75 Fountain Street, Suite 100
Providence, RI 02903
401.272.3499
617.673.0194 Fax
tuftshealthplan.com

October 18, 2018

VIA EMAIL

Lauretta Converse, Health System Transformation Project Director
Executive Office of Health & Human Services
State of Rhode Island

Re: Public Comments on Year 2 Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities

Dear Ms. Converse,

Tufts Health Public Plans (THPP) appreciates the opportunity to provide comments on the draft Program Year Two (PY2) Accountable Entity (AE) program requirements. We welcome EOHHS's efforts to engage the market in making design decisions that help move the program towards long-term success. As a new entrant to the Rhode Island Medicaid market, THPP is excited about the opportunity to contribute to this historical movement in the State.

The AE program is built on a solid policy foundation with the right long-term goals and many appropriate building blocks. At the same time, like with any complex program that strives to deliver frontier innovations, there are opportunities for refinement towards more robust methodologies, better-aligned incentives, and more practical implementation requirements. With dynamic engagement with the market and relentless commitment to enhancement, the AE program is well positioned to deliver on its promise of transforming the way care is delivered to Rhode Islanders.

Moving to value-based care models is a ground-breaking effort, the success of which will likely require considerable changes in the system. As a policy maker, EOHHS has the critical responsibility of setting program rules that encourage thoughtful innovation while maintaining market stability, by first and foremost protecting members and preserving access to care, along with promoting value-based incentives for payers and providers, and maintaining vibrant market competition.

To effectively facilitate this, we encourage EOHHS to leverage lessons learned from across the nation while being attentive to unique needs and characteristics of the RI market. Given the diversity of a relatively small number of payers and providers in the State, we believe the program should allow for expanded flexibility around a set of core principles, so that program participation and innovation can both be maximized.

Below we offer specific comments that we encourage the State to consider. Our comments apply broadly to the program design and are not restricted to proposed PY2 changes.

1) TCOC requirements _ historical experience

We are supportive of the overall TCOC methodology and believe it allows for fair and responsible target setting and measurement of provider performance. We are concerned, however, that the methodology as defined prohibits a new entrant like THPP from meeting the requirement as we do not have access to three years of historical experience

75 Fountain Street, Suite 100
Providence, RI 02903
401.272.3499
617.673.0194 Fax
tuftshealthplan.com

data. A practical way to mitigate this deficiency, we believe, is for the State to provide assistance by leveraging the encounter data that the State collects from MCOs for rate setting and other mission-critical purposes.

Specifically, actuarial analysis of historical experience, which produces aggregate results such as PMPM costs, utilization, risk scores, etc., should be performed on members attributed to each provider organization, following a methodology defined by the State in consultation with the market. The outputs should be provided to the provider organization and the MCO(s) in negotiation with the provider. The analysis should capture all members attributed to the provider to maximize data credibility, with appropriate adjustments for rate cell and acuity mix to account for membership shifts and variations.

In the longer term, we believe TCOC determination should be predominantly the State's responsibility, with limited refinement permitted at the MCO-AE level. Besides promoting consistency and transparency of the methodology which ultimately makes it more robust, the underlying core analytics housed within EOHHS will also support measurement of success and long-term program enhancement with data-driven rigor. EOHHS has indicated its intent to introduce a standard risk adjustment model, a crucial element of TCOC target setting, to be applied across the market. We see this as a strong fit with our suggested vision.

2) TCOC requirements _ risk adjustment

Risk adjustment is an essential component of any TCOC methodology. We support EOHHS's position that risk adjustment should be incorporated into the MCO-AE TCOC targets, and we applaud EOHHS's commitment to bringing in a standard risk adjustment methodology to be applied across the market. