

Good afternoon Patrick and Libby,

Thank you for the opportunity to provide feedback on the recent policy statements released from your office related to the Accountable Entities in Rhode Island. I appreciate the spirit of dialogue and inclusion as you continue the development and refinement of the RI AE system.

I will offer my comments to each of the three policy statements separately.

- Risk Adjustment Policy Statement

- General Comment: timelines may be too aggressive in this policy area.
- It is my understanding that RI lags the rest of the country in its expectation that MCOs assume full-risk and subsequently to have AEs take on downside risk as well. As laudable as this may be for the rest of the country, there are concerns regarding our readiness to move in this direction.
- I will leave it to the MCOs to comment on their capacity to assume full-risk.
- I do have concerns regarding AE ability to take on downside risk as well. In principle, this makes sense. However, the timeframe needs to be more fully vetted, and the tools for appropriate analysis to be in that position need to be very carefully assessed. Experts in this area, that EOHHS has brought to RI to assist in the AE initiative, have identified a glide-path of at least 5 years past the initiation of an AE like program to see AEs ready to take on downside risk.
- This also assumes there will be the requisite systems and data available to allow the AEs to evaluate and monitor performance and impact of such, for a period of time, to understand implications in this area. They have also suggested a small roll-out with certain cost buckets excluded – such as pharmacy.
- Actuarial services and the knowledge and skills in this area are lacking within the RI AE system. Full transparency and support for a system that provides uniformity and consistency in modeling is a desired outcome.
- Commencing in dialogue as of April 1, 2019 is fine. Application of rates effective July 1, 2019 may be too aggressive. However, that will be a discussion between the MCOs and EOHHS. If the trickle down to AEs follows, further dialogue with AEs will also need to occur.
- The reference to the inclusion of SDOH, neighborhood stress and other factors to have a risk adjustment algorithm in place will require clarity on the data to be obtained, validation of that data and testing to fully understand the application of such data and algorithms. There is much at stake to assure accuracy and integrity of the data and subsequent interpretation and application of data resulting in a financial impact based on this work.
- I welcome the opportunity to participate in dialogue with EOHHS, MCOs and other AE colleagues to look at a standardized risk-adjustment methodology to total cost of care (TCOC). The thought of having two (currently) and the potential for up to four TCOC models is distressing. The level of effort and time it takes to understand various models and the implication of them is significant. As indicated earlier, the level of knowledge in this area is limited and the uniformity of models can reduce waste in administrative functions. Four distinct models only benefit the consultants that will need to be hired to learn and understand the differences.
- Discussions on movement to downside risk are essential.

- Managed Care Delegation Policy Statement
 - General Statement: Timelines are too aggressive. Beginning further dialogue initiation would be better for June or later.
 - MCO related credentialing and certification requirements will need to be addressed
 - We need more clarity on the cost of these services and how that will shift to AEs
 - We need to better understand the full scope and definitions of care management to be clear on what is on the table and to eliminate any erroneous assumptions and expectations.
 - Duplication will always exist. We will need to determine the acceptable levels of duplication.
 - Administrative systems to manage the myriad aspects of care management are costly and many are imbedded in existing organizations. Determining how to size and scope them appropriately will be critical.
 - In the current system of reimbursement for care management, some of the services are reimbursed by some Medicaid payors while others do not have codes turned on and thus are under-supporting current care management.
 - Standardized financial modeling needs to be clear, and this modeling includes clear definitions of types of care management services, who can provide these services, and the reimbursement that can and should be attached to such services.
 - Care management for Medicaid takes many forms and functions, depending on the populations identified. Clarity is needed to determine what is included and expected for each population. For example – what is required for children with special needs differs from what is required for an adult with several chronic diseases, or from an adult with serious and persistent mental illness.
 - Other functions need more clarity.
 - Regardless of the functions that may be delegated to AEs from MCOs, there needs to be full transparency and analysis of the ROI of making any changes. The ROI is not just in terms of financial gain. We must look at the full range of outcomes, based on what data can tell us as well as what other evidence informed initiatives can tell us.
 - The fact that other states may be doing something does not necessarily mean it is a good thing or that RI has it wrong.

- Member Assignment Policy Statement
 - The current system for member assignment is problematic.
 - Fixing the current system may result in improvements that are not fully appreciated.
 - Most members have an allegiance to their “PCP” whether in primary care, behavioral health, or other specialist with whom they align and not their AE. Whether they are with one MCO or another may not be important to them, particularly if they have not been part of the “shopping and selection process” for an MCO.
 - Unless an MCO is limiting care or access to specialist, for example, the member may not care about their MCO assignment. It is the practice they want to be sure does not change, unless they make the choice to do so.
 - It would be clearer to expand the term beneficiary/provider relationship in the document to include PCP, BH, etc. as was discussed in the public meeting.
 - Dialogue to begin July 1, 2019 is fine. Implementing this change without further discussion is problematic.

I am not aware of who the other constituent groups are that have been invited to discuss or review these policy statements. While the identified entities in the policy statements are the MCOs and AEs, there is likely to be impact to the broader EOHHS community that could benefit from an understanding of potential changes that will impact their constituents.

Thank you for the opportunity to offer comments and feedback on these policy statements.
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