Memorandum

To:	Interested Parties
From:	Deborah Correia Morales Medicaid Accountable Entity (AE) Program Director & Administrator for Medical Services Executive Office of Health & Human Services/Medicaid Program
Date:	December 13, 2019
Re:	**Summary of Responses to HSTP AE Program Year (PY3) Three Requirements**

EOHHS received public comments regarding the proposed Medicaid Accountable Entity (AE) Performance Year (PY) 3 requirements from the following organizations:

- Blackstone Valley Community Heath Care
- State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
- Integrated Healthcare Partners
- Integra Community Care Network
- Lifespan
- Neighborhood Health Plan of Rhode Island
- Providence Community Health Centers
- Prospect Health Services Rhode Island, Inc
- Rhode Island Parent Information Network
- Tufts Health Plan
- United Healthcare Community Plan of Rhode Island

Below is a summary of responses to the public comments for the following PY 3 requirements:

- Attachment H – AE Certification Standards
- Attachment J – AE Total Cost of Care Requirements
    - Risk-Bearing Provider Certification
    - Quality
- Attachment K – Incentive Program Requirements
- Attachment M – AE Attribution Guidance

Attachment H- Accountable Entities Certification Standards	
Topic	**Response**
HSTP Project Plan	Based on feedback from the stakeholder process conducted by Day Health Strategies, the EOHHS is integrating the HSTP project plan into the certification and re-certification process. This is no longer an MCO requirement. HSTP project plan milestones with no longer be linked to incentive funds, instead each MCO and AE will identify specific project-based Quality Improvement metrics that the AE is using to track and monitor the success of its HSTP projects/interventions.
Data Analytics, Health Information Technology (HIT), Member Engagement and Social Determinants of Health	The certification standards have not been significantly modified since the inception of the AE program and the release of the standards in 2017. The certification standards represent the ideal capacities an AE would have to be a fully certified AE. EOHHS anticipates that AEs will use incentive funds to build infrastructure and add needed capacity over the course of HSTP.
Breadth of Provider Network	The term "participating provider" is intended to include all providers within an AE network such as medical, specialty, behavioral health (BH), and social service based.
	Provider partnerships are partnerships primary care has with specialty providers such as behavioral health and social services providers. EOHHS has not defined the parameters of such partnerships to allow flexibility in varying types of arrangements depending on an AEs readiness (compacts to formal legal binding agreements).
	An AEs analytic profile/gap analysis may identify specific gaps in care/services that inform an opportunity for the enhancement of their AE network and referral arrangements.
	In terms of the requirements for direct services within the AE, this requirement does not refer to an AE credentialing primary care physicians. The requirement is that direct service capacity within an AE include PCPs that are RI licensed and credentialed by Medicaid MCOs.
	To the extent that the AE employs BH providers directly or through contractual referral arrangement it should ensure that its providers meet and adhere to the guidelines established by RI Mental Health Law.
	The BH capacity of an AE can be either direct service capacity (in house) or through referral arrangements with a preferred network of BH providers inclusive of Medication Assistance Treatment (MAT).
Governance	EOHHS is committed to ensuring that the Medicaid AE Governance committee reflect the breadth of the providers that service the Medicaid population for both adults and children, including BH and social services. It is key that the Medicaid consumer voice is also part of governance. The Governance committee should include for both adults and pediatrics: 1. Primary care provider 2. BH provider 3. Medicaid member/rep 4. Community Based Health Organization (CBHO)
	EOHHS has allowed flexibility regarding the Community Advisory Committee (CAC) within each AEs condition of certification. Of the 7 members of the CAC, 4 are to be Medicaid beneficiaries or family representatives/caregivers regardless of current attribution to the AE and 3 remaining members are to be community representatives that advocate or work for organizations that primarily serves the Medicaid population, including a representative from a Health Equity Zone

Health Information Technology (HIT)	Certification standards are to be revisited on annual basis. HIT, including the outputs from the HIT roadmap currently underway, will be evaluated as part of the annual review.
Integrated Health Home (IHH)	AE is responsible for coordination with key providers of care whether formally a part of their AE network or not. Coordination of care will prevent duplication of services being provided. EOHHS will continue to work collaboratively with the Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH) regarding the facilitation of discussion and partnerships involving the CMHOs (IHH/ACT programs).
Member Engagement	It is at the discretion of the AE how it will invest cost effective technologies to engage members in their care by using incentive funds and/or shared savings to meet gaps in care and manage its attributed populations. The technologies listed are not an all-inclusive list of technologies.
Pediatric Population	Children are not part of the IHH program but may be part of CEDARR Health Homes.

