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March 27, 2019

BY ELECTRONIC AND OVERNIGHT MAIL

Libby Bünzli
Special Assistant to the Medicaid Program Director
Executive Office of Health and Human Services
Virks Building
3 West Road
Cranston, RI 02920

Re: Medicaid Program Policy Statements

Dear Ms. Bunzli:

I have been asked by Tufts Health Plan to provide comments on the policy statements issued by the Rhode Island Executive Office of Health and Human Services ("EOHHS") on the reassignment of Medicaid beneficiaries and the risk adjustment of premiums. This letter presents information for EOHHS's consideration to revise the current proposals to ensure that the goals identified by EOHHS are fully realized.

Reassignment of Medicaid Beneficiaries

EOHHS has proposed that, effective July 1, 2019, if a provider participating in an Accountable Entity ("AE") terminates it agreement with a managed care organization ("MCO"), EOHHS will automatically reassign Medicaid beneficiaries enrolled in that MCO who are attributed to the AE to other MCOs with which the AE has a contract. The reassignment will be subject to the right of each beneficiary to opt out and remain with his or her current MCO. We strongly support this proposal as an important mechanism for ensuring the continuity of care in the Medicaid managed care program.

The EOHHS proposal states, however, that, the AE's beneficiaries will be reassigned *equally* to the remaining MCOs with which the AE has a contract. While well-intentioned, we believe this approach to reassignment should be modified to adequately support the success of AE-MCO relationships, which is a stated goal of the EOHHS proposal. In particular, we recommend that all beneficiaries attributed to the AE be reassigned first to other MCOs with fewer than 5,000 AE-attributed members until each MCO reaches the 5,000 member threshold with that AE. Thereafter, AE-attributed members would be assigned equally among all MCOs.

Below is an example of how this methodology would work in practice:

	MCO A	MCO B	MCO C	MCO D
AE-Attributed Members Prior to AE Termination with MCO A	5,000	3,000	3,500	6,000
AE-Attributed Members Following AE Termination with MCO A	0[1]	5,500	5,500	6,500

In this scenario, MCOs B and C would each be assigned the number of members necessary to reach the 5,000 member threshold with the AE (2,000 members for MCO B and 1,500 members for MCO). The remaining 1,500 members from MCO A would then be assigned equally to MCOs B, C and D (500 members per MCO). This type of methodology will facilitate the enrollment of the minimum number of AE-attributed members in each MCO that is required to make value-based purchasing initiatives viable.

It is well-settled that payer arrangements with small accountable care organizations ("ACOs") face overwhelming obstacles. Research recently published in *Health Affairs* indicates that smaller ACOs (with fewer than 10,000 or 20,000 attributed lives) experience more erratic financial and quality of care performance due to "statistical noise" resulting from inadequately sized risk pools.[2] Moreover, there is strong evidence that Medicaid ACOs require larger scale than other ACOs to achieve efficiencies. The reasons for this discrepancy are discussed in a white paper issued by the actuarial firm Milliman.[3]

There are several reasons why AEs require a substantial number of attributed beneficiaries with *each MCO* to be successful. First, an AE must have a sufficiently large risk pool to avoid aberrant performance results. Even if an AE has a sizable population enrolled among several MCOs, the risk-sharing calculations and associated risk corridors are applied by each MCO at the individual MCO level. Thus, each MCO-AE risk pool must be large enough to yield valid results. Second, AEs frequently need to develop customized information technology interfaces and other data sharing arrangements with each MCO. The time and expense associated with this type of activity is not justified if only a small number of members are covered by the

[1] This assumes no AE-attributed members opt out and remain with MCO A.
[2] Barr, Lynn, Anna Loengard, LeeAnne Hastings and Tim Gronniger "Payment Reform in Transition – Scaling ACOs For Success." *Health Affairs*, May 11, 2018.
[3] Anders, Larson, Rebecca L. Johnson and Zach Hunt. "Seven key challenges for Medicaid states considering alternative payment models." Milliman. January 29, 2019.

particular MCO-AE arrangement. Third, AEs must work out other types of operational coordination with each MCO, including care management hand-offs, quality improvement protocols and member communications. Again, a sizable enrollment with the MCO is necessary to justify this investment.

Many state Medicaid programs, including Rhode Island's, have recognized the importance of creating scale within ACO-type entities by imposing minimum attribution requirements. Where ACOs contract with the state Medicaid program itself, an ACO only manages one risk sharing pool, one data sharing arrangement and one set of coordination protocols. Thus, in these states, applying the minimum threshold to the ACO as a whole is the only relevant option. However, in states such as Rhode Island that require ACO-type entities to contract with MCOs, the Medicaid program should encourage a higher MCO-specific minimum attribution as well as minimum attribution at the ACO level. The member reassignment proposal set forth above will help achieve this goal.

Risk Adjustment

It is well understood that risk adjusting premiums is a complex undertaking that is prone to error if not carried out in a careful and deliberate manner. A truncated timeline increases the likelihood of design flaws that will result in inequitable treatment for MCOs. EOHHS may want to consider a phased and blended approach to ensure stability of the program by applying a 50/50 blend of adjusted and unadjusted rates in the first phase and only moving to full risk adjustment upon stability in the market based on credible data.

