TUFTS Health Plan

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

RE: Executive Office of Health and Human Services Draft Managed Care Strategic Goal-Setting Policy Statements

Dear Ms. Bünzli,

Thank you for the opportunity to provide comments on the Executive Office of Health and Huma Services ("EOHHS") Draft Managed Care Strategic Goal-Setting Policy Statements ("the policy statements"). Tufts Health Plan ("THP") appreciates EOHHS's extensive engagement with the market in the development and implementation of the Accountable Entities ("AE") program. We look forward to continued collaboration as we move toward the shared goals of care delivery transformation, promotion of value-based payment models, and an enhanced beneficiary experience.

We believe that the three draft policies move the AE program, and the Medicaid managed care program as a whole, in the right direction. Thoughtful execution of these policies—prioritizing member protection while maximizing the impact to AE provider accountability and MCO competition—will be critical to their success.

Below we offer specific comments on each of the three draft policy statements:

Member Assignment Related to Accountable Entities Policy Statement

We support the concept of prioritizing member-provider relationships and minimizing member disruption as the market transitions to the AE model. The AE program is built on the premise that provider accountability for attributed members will result in improved cost and quality outcomes and increased member satisfaction. It is THP's experience that this works best when the member's relationship with his/her provider is maintained.

The draft policy statement specifies that "if a provider participating as an AE elects to terminate its provider contract with a single MCO, EOHHS will reassign Medicaid beneficiaries who are members of the terminated MCO equally to the remaining MCOs with which the AE has an AE contract in place." We suggest several areas of refinement necessary to achieve the policy's goals of creating a robust AE program:

Minimum Membership Threshold

A critical underlying element to a successful AE-MCO arrangement is the size of the population that the AE is managing under a total cost of care ("TCOC") model. AE arrangements with smaller

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attributed membership face increased challenges from start-up/infrastructure costs, claims volatility, and credibility of cost and quality measurement.

To ensure that AE contracts that result from the member assignment process are of sufficient scale to support performance stability and justify infrastructure development, we suggest the inclusion of a provision that recognizes the importance of a minimum membership threshold to the success of AE arrangements. To that end, the member assignment process should first enable each remaining MCO to achieve a 5,000 member minimum membership threshold for actuarial stability. After this threshold is achieved, the process should then entail equal assignment of members to the remaining MCOs.

A survey of other states across the country with Medicaid ACO programs shows that common thresholds are 5,000 lives or more. 5,000 is also the minimum attribution size for ACOs participating in the Medicare Shared Savings Program ("MSSP"). This is especially critical as providers transition to two-sided risk, which is an explicit direction set by EOHHS, and already contemplated by some providers in the RI market.

PCP-Member Attribution

As we note above, the PCP-member relationship is critical to the success of the AE program and TCOC arrangements. For this policy to be effective, a credible source of attributed membership between an MCO and AE must be clear. At the outset, in order to help ensure the success of the policy, EOHHS should collect and validate attribution information, working closely with both the MCOs and AEs. Longer term, we suggest that EOHHS define broad attribution rules, routinely collect attribution information, and maintain a centralized, continuously validated repository for beneficiary attribution data, to ensure consistency of methodologies as well as supporting analytics and reporting on TCOC and quality performance.

Beneficiary Communications

To help ensure a seamless beneficiary experience, the state should lead a rigorous communication process and coordinate with the impacted AE providers, MCOs, and other appropriate stakeholders to ensure consistency in messaging, ample time for member choice both before and after the assignment, and robust on-the-ground support.

Continuity of Care

Consistent with related termination provisions in the EOHHS-MCO contract, an MCO exiting coverage for a given AE's population should be required to collaborate with EOHHS, the AE provider, and the other MCOs in the member transition process. Amendments to the MCO contract may be necessary to set parameters regarding member communications and to facilitate transfer of member information, such as prior authorizations and care plans, to ensure continuity of care and to further define the roles of EOHHS, the MCOs, and the AEs under the policy.