Attachment J – Accountable Entities Total Cost of Care (TCOC) Requirements

Topic	Response
New Program Entrants	EOHHS clarifies that new entrants into the AE program will be granted a grace period before downside risk is required. This policy is reflected in the TCOC technical guidance, where new entrants will enter the program at the Year 1 level of risk and level of market weighting.
Definition of Hospital-Based AE	The intention of EOHHS is to align with AE program with the OHIC APM methodology and its division between hospital-based and physician-based ACOs as it appears here. The program requirements and technical guidance have been revised to clarify this intention.
MCO Provision of Complete and Timely Data to AEs	EOHHS has received multiple comments both during the public comment period as well as during Program Year 1 (PY1) that AEs are not being provided the data they think necessary to impact total cost of care. Therefore, PY3 TCOC reports from MCOs will include additional specificity in Program Year 3 (PY3).). For example, the program requirements and technical guidance now require monthly reporting that includes member months by rate cell as well as expenditures for attributed members over a recent 12-month period.
Introduction of changes to TCOC methodology	EOHHS will be running a financial simulation of risk under the standardized TCOC methodology and will provide to MCOs and AEs the results.
Request for clarification regarding MCO provider rosters	EOHHS provides a standard AE provider roster template that the MCOs submit directly to DXC Technology. It is at the discretion of the MCO how the data is collected by each AE.
Structuring risk to promote symmetry and shared responsibility between MCO and AE.	EOHHS concurs that symmetry in risk is an important feature of a sustainable program. As the program matures, risk will become increasingly symmetrical

Attachment J – Accountable Entities Total Cost of Care Requirements: Risk-Bearing Provider Certification

Topic	Response
Clarification of RBPO certification and program participation	If an AE eligible to assume downside risk for PY3 is not certified as a risk-bearing provider, the AE will be ineligible for the AE incentive program and ineligible for shared savings within the AE program for PY3 . It is our intent, however, that OHIC will work with AEs to ensure that they have the appropriate mechanisms in place to accept downside risk.
Requirement for reserves for AEs entering into full risk arrangements	The requirement that AEs entering into full risk arrangements maintain secured liquid assets that cover two months of claims was established in PY1 and PY2 as a precursor to the formal RBPO certification process. It was

	inadvertently kept in from the prior program year's document but will be removed in the final version for PY3.
Clarification of the role of OHIC in RBPO certification	Regarding concerns over OHIC's role in certifying AEs to bear risk, EOHHS clarifies that, under the terms of EOHHS's MOU with OHIC, OHIC is not exercising independent authority over AEs. Instead, the Medicaid Director has chosen to exercise his discretion over the parameters of the AE program to require AE's accepting downside risk to receive a certification of their risk-bearing capacity. The Medicaid Director has chosen to delegate the work of reviewing RBPOs to OHIC staff as his agent, but ultimately, the Medicaid Director reserves the authority to approve or deny any AE RBPO application
Request for input by AE and MCO into the standards by which OHIC will evaluate downside risk readiness.	OHIC will be working with AEs regarding the pre-certification process for PY3. While EOHHS will consider in its review AE prior experience managing risk, PY3 certification will not include a separate process for experienced entities. However, since EOHHS' aim is to ensure the long-term viability of Medicaid providers while also limiting unnecessary regulatory burden, we anticipate learning and developing the RBPO program with experience.

