

75 Kilvert Street
Warwick, RI 02886

September 30, 2019

Leah DelGiudice
Executive Office of Health and Human Services
3 West Road, Virks Building
Cranston, RI 02920
Submitted via email: leah.delgiudice@ohhs.ri.gov

RE: Accountable Entities Roadmap

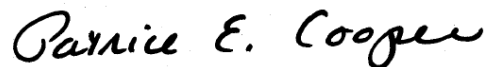
UnitedHealthcare Community Plan of Rhode Island (UnitedHealthcare) appreciates the opportunity to provide feedback to the Executive Office of Health and Human Services (EOHHS) on the State's Accountable Entity (AE) Roadmap. We support EOHHS's objectives to promote patient-centered and value-based care, while testing market-driven reforms to drive quality, reduce costs, and improve outcomes for the Medicaid population. Continued collaboration between EOHHS, managed care organizations (MCOs), and AEs is the foundation for working towards improved quality and health outcomes.

We have developed a keen understanding of the unique needs of Medicaid enrollees in Rhode Island as a partner to EOHHS for more than 25 years and by currently serving approximately 90,000 Rhode Islanders. We also have extensive national experience supporting Medicaid and dually eligible individuals and the providers who serve them in 31 States and the District of Columbia. Through our national experience, we have developed a diverse value-based payment (VBP) portfolio that includes over 300 Accountable Care Organizations. It is through these lenses we offer the following feedback on the AE Roadmap.

We welcome the opportunity to collaborate with EOHHS to develop an approach to expand both the capacity of Accountable Entities as well as aligned incentives to achieve the State's goals. Should you have any questions or seek further information, please do not hesitate to contact me by phone (401) 732-7439 or by email at PCooper@uhc.com.

Thank you for your consideration of our comments.

Sincerely,



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

INTRODUCTION

We appreciate the opportunity to offer our perspectives on the revised EOHHS AE Roadmap. Rhode Island's commitment to leveraging its managed care program to facilitate movement away from volume-driven payments and towards VBP arrangements and accountable care has resulted in increased accountability to taxpayers, beneficiaries, and legislators through budget predictability and stability.

We agree with the need to improve the health and well-being of individuals covered through the Medicaid program and we believe, as EOHHS does, that building partnerships and aligning financial incentives across payment, delivery, and social systems are critical elements of this strategy. However, we believe that the program design, as currently conceived, presents opportunities to improve the enrollee experience and further advance the system's ability to take on risk for the total cost of care (TCOC).

We appreciate EOHHS's transparency and commitment to stakeholder engagement and offer the following comments on the AE and MCO programs as they are outlined in the AE roadmap.

SPECIALIZED AE PROGRAM FOR DUAL ELIGIBLES

We agree with EOHHS that high quality, integrated, and aligned care is essential for improving health outcomes for individuals who are dually eligible for Medicaid and Medicare (Duals). To increase the likelihood of success and program sustainability, VBP strategies for Duals must ensure that providers achieve sufficient scale to be successful in transformation to VBP.

Taking accountability for people who are dually eligible requires designing a system of care that includes a wide range of services delivered by multiple entities across multiple settings. We believe that the goal of keeping people safely in the setting of their choice – enabling them to succeed in the least restrictive, most comfortable settings possible – can be achieved by making diverse supports available to complex individuals and orchestrating these supports in ways that improve quality, satisfaction, and cost outcomes.

Building a rich and comprehensive system of care for people who are dually eligible, which often includes aligning a wide range of long term services and supports (LTSS), requires substantial expertise, perseverance and sophistication in order to manage substantial payment and programmatic misalignments. As the State develops VBP programs for Duals, we encourage the State to align incentives between Medicaid and Medicare and address system barriers that undermine value-based transformation for this population. For example, a VBP approach that rewards nursing facilities for avoiding hospital utilization such as ED visits, inpatient admissions, and readmissions would increase Medicaid costs, but most of the savings would accrue to the Medicare program.

To avoid cost shifting between programs, we encourage the State to consider the following:

- Align state-based quality metrics to CMS Star quality measures, where possible.

- Identify quality incentives that bring value to both the Medicare and Medicaid systems (e.g., reducing unnecessary ER utilization, inpatient stays and readmissions).
- Allow MCOs flexibility to develop shared models and models that operate in tandem, allowing for incentives rewarded through affecting quality and savings for Duals.
- Place accountability for managing whole-person costs within a single provider organization that has an incentive to manage medical services, behavioral health needs, LTSS, transitions of care, emergency room utilization, etc.