Health System Transformation Project ("HSTP"): MCO-Incentive Management Pool (IMP)

The current MCO-IMP program is structured to provide an incentive for MCOs and AEs to engage in as many contracts as possible, rather than focusing on fewer, more meaningful arrangements. To further align with the policy statement, EOHHS should consider modifying the HSTP incentive

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structure to provide opportunity to earn full MCO-IMP through fewer, more concentrated, MCO-AE contracts.

Managed Care Organization and Accountable Entity Risk Adjustment Policy Statement

We support the introduction of risk adjustment to the RI Medicaid program. A robust risk adjustment program is a crucial advancement to ensure MCOs/AEs provide effective care to the most vulnerable members while normalizing for population risk profiles.

We appreciate the collaborative and transparent process that has been initiated, and encourage EOHHS to continue the extensive market engagement throughout the design, testing, and implementation phases. We ask EOHHS to consider the following as essential parts of a sound process of introducing risk adjustment:

- Credible encounter data collection is a threshold requirement for risk adjustment. Building upon substantial recent efforts, EOHHS should validate the state of data quality, including allowing the market to address significant data gaps
- While choosing an off-the-shelf risk adjustment model is appropriate, various products in the market are calibrated differently and therefore produce different results for the RI Medicaid population. EOHHS should conduct a model comparison and clarify its choice
- Technical parameters on a host of topics need to be thoughtfully developed, such as treatment of small membership sizes, short-duration members, truncation, etc. EOHHS should consult the market and make balanced decisions
- We strongly suggest that EOHHS conduct pre-launch simulation of risk adjustment, not only to inform market participants of the associated financial impact, but also to leverage simulation as a powerful mechanism to test the program on its design and operationalization. This is a best practice adopted by most public programs
- Timely and detailed reporting is essential to program transparency. With market inputs, EOHHS should define the scope and cadence of the reporting package at the early stage of risk adjustment development, which informs design and implementation decisions

A key lesson learned recognized by many states and authorities from implementing risk adjustment is that the balance between improvement and stability is important. We encourage EOHHS to aim for establishing a compelling program that will remain stable for several years following the initial launch, and caution against the approach of making frequent changes.

Managed Care Organization Delegation to Accountable Entities Policy Statement

We support EOHHS's advocacy for care management delegation to AE providers, which is a pillar of provider accountability in value-based payment arrangements. Delegation free of duplication not only maximizes resource efficiency, but also promotes patient-centered payer-provider integration.

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We seek to highlight several considerations related to delegation in support of EOHHS's role in policy development and implementation oversight. As with other key initiatives, we advocate for EOHHS' vigorous stakeholder engagement in this effort.

- Most AE providers need time and investments to develop strategies and capabilities towards delegation. Infrastructure, staffing, and organizational configuration are just a few of the key elements that must be in place for delegation to be successful. As such, it is important that the delegation policy allow for services to be delegated at the appropriate cadence and with the necessary lead time
- We suggest further defining the scope of care management to differentiate across various programs that fall under the general category of population health. For example, components of care management can include complex care management, chronic condition management, behavior health & substance use disorder management, transitions of care, etc., which entail different delegation models. AE-MCO partnerships may view certain components more appropriate for delegation in the near term
- We suggest providing further clarity on delegation elements not considered part of the initial scope of the policy, particularly utilization management and other traditional health plan functions such appeals and grievances. Utilization management requires additional degree of due-diligence to comply with the Utilization Review Accreditation Commission
- Compliance and existing accreditation standards for MCOs are threshold requirements that must be considered for any delegation model design. At a minimum, MCOs must establish strong oversight mechanisms on delegated responsibilities, which AE-MCO partnerships should seek to establish in administratively efficient manners
- A vital enabler of successful delegation is information exchange between MCOs and AEs, which is largely at a rudimentary stage across the market. EOHHS could play a meaningful role in facilitating commitment to information sharing and accelerating advancement towards interoperability
- Care management being a critical driver of TCOC improvement, its delegation should be commensurate with provider performance accountability. Accordingly, requirement for delegation should be conditioned upon AE providers assuming meaningful, two-sided risk

We appreciate the opportunity to provide comments on the important draft policy statements and we look forward to a continued dialogue as the policies are refined and finalized.

Sincerely,

Kristin Lewis

Kristin Lewis
Senior Vice President, Chief Public Affairs Officer