intensive collaboration and coordination and are massive undertakings on part of the AE. BVCHC recommends that consideration for partial payment commensurate to the level of milestone completion (as agreed upon by the AE and MCO with EOHHS approval) be added to PY2.

3. AEIP Required Milestones

The prescribed activities for use of AEIP funds on page 15 explicitly mandate the use of at least 10% of funds towards electronic clinical data exchange between the AE and MCO. BVCHC feels strongly compelled to point out that any such exchange of clinical information be constrained to that data which is necessary for calculating clinical quality measures in the quality measure slate as opposed to the bulk sharing of EHR data. BVCHC maintains patient privacy as an utmost priority.