Attachment J – Accountable Entities Total Cost of Care Requirements: Quality

Topic	**Response**
Implementation Manual-Quality Measures	A number of the public comments received regarding the quality and outcome measure implementation have already been addressed as part of the AE quality workgroup meetings throughout 2019. EOHHS will revisit the question of PY 2020 final quality measurement be based on electronic data and manual documentation for members that remain non-compliant based on electronic clinical data measurement during the planned 2020 AE/MCO Work Group meetings to discuss QPY4.
	EOHHS will not keep optional measures slates for QPY3. Allowing optional measures does not allow for comparison of performance across measures for AE/Plan and poorer performing measures may be replaced with better-performing measures. Based on broad stakeholder feedback, standard core set of quality measures is valuable for evaluating the performance of the program. EOHHS is committed to a core set of measures for the remainder of the program. Variable HSTP Project Based measures allows each MCO and AE flexibility to link incentive dollars to optional metrics.
	Trending determinations for The Healthcare Effectiveness Data and Information Set (HEDIS) 2020 are not yet available, however based on input from various SMEs, EOHHS believes there will be minimal impact since the measure has always been run from claims following the mental health practitioner definition.
	Language in the implementation manual will be further clarified to explicitly state the codes listed to define an active patient. The Quality and Outcome implementation manual will be updated accordingly.

	EOHHS will determine possible variation from the three-point standard once it has reviewed QPY2 performance data. AEs and MCOs will be invited to offer their recommendations, but EOHHS retains its authority to establish program policy.
	The Implementation Manual provides examples of how to calculate the improvement target in the Excel model provided with the Implementation Manual.
	EOHHS decided to use patients with a primary care visit for all non-HEDIS measures since the current Quality Measure Slate non-HEDIS clinical measures (Tobacco Use, Depression Screening, and Developmental Screening) are intended to measure whether certain processes have been put in place when a patient comes in for a visit. Including the entire attributed population would conflate these processes with member engagement. Member engagement will be discussed during the Member Engagement Workgroup Meetings.
	Language in the implementation manual will be modified to be consistent with the Excel model provided in the Implementation Manual. Performance must be above the threshold to earn partial credit based on the sliding scale. Performance must be equal to or above the high achievement target for full credit.
	The modification to use Program Year 1 and Program Year 2 data was made based on previous feedback from the AE/MCO Work Group, expressing concerns about the quality of QPY1 data. During the 9/11/19 feedback to the AEs/MCOs, EOHHS laid out the methodology described to set interim targets using QPY1 data and final targets once QPY2 data are available.
	Benchmarks will be set using national, state, and/or regional standards, but will also consider AE performance.
	EOHHS will make a modification to the following provision in the Quality and Outcome Measure Implementation Manual, *"Should OPY2 data deviate significantly from the OPY3 benchmarks, EOHHS will re-assess the OPY3 benchmark and notify AEs by November 30, 2020."* based on feedback.
Implementation Manual-Outcome Measures	EOHHS notified AEs and MCOs of the intent to utilize the "Emergency Department Utilization among Members with Mental Illness" measure, and provided baseline data, multiple months ago specifically to afford MCOs and AEs the opportunity to commence work on improving measure performance. AEs/MCOs also raised this when EOHHS requested feedback from the AE/MCO Work Group. At the time, EOHHS decided to include this measure as a pay-for-performance measure for Outcome Performance Year 3. This measure uses claim data. MCOs can provide AEs with information on utilization by diagnosis. In addition, there is no federal prohibition on MCO sharing of member-level information on those attributed members with the mental illness diagnosis codes used for this measure. There are proactive steps that AEs and MCOs can take to work on reducing Emergency Department utilization among members with mental illness. EOHHS encourages AEs and MCOs to start taking those steps now, if they have not already.
	The production of the quarterly outcome rates for the AEs is part of the MCO data sharing and collaboration process. The purpose of this information is to inform ongoing work between MCO and AE on intervention to address the metrics.

