UnitedHealthcare
Community Plan

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State of Rhode Island
Executive Office of Health and Human Services
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Submitted via Email: *Libby.Bunzli@ohhs.ri.gov*

RE: Policy Statements related to Accountable Entities (AEs)

UnitedHealthcare Community Plan of Rhode Island appreciates the opportunity to provide feedback to the Executive Office of Health and Human Services (EOHHS) on policies related to the state's managed care program and Accountable Entities (AE) programs. It is apparent that EOHHS has put considerable effort into the development of these policies. We appreciate your commitment to engaging stakeholders, and thank you for the opportunity to offer our perspectives.

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. We also bring a perspective across the national landscape, serving 6.45 million individuals in Medicaid across 30 states and Washington, DC. It is through these lenses that we offer our responses below.

We appreciate the opportunity to provide feedback to EOHHS and look forward to the opportunity for constructive discussion and collaboration with EOHHS about the recommendations included in the following pages. Should you have any questions or seek further information, please do not hesitate to contact me at (401) 732-7439 or Pcooper@uhc.com.

Sincerely,

Patrice E. Cooper

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Chief Executive Officer
UnitedHealthcare Community Plan of Rhode Island

BACKGROUND

EOHHS has requested feedback regarding the future of its AE initiative, and we appreciate the opportunity to offer our perspectives. Rhode Island has been a leader in using managed care to facilitate movement away from volume-driven payments and towards advance value-based payment (VBP) arrangements. The State has been very successful in managing risk and improving health outcomes through its managed care and AE programs. This firm foundation has resulted in accountability to taxpayers, beneficiaries, and legislators through budget predictability and stability.

Managed care organizations (MCOs) can build on the past successes in Rhode Island by developing models that meaningfully engage providers, informed by a provider's experience, resources, interest, and capabilities, to ensure improved health outcomes for Medicaid beneficiaries. Allowing MCOs the flexibility to engage providers in a meaningful way by aligning payment models to their skills and interests advances delivery system transformation and improves outcomes and quality to facilitate a more sustainable program.

We continue to support the State's goals, objectives, and models for achieving better integrated care, improved health outcomes and more efficient use of state resources. These goals are consistent with our ongoing work and we are excited to be a partner to the State as it refines its VBP initiatives.

DELEGATION TO ACCOUNTABLE ENTITIES

UnitedHealthcare Community Plan of Rhode Island strongly supports EOHHS's goal of increasing collaboration and coordination between MCOs and AEs. We also agree with EOHHS that AEs vary in their ability, interest, capability, and willingness to take on financial risk. Given the variability among AEs, we encourage the State to grant MCOs flexibility to engage AEs meaningfully, informed by their experience, resources, interest, and capabilities, to ensure improved health outcomes for Medicaid beneficiaries. Allowing MCOs the flexibility to engage with AEs ensures the advancement towards more sophisticated VBP arrangements by allowing practices time to evolve to be able to accept increasing levels of risk. Effective practice transformation takes time, culture change, leadership, and resources.

We also agree with EOHHS that a "one size fits all" approach to delegation is not appropriate because AEs differ in their readiness to engage more closely with care management strategies. The supports needed will be specific to each AE's experience and level of interest in participation but commonly include data analytics (including risk stratification and predictive modeling), evidence-based medicine tactical support, information technology, and data flow.

As an example, provider data infrastructure often is not sufficient to afford an advanced degree of care management. To be successful, AEs will need to develop or have access to tools that support clinical model capabilities including sophisticated clinical analytics, access to real-time utilization information, strategies to manage care transitions, and capabilities to track and report performance metrics. AEs may lack the technology for appropriate documentation and receiving/sharing information, and may not have the capacity to build complex data models necessary to accelerate population health management efforts. MCOs, however, are uniquely positioned to support the delivery system through a whole-system view of an individual across multiple providers and provider types. MCOs can work with their providers (inclusive of AEs) to deliver data analytics that leverage this whole-system view to drive system improvement.