As we have previously stated, we believe the State should align enrollment of Duals within the same Medicaid and Medicare organization leveraging Dual Special Needs Plans (DSNPs). Aligned enrollment methods help to mitigate system complexities and fragmentation facing Duals, as well as cost-shifting that occurs between multiple payers.

ALTERNATIVE PAYMENT MODELS

Alternate Payment Methodologies (APMs) Requirements for Comprehensive AEs

Not all providers are interested in, or prepared for, entering into VBP arrangements with MCOs that include shared risk. These sophisticated models require each party has the clinical acumen and financial viability to deliver on the VBP requirements and appropriately bear risk. EOHHS should allow MCOs the flexibility to align VBP models with each provider’s operational and clinical sophistication and readiness to accept risk. Meeting providers “where they are” in their ability to participate in VBP arrangements is critical to success. This is especially true for populations with complex health needs, like dual eligibles, as not all providers are equally prepared to manage that complexity or assume risk for these populations.

Health care delivery transformation from fee-for-service to VBP takes time, significant investment, and practice-level culture change. The sophisticated analytics required to support clinical activity, risk stratification, and patient outreach take time to develop and will vary depending on the AEs starting point, complexity, and availability of technological and other supports and the capital available to invest in practice transformation.

We do not support mandating providers to adopt VBP methodologies that include shared risk. Instead, we encourage EOHHS to develop program design elements that provide MCOs and providers with flexibility to define VBP partnerships to ensure the model accommodates a range of options that work for each practice (e.g., quality-based incentives, shared savings, and full risk). This approach ensures that providers are not required to participate in a VBP arrangement that is beyond their interest level, capabilities, or capacity to tolerate financial risk.

We recommend EOHHS be flexible with providers that are not prepared to assume risk. Additional flexibility is also likely to be needed to increase the number of providers that would be willing to pursue participation in advanced APMs. History demonstrates that provider groups that have failed did so because they were not ready to take on full-risk, which caused disruption of care, confusion to the community, and reduced delivery system capacity, ultimately placing taxpayer dollars at risk.

Specialized AE Alternative Payment Methodology

We agree with the State that a TCOC model may not yet be appropriate for the dual eligible population, at least not initially.

As the State begins to develop more advanced VBP models for dual eligibles, we encourage the State to consider the following:

- Find ways to normalize for fluctuations in the small populations assigned to each Specialized AE. These small populations can cause sharp changes in baseline cost and targeted quality metrics.
- Design equitable models for the population, which must account for the reality of less PCP 'impactable' (e.g., total cost less nursing facility room and board and HCBS expenses) LTSS spend improvement opportunities.
- Account for coordination of benefits; Duals have other forms of insurance (Medicare), so there is not always a direct relationship between utilization, cost, and quality outcomes.
- Explore flexibilities within the 1115 Demonstration waiver regarding VBP, including a possible amendment of VBP requirements as they currently stand.

We recognize the importance of collaborating with providers and incentivizing them to achieve the Quadruple Aim of improving population health and patient experience, delivering the best possible quality outcomes, reducing medical costs and trends, and improving the work life of health care clinical and support staff for this population. We welcome the opportunity to share our experiences operating VBP programs for providers serving Duals across the country with EOHHS should that be helpful.

PROGRAM MONITORING, REPORTING, & EVALUATION PLAN

We recommend that the State look for opportunities to streamline the AE and MCO programs and simplify system administration to accelerate integration of services and penetration of VBP. For example, we encourage EOHHS to consider the following:

- Create a centralized repository to house all documents related to the AE program to provide participants with a one-stop shop for the most up to date, relevant documents.
- Include a comprehensive list of required reports within the Roadmap, including use and expected frequencies of submission. The current list in the revised Roadmap is not a comprehensive list.
- Consider one monthly meeting with all MCOs, AEs, and EOHHS to ensure all parties are on the same page with program expectations and have equal representation.

Lastly, we request clarification from EOHHS as to whether the meetings referred to under the *In-Person Meetings with MCOs* section are the existing EOHHS Oversight monthly meetings with each MCO or if this section refers to a different set of meetings.

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 are honored to serve as an MCO in the State of Rhode Island, and we look forward to continued collaboration with EOHHS on the AE program. As always, we welcome the opportunity to provide any clarifications or offer additional feedback to EOHHS.