The following are risks raised by the proposed implementation of risk adjustment in an expedited manner:

- ***Inadequate enrollment***. Expert analyses have found that risk adjustment transfers were more variable for insurers with a smaller market share. An American Academy of Actuaries study found that "insurers with a larger market share were by definition closer to the market average while small-market-share insurers were more likely to be skewed toward either low-risk or high-risk individuals."[4] Likewise, a CMS discussion paper found that, "in the individual market, on average, smaller issuers received risk adjustment payments while larger issuers owed risk adjustment charges. However, there was substantial variability in payments and charges particularly among smaller issuers. Risk adjustment transfers as a share of issuer premiums varied much less for larger issuers (those with more than 120,000 billable member months) than for smaller issuers (those with less than 12,000 billable member months)."[5] Finally, a Milliman study concluded

[4] America Academy of Actuaries, "Insights on the ACA Risk Adjustment Program," April 2016, p. 9: **http://actuary.org/files/imce/Insights_on_the_ACA_Risk_Adjustment_Program.pdf.**
[5] CMS, "March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting – Discussion Paper," March 2016, p. 96: **https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.**

that: "The smaller the plan, the more expansive the range of results." In Milliman's "'perfectly priced' and undifferentiated marketplace, risk adjustment does not overtly address volatility for any size issuer and does not offer material protection against loss for small issuers."[6] Tufts Health Plan currently has fewer than 10,000 Rhode Island Medicaid members. As a result, it faces particular uncertainty as to whether any risk adjustment model would accurately reflect its experience in the upcoming year. This problem could be mitigated by deferring risk adjustment until enrollment levels are higher.

- ***Impact of coding practices and operational challenges***. Risk adjustment models are only as reliable as the data that is fed into them. A risk adjustment score may reflect an MCO's effectiveness in collecting encounter data and documenting diagnostic codes, not only the actual relative acuity of the MCO's members. The American Academy of Actuaries has noted that "risk adjustment experience can vary among insurers due to operational issues (e.g., technical issues with loading enrollment and claims data, timely processing of claims), which may have impacted some small or new insurers to a greater degree than large and more established insurers. Similarly, newer insurers might not have sophisticated coding practices. As time goes on, operational and coding differences among insurers will likely narrow."[7] This conclusion was echoed in the CMS discussion paper referenced above.[8] Thus, we believe that recent entrants into the Rhode Island Medicaid program that have not previously focused resources on capturing diagnostic codes for risk adjustment purposes would be severely disadvantaged if the new system were implemented on July 1, 2019. A one-year delay would provide time to level the playing field among all MCOs in the market.

- ***Challenges in selecting the right risk adjustment model***. While there are a number of commercially available risk adjustment models, great care must be taken to select the model that is most appropriate for the Rhode Island Medicaid program. A Robert Wood Johnson Foundation report on risk adjustment found that **"**the overall evidence about risk-adjustment effectiveness in Medicaid is inconclusive."[9] While somewhat dated, a Society of Actuaries article provides a good overview of the types of decisions that states must make before selecting a risk adjustment model:

    - Decide which risk adjustment system will be used (CDPS, ACG, etc.).

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[6] Milliman, "Sizing up ACA Risk Adjustment Volatility: How the Interplay Between Risk Adjustment and Issuer Size Influences Profitability Under the ACA," June 2016**,** pp. 1-3: **http://www.milliman.com/uploadedFiles/insight/2016/2250HDP_20160622.pdf.**

[7] America Academy of Actuaries, "Insights on the ACA Risk Adjustment Program," April 2016.

[8] CMS, "March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting – Discussion Paper," March 2016, pp. 93-94.

[9] RWJF, "Risk Adjustment: What is the Current State of the Art and How Can it be Improved?" July 2013, p. 17: **https://www.rwjf.org/en/library/research/2013/07/risk-adjustment---what-is-the-current-state-of-the-art-and-how-c.html**

- Decide what type(s) of data should be used in the risk adjustment system (the plan may be to change this over time).
- Decide which Medicaid eligibility groups should be risk-adjusted, and which subpopulations should be excluded (i.e., enrollees with HIV/AIDS).
- Decide whether to employ a prospective or concurrent risk adjustment system.
- Decide whether to base the risk adjustment factors on the individuals enrolled during the rating period or during the experience period ("individual" vs. "aggregate" approach).
- Decide whether or not to customize the risk weights inherent in the risk adjustment model.
- Decide on criteria for including individuals in the risk adjustment calculations (minimum eligibility during experience or rating period, etc.).
- Develop criteria for claims records to be included in the risk adjustment model. This step is designed to ensure that the data being used in the risk adjustment calculations is consistent with the rating algorithms and that it is consistent across all comparative organizations.
- Determine the phase-in schedule and whether or not risk corridors will be used. Typically, adjustments to managed care capitation rates are phased in over time as the risk adjustment process, data and calculations are refined.
- Select the timing of updates to risk scores (e.g., annual, semi-annual, quarterly)
- Engage in data testing and validation.

The article closes with the following: "Due to the financial implications associated with the risk adjustment system implementation methodologies, all stakeholders need to work collaboratively to openly share and discuss data and implementation decisions."[10] We strongly endorse the Society's emphasis on multi-stakeholder collaboration, and believe it would be a significant mistake to implement risk adjustment before a thoughtfully structured collaborative process that addresses all of the relevant decision points can be completed.

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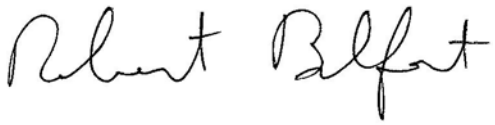
[10] Society of Actuaries article from Health Watch, "Risk Adjustment in State Medicaid Programs," January 2008: **https://www.soa.org/library/newsletters/health-watch-newsletter/2008/january/hsn-2008-iss57-damler-winkelman.pdf.**

We appreciate the opportunity to submit these comments. Thank you for your consideration of our views.

Sincerely,



Robert Belfort

cc: Mary Mahoney
Senior Vice President and Chief Legal Officer, Tufts Health Plan

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