The operational and financial considerations necessary for successful implementation of EOHHS's envisioned approach will depend on the AEs' readiness to provide enhanced care management services, clinical and support staff availability, technology infrastructure, and data accessibility. Delegated entities should have formal care management staff recruitment strategies, training processes, and operating procedures. These entities should be prepared to have their performance tied to quality and outcomes, and they should be experienced at effectively managing care and services, use evidence-based protocols, and have outcomes and data to support their model. They need to have sophisticated systems and complex accreditation compliance processes in place to monitor the effectiveness of their care management model and the ability to change as the needs of members change. Depending upon the level of delegation, these systems need to be able to share data and communicate with other participants of the health care system.

Additionally, before finalizing an approach to delegating care management to AEs, we encourage EOHHS to consider the following:

- *Fiscal soundness*. AEs should demonstrate financial viability to ensure they have the resources as needed for events such as hiring additional staff, implementing appropriate infrastructure to manage care effectively, and their ability to bear risk.
- *Technology*. Technology considerations are vitally important to ensure that AEs have the capacity to send and receive clinical data, document care coordination and care management activities, and process referrals for services to outside organizations that the AE is not equipped to deliver.
- *Complex populations.* It will be necessary to determine if AEs have the capability to serve complex populations, such as individuals with opioid use disorder. These populations require an advanced level of care planning that often require unique relationships with community agencies.
- *Technical Assistance*: It is important to note that AEs will need clearly articulated expectations coupled with technical assistance if the State expects them to take on care management responsibilities. Ongoing oversight, including feedback (from the

State and contracted MCOs) on performance measured against regulatory requirements will be critical for process and program improvement.

While we are well positioned to support and promote providers in value-based arrangements, we have found delegation arrangements are not always optimal. Not all organizations are well equipped to perform care management responsibilities or well equipped to manage the financial risk of the Medicaid population. Additionally, delegating care management to entities whose values are not aligned to the health plan or fee-for-service arrangements that do not tie performance to quality and efficiency do not work as well to improve quality, gain efficiencies, or achieve member satisfaction.

Maintaining responsibility of care coordination with the MCO – even when external entities are involved – ensures a single responsible entity is accountable to achieve program goals and maximum savings. This will facilitate whole-person care and streamline administration. Should the State elect to force delegation of certain services to the AEs, MCOs should also be given discretionary authority over the design and integration of external entities. MCOs should be allowed to contract with AEs within an approved range of delegated activities. This includes sufficient flexibility to allow MCOs to determine strategic partnerships with the AEs that builds upon the organizations' strengths, minimizes duplication between MCOs and AEs, and prioritizes high quality, patient-centered care.

Additionally, we have concerns about AEs' ability to comply with the care management functions outlined in the NCQA Complex Care Management accreditation standards. MCOs are contractually required to maintain NCQA accreditation status and are ultimately accountable for any function it delegates to a sub-contractor. We have concerns that an AEs' ability to take on care management functions is not being fully considered, especially given the administrative burden that the AEs will need to assume to meet the rigor of the Complex Care Management Standards for NCQA.

Finally, the actual communication and the process for communicating (such as access to Centralized Enrollee Record) between the MCO and the AE is fraught with potential issues and breakdown in process. Member confusion over who to call and who is the primary entity responsible for solving their problems and delivering their services, supports, and meeting their functional needs can become an issue if not properly coordinated.

Our Approach

We have created a strong collaboration and reporting structure to allow AEs to provide first line care management for our members enrolled in AEs. Our current case management program has undergone a rigorous review process and it requires a great deal of time, energy, and resources to replicate our program. We currently leverage our case management program to meet our members' complex case management needs and this program is operational in every state and line of business with highly qualified staff and technology to touch our highest risk members. We have found this particularly helpful in

complicated conditions such as ESRD and transplant. Our case management program leverages our enterprise expertise to address the needs of our most complex members.

We also have developed a process for AEs to refer members for our care management program, for example for Chronic Heart Failure (CHF) care management, which can include remote patient monitoring. Caring for complex members requires collaboration, transparency, and a long-term commitment to working together to improve health and affordability is essential.

MEMBER ASSIGNMENT RELATED TO ACCOUNTABLE ENTITIES

We agree with EOHHS that maintaining a patient-centered delivery system is inherent to improving beneficiary outcomes and engaging and empowering consumers. We also believe that reassigning beneficiaries to other MCOs simply due to a contractual change can be very disruptive and confusing to a beneficiary. If an MCO/AE contract were to terminate, this would not immediately affect the beneficiary/provider relationship, as the beneficiary Primary Care Physician (PCP) assignment would remain unchanged. We feel that EOHHS' policy on MCO requirements for AE contracting, including the collaboration of the continued development of a sustainable program, stresses the importance of cultivating deep strategic relationships between the MCOs and AEs. Additionally, we believe that the proposed program design presents opportunities to improve the enrollee experience and to advance the system's ability to take on risk for the total cost of care.

We believe that the EOHHS can implement several policy changes that may better encourage continuity of care for individuals and support the State's commitment to value-based payment models:

- The State should set a maximum payment threshold for AEs. For example, the State can set a ceiling for reimbursement rates for AEs (% of FFS Medicaid) to entice AE participation and encourage adequate distribution of beneficiaries across the State's contracted MCOs (including an equitable mix of high risk individuals). This will promote continuity of care for members by ensuring that all of the MCOs in the market can afford to contract with high quality, high value providers. Payment thresholds support delivery system reform, strengthen access, quality, and efficiency, and help to assure efficiencies across the market.
- Consider unintended consequences of the EOHHS's draft policy. Moving a member from one MCO to another due to change in AE contract status with that MCO may lead to unnecessary disruption and confusion for the member and does not preserve an individual's existing choice of Medicaid plan, network (including specialty care), and benefits.
- Protect against anticompetitive behavior to ensuring members have adequate access across the State. We encourage EOHHS to require AEs to negotiate in good faith with all MCOs that seek to contract with them.

MANAGED CARE ORGANIZATION AND ACCOUNTABLE ENTITY RISK ADJUSTMENT

UnitedHealthcare commends EOHHS for moving to risk adjusted rates for State Fiscal Year 2020. We agree that the risk-adjusted rates should be the basis for Total Cost of Care (TCOC) targets, and we encourage EOHHS not to prescribe the exact TCOC methodology. This change in methodology will likely require MCOs to re-baseline performance for year over year comparisons. Given the multiple Performance Years that remain active, this will require administrative resources to track financial performance.

We agree that the State should consider adding a risk adjustment to the Medicaid program; however, we encourage the State not to add additional complexity to the program, especially without pursuing a thorough stakeholder engagement process. Successful engagement strategies will help the State understand the needs and desires of both the MCOs and the AEs/providers that would participate to inform ultimate program design. Additional risk adjustment factors would need to be captured consistently in claims as a standard billing code in order that all AEs performance could be measured. Non-standard coding is challenging and adds administrative cost to the AEs and MCOs.

Additionally, we encourage the State to ensure incentive payments made to providers through value-based arrangements are considered as part of year-over-year Medicaid rate setting. Excluding these payments from rate development can have the unintended consequence of reducing future opportunity to provide incentives to providers as a result of continued decrease of rates overtime.

Finally, we urge the State to develop rates that accurately reflect the acuity of the population. Actuarial soundness in developing the capitated payments is essential for the long-term viability of the Medicaid program, including an allocation for administrative and risk/contingency costs. Adequate funding is necessary for a sustainable program, and the Medicaid must be reasonable, appropriate, and attainable.

CONCLUSION

At UnitedHealthcare, we are driven and guided by our mission – helping people live healthier lives. This commitment extends to all of our members in Rhode Island. We believe that our recommendations will support Rhode Island in achieving its goals of improving care while managing costs and improving system efficiencies. We look forward to continued collaboration with EOHHS, and we are happy to provide additional information or clarification on any points made in this document.