Integrated Healthcare Partners

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Respondent Information

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Integrated Healthcare Partners is pleased to respond to the proposed EOHHS Medicaid Infrastructure Incentive Program Requirements for Program Year 2.

We fully support the State of Rhode Island's Accountable Entity Program development and look forward to working with EOHHS and its Managed Care Organizations (MCOs) to make the AE initiative a success.

IHP encourages EOHHS to maintain its collaborative approach towards finalizing the PY3 requirements and in finalizing this set of PY2 requirements. We find it unfortunate that these PY2 incentive requirements were not reviewed collaboratively with all AEs and MCOS engaged in the initiative prior to distribution. There have been other policy statements EOHHS has promulgated with public comment that resulted in more clarity and better understanding within the AE community. As a general note, we are recommending longer timeframes for reviewing and processing, with more lead time and engaged public discussion. RI benefits with a better product to serve our communities.

L1: Total Cost of Care Requirements

- **Self-Assessment of Health Status** – We support the change proposed to eliminate.
- **Trend Factors** – We recommend that EOHHS change this to reflect the actual trend factor for the reporting period.
- **Downside Risk** – We recommend pushing out the effective date for the start of downside risk
- **Downside Risk 75% Shared Loss** – IHP believes that constraints in the model do not allow the AEs time and resources for sufficient savings.
- **Weights for Baseline Year Periods** – We recommend the weights for the baseline year calculations be brought back into the equation, as was included in the pilot period TCOC.
- **TCOC Calculations** – We recommend that EOHHS require all MCOs to utilize the same format of TCOC templates for the calculation of shared savings.
- **PY2 Data Collection with the MCOs** – Although the timeline for PY2 data collection is not included in this document, it is our observation that all of the AE MCOs EMR extracts may not occur within the

expected timeframe. If an AE can create the aggregated, validated file, it should not be penalized and exempted from the increase in PMPM.

- We recommend you allow data collection to occur at the individual provider and/or AE level by the MCO.
- We recommend you allow data collection through a combination of EMR extracts, medical record reviews, and self-reporting, as determined for each AE in conjunction with the MCO and the AE.

L2: Incentive Program Requirements

- **Additional Program Year Two Incentive Funding for Clinical Data Exchange and Validation Activities** – Page 6 -Although IHP supports the additional funding for Clinical Data Exchange and Validation, we are offering the following feedback for improvement/consideration:
  - We do not support the exemption component.
  - We recommend a definition of Clinical Data Exchange and Validation be developed in conjunction with the AEs and MCOs.
  - Our observation is that there are now three pathways to achieve clinical data exchange: 1) IMAT, 2) EOHHS appears to be recommending a path where network-based AEs provide a unified, validated file from a reporting/analytic system and 3) MCOs are encouraging AEs to engage with them to allow extracts from the multiple EMRS, where the MCOs would then aggregate and validate the files for the network-based AE. The exemption, although not fully clear, appears to penalize those AEs who follow the suggested path from EOHHS or the IMAT solution. We believe this is unfairly punitive.
  - IHP recommends that the exchange of clinical information be constrained to the data which is necessary for calculating clinical quality measures in the quality measure slate as opposed to the bulk sharing of EHR data.
- **AE Incentive Pools -** Page 8 states that a "material reduction" in attributed lives warrants a reduction in Accountable Entity Incentive Pool (AEIP) funding commensurate to the reduction. The document then continues to read, "The AEIP will not be increased if there is a growth in the attributed lives so as to not exceed the HSTP funds available to EOHHS for this initiative." Although IHP understands the reason for this, it also believes that EOHHS should reconsider this provision. There is fluctuation in attribution during the course of the program year and the AE's do not have control or insight into the logic used to attribute patients (i.e. unexpected addition of high risk members without direct notification to the AE, IHH members with a non IHP PCP etc..) without any opportunity for an increase in funds necessary for covering added lives. IHP recommends either allowing the potential for additional funds or striking this clause completely.
- **Partial Fulfillment** – (Page 11) We believe the new language regarding the "failure to fully meet a performance metric under its AE Health System Transformation Plan within the timeframe specified, will result in forfeiture of the associated incentive payment (i.e. there will be no payment for partial fulfillment)" is restrictive and punitive. However, it appears to be contradicted in the following bullet that states MCOs must develop "a process by which an AE that fails to meet a performance metric in a timely manner (thereby forfeiting the associated Health System Transformation Project Plan Payment). We recommend removal of the "forfeiture" of the associated incentive payment.
- **Payment and Reconciliation** – (Page 12) The MCO will maintain a report of funds received and disbursed by transaction in a format and level of detail specified by EOHHS. We recommend that

EOHHS require the MCO to provide information, along with the payment to the AE, that informs them as to what it corresponds to, i.e. what project and what milestone of fixed milestone

- **Ten Percent of PY2 Funds** – (Page 12) IHP supports the change in language to include AE's partners in the utilization of the 10% funding.

  "Consistent with these priorities and the requirements of the AE Certification Standards, Comprehensive AEs shall be required to demonstrate that at least 10% of Program Year 2 incentive funds are allocated to partners who provide specialized services to support behavioral healthcare, substance abuse treatment and/or social determinants."

