May 30, 2019

TO: Deborah Correia Morales, AE Program Director, Rhode Island Medicaid
Executive Office of Health and Human Services

FROM: Matthew Harvey, Sr. Director of Government Programs,
Integra Community Care Network

RE: Feedback on AE Program Year Two Amended Requirements Documents

Integra welcomes the opportunity to provide feedback on the Program Year Two Requirements Documents for the Medicaid Accountable Entity Program. We look forward to collaborating closely with EOHHS to continue to improve and refine this important program.

Comments on L1: Total Cost of Care Requirements

Integra supports the removal of Measure #11 (Self-Assessment/Rating of Health Status) from the Comprehensive AE Common Measure Slate for PY2. We would also like to take this opportunity to provide some general comments on the AE program's TCOC requirements.

Variations in TCOC methodologies and quality methodologies among AE contracts with MCOs add considerable complexity to an already-challenging program. We encourage and support efforts by EOHHS to standardize these critical features of the AE program across all MCO/AE relationships. We look forward eagerly to PY3guidance which will establish a common set of quality measures and benchmarks and a common scoring methodology.

Rather than require MCOs to submit their TCOC methodology to EOHHS for approval, we recommend that EOHHS require a standard methodology for establishing a TCOC benchmark and measuring TCOC performance, including a standardized benchmark time period, approach to risk adjustment and member mix, programmatic adjustments, trend factors, etc.

Comments on L2: Incentive Program Requirements

Additional Program Year Two Incentive Funding for Clinical Data Exchange and Validation Activities

Integra supports the allocation of additional funding to support clinical data exchange reporting.

We recommend that EOHHS clarify under what circumstances an AE would be granted an exemption from clinical data exchange reporting. Because of the complex and heterogeneous collection of EMRs used within our primary care network, we anticipate not being able to conduct electronic reporting of clinical data from a majority of our practices. If this limitation requires that we are granted such an exemption, we believe that we would uniquely benefit from additional funding to enable us to build the infrastructure to allow us to participate in clinical data exchange reporting in future years.

We strongly recommend that EOHHS make these additional funds available to all AEs, to ensure the necessary resources to create a level playing field around electronic reporting.

We also recommend that EOHHS establish a single platform for clinical data reporting (such as EOHHS's contract with IMAT) rather than allowing each MCO to require its own data reporting platform. Building multiple data feeds to multiple vendors will be costly and inefficient.

Stipulation of Deadlines Associated with Performance Milestone Achievements

Integra generally supports the spirit of these proposed deadlines. We note a potentially unintended interaction between the deadline for the AE's submission of an HSTP plan to the MCO (60 days, page 15) and the MCO's submission of the HSTP plan to EOHHS (60 days, page 16). Since the MCO is required to submit the plan to the state within 60 days, it is extremely likely that MCOs will hold AEs to an even shorter deadline, since the MCO will require time to review and approve the plan. Indeed, experience in PY1 suggests that this review and approval process may require multiple review and resubmission cycles, especially as feedback from one MCO may result in changes that need to be resubmitted to another MCO.

We recommend that EOHHS modify the deadlines to accommodate this complex review cycle, perhaps as follows:

- AEs must submit HSTP plans to MCOs within 60 days of execution of an APM contract.
- MCOs will make best efforts to approve HSTP plans within 30 days of submission.
- MCOs must submit internally-approved HSTP plans to EOHHS within 5 days of approval.

We also strongly recommend that EOHHS explicitly develop an HSTP plan approval process that includes the AE. We believe it is inefficient to require the MCO to represent the AE's plan to EOHHS, and for the MCO to represent EOHHS's comments to the AE. If EOHHS does not approve an AE's HSTP plan, EOHHS should share feedback directly with the AE as well as the MCO, and offer the AE the opportunity to meet directly with EOHHS to discuss the feedback.

AEIP Performance Milestone Requirements

Integra recommends that EOHHS remove the stipulation that an AE cannot submit the same SDOH, BH and/or SUD provider agreement under multiple MCO contracts. This is a *de facto* requirement that AE's create two such agreements, which, depending on the scope of the agreements, may result in duplication, inefficiency, and unnecessary administrative overhead. EOHHS should replace this requirement with a provision requiring any SDOH/BH/SUD provider agreement to be sufficiently broad so as to ensure that it covers a sufficient number of members attributed under each MCO contract.

In the past, we have submitted feedback suggesting that tying 15 percent of an AE's HSTP funding to reporting of outcome measures by an MCO is misguided. Because the AE has no control over the collection, reporting, and submission of this data, this does not actually represent an incentive for the AE at all; instead, a significant portion of our funding is at risk based on an activity of our MCO partner.

(We will also note that including four required outcome measures and two MCO/AE-specific measures means that an AE with two MCO contracts is potentially tracking at least eight distinct outcome measures. It may be difficult, given the size and scope of the AE program, to meaningfully manage such a large outcome measure slate. We eagerly await standardization of outcome measurement in PY3.)

We would also like to reiterate our concern with changing the reporting timeframe on this milestone from quarterly to annually. We recommend that EOHHS consider an alternative approach that minimizes the reporting burden on MCOs but still ensures a regular flow of funding to AEs.