Attachment K – Incentive Program Requirements	
Topic	**Response**
Accountable Entity Incentive Pool (AEIP)	Member attribution count is communicated yearly in a memo to the MCOs for attestation by the MCO and AE. EOHHS has continually attempted to establish all required elements of the upcoming Program Year (PY) prior to 7/1 of a new PY. As such, the member attribution count "snapshot" is to be captured at minimum, 30 days before the start of the new PY.
	HSTP funds have been budgeted for each PY through the end of the budget based on the total allocation of AE incentive pool. As a result, EOHHS will not increase the Accountable Entity Incentive Pool (AEIP) or Managed Care Organization-Specific Incentive Pool (MCOIP) if there is a growth in attribution as to not exceed the total budgeted funds of the incentive program.
	The performance milestones in the APM contract requirements could be those included from the variable milestones described in the AEIP and MCOIP Performance Milestone table and/or other agreed upon performance metrics between the MCO and AE.
	Agreement with SDOH and BH providers should be used to build capacity to address SDOH, specifically non-Medicaid billable services such as housing, food insecurity, etc. Contracts may also be specific to care coordination, integration of services, etc. The gap analysis/analytic profile done by the AE should be used to inform gaps and needs in care and services. EOHHS is working with the Rhode Island Department of Health (RIDOH) on the implementation of a strategic plan for the provision of CBO support through the HSTP and AE program that will likely provide more detailed guidance.
	The following language, "require a process by which an AE that fails to meet a performance metric in a timely manner (thereby forfeiting the associated HSTP payment) can reclaim the payment at a later point in time (not to exceed on year after the original performance deadline) by fully achieving the original metrics in combination with timely performance on a subsequent related metric." is direct language from the Special Terms and Conditions with CMS under the RI Waiver. This statement refers to the grace period or opportunity for the AE to achieve a metric/milestone within one year of the target date. This does not apply to fixed milestones or pay for reporting metrics.
	EOHHS is committed to continuation of the 10% of AEIP funds to the implementation of a CBO partnership to address Social Determinants of Health (SDOH). As mentioned, EOHHS is working with DOH on SDOH efforts to identify CBO needs to engage in meaningful valued based arrangements with the health system.
	New AEs receive the level of funding per the allocation methodology for the specific PY in which they are entering. EOHHS believes this is equitable given eligibility for HSTP funds is strictly based on an approved AE TCOC contract with an MCO and being certified in a given PY. AEs who participated at the onset made a commitment to the upfront work and investment.
Allowable/Disallowable Expenditures	EOHHS will take into consideration the recommendation to include a specific attestation that earned HSTP incentive funds will be used for allowable expenditures as a standard attachment to the MCO/AE contract. However, given this is part of the MCOs contract with an AE, the attestation form is the responsibility of the MCO.

	AEs can certainly use HSTP funds to address SDOH and specific non-Medicaid billable services as well as potential incentives etc. AEs should not use HSTP funds to substitute or duplicate payment for services that are already available through other State and Federal programs.
Central Investments	EOHHS is currently engaged in an HSTP budget process. Once this is complete it will be shared and discussed with the AE Advisory Committee.
Managed Care Organization Oversight	EOHHS created a standard AEIP quarterly report form to document progress in meeting identified milestone and metrics/targets as well as payments from MCOs to AE. This form has been used since the inception of the program and is submitted quarterly by MCOs to EOHHS as part of their MCO reporting requirements.
	A mutually agreed upon contract exhibit would satisfy the requirement for the Incentive Funding Contract Amendment.
AEIP & MCOIP Performance milestones and metrics	EOHHS believes that having a standard set of incentive-based milestones and metrics across MCO and AE including the allocation of incentive funds will further and foster collaboration between both parties.
	EOHHS is committed to moving to performance-based measurement for PY3. The HSTP MCO and AE project-based performance measures can be process measures of your current AE project. Each AE is implementing at minimum 3 core projects. EOHHS anticipate that as part of implementing these projects the AE in collaboration with their MCO partner has a method to track and measure the success of the project and intervention similar to a quality improvement project.
AEIP Payments	In PY1 EOHHS made payments for fixed milestones as they were achieved. Starting in PY2 EOHHS made quarterly payments across all three incentive categories.

Attachment M – Accountable Entities Attribution Guidance	
Topic	**Response**
IHH Removal	Due to the complexity of Attribution by IHH, EOHHS is standardizing Attribution based on Primary Care provider. AE is responsible for coordination with key providers of care whether formally a part of their AE network or not. Coordination of care will prevent duplication of services being provided.
Request costs be assigned per monthly attribution rather than per annual attribution	EOHHS will be simulating TCOC targets under the new methodology and assessing the appropriateness of these two attribution methods for assigning TCOC. Final determination of how costs are assigned will be contained in the final version of *TCOC Technical Guidance.*
Request that AEs be provided additional detail in monthly attribution reports.	EOHHS will require additional attribution detail from MCOs in their quarterly submission including for each member a count of qualifying provider visits and which AE each visit was applied to, along with the attribution disposition.