  IHP also recognizes that the wording in the table on Page 15 is not aligned with the above; See the Developmental Milestones row of the table it still reads,

  "Execution of an agreement with SDOH, BH, and/or SUD Provider by the end of the calendar year 6."

  IHP recommends this language be changed to indicate the funds can be used to support a ''new agreement or an existing partner that provides SDOH, BH, and/or SUD related services".

- **Annual Reporting on Outcome Metrics** – **Ambulatory Care Sensitive ED Visits** – (Page 15, Row 2 in the table) IHP recommends that this measure be aligned with how all the MCOs identify Avoidable ED visits and that the name be changed to reflect it as Avoidable ED visits.

- **Developmental Milestones: Variable Percentage Allocations Based on the HSTP Project Plan** – (Page 15, Row 3 in the table) The note is not clear, and we recommend discussion with the AEs and the MCOs. IHP would also like to understand more of the logistics in how the MCO would know if the AE has adequate capacity to support the validation process. The details of this may render it challenging, time consuming or impossible. We would also recommend that each MCO have the same process to validate that.

- **APM Contracting with AEs** – IHP recommends that EOHHS allow more time for contract negotiation (60 days from completion of the L1 and L2) and that the contract negotiations can only start when a final version of the L2 document is available. The contract amendment will reference provisions from the finalized document.

- **AEIP Program Implementation** – (Page 16, Row 1) Implementation of Shared Management Structure meeting per quarter. Please confirm this replaces the JOC requirement.

- **HSTP Plans within 60 days of Contract Signing** – (Page 16, Footnote) IHP believes this is too aggressive of a timeframe and recommends EOHHS allow for at least 90 days (preferably 120 days) from contract signing. It appears that working with the MCOs proved valuable for accuracy to meet EOHHS expectations. IHP also encourages EOHHS to reconsider the PY1 HSTP template. Excel has limitations; though the layout was very nice, we had to write our plans in MS Word, so that the entire plan was visible and flowed more appropriately than it did in the excel file. We then had to transfer to Excel. This caused additional administrative burden.

- **AEIP Program Oversight** – (Page 17, Top of Page) Quarterly Report on results of monitoring of member access to care (5%). We recommend that EOHHS require the MCO to share these monitoring results with the AEs.

- **AEIP Program Oversight** – (Page 17, Top of Page) Completion of required operational, quality, and financial reporting to EOHHS on AE initiative (10%). As frequency of report delivery from the MCO to the AE is a concern for us, IHP is interested in knowing which reports are included and with what

frequency they are delivered. Depending on what reports are being shared with EOHHS in this provision, it may also be prudent to have the report shared with the AE.

- **Implementation Status** – (Page 17, Last Row of Table) IHP recommends these status reports be shared with the AE and perhaps even developed in conjunction with the AE.
- **AE Specific Core Projects: Workplan and Budget** – (Page 10) In the first bullet , last sentence, the guidance states: "To avoid duplication, each core project must include MCO specific milestones…"

The AE initiative is a multi-year approach to transform the delivery of healthcare for the Medicaid population in RI. We applaud the leadership from EOHHS to bring this change to the state. This is a complicated initiative and one that we believe can and will transform our delivery system. Each AE has developed in a unique manner that reflects the needs of the communities in which they operate and the philosophies of the organizations that have come together to best serve its patients.

IHP provides healthcare and related services to all its patients, regardless of ability to pay or health insurance coverage. We do not offer different brands of care and services based on payment or financial support. Our care is delivered based on patient need and clinical presentation. By creating two (and soon to be three) separate and distinct HSTP plans and initiatives, we are artificially setting up initiatives and tracking mechanisms that at times resemble a game of "putting a square peg in a round hole," and this has been frustrating. The current bifurcation of HSTP plans is an artificial exercise and an administrative burden.

Our proposal is to allow each AE to function and operate as ONE AE. Allow us to establish one master plan for our AE and apportion the costs and funding for our initiatives to each respective MCO, based on the attribution percentage (dollars allocated based on attribution). Treat our AE as one program and develop an oversight mechanism and review process that brings representatives from each of the MCOs into an EOHHS-administered process to determine the relevance, appropriateness, and alignment of each AE HSTP plan consistent with the HSTP priorities for the state of RI.

EOHHS currently has the final say in approving each of the MCO-approved HSTP plans for each AE. The independent review of two and (and soon to be three) MCO-approved AE HSTP plans could be better aligned and coordinated if the AE HSTP plans were reviewed and evaluated as one plan with the correct MCO-based funding clearly identified.

We propose the creation of a true Joint Operating Committee approach for each AE, with all MCOs represented, to align the AE's HSTP plan as one coordinated and integrated plan for the benefit of its attributed Medicaid patients. The AE could present its master HSTP plan to all MCOs (together) with their recommended cost distribution. Collectively, they could determine the appropriate actions and related costs, make modifications and then agree to one final version to submit to EOHHS. This approach would further support and align the concept of a multi-year, well-coordinated AE initiative. We believe this approach is consistent with the Medicaid Director's strategic initiatives as well as OHIC's investment in their efforts to eliminate waste and reduce administrative healthcare burdens.

IHP is happy to work with EOHHS and the MCOs in developing a refined process for the submission and review of HSTP plans. We appreciate the opportunity to provide feedback and to work collaboratively with all parties to improve the healthcare system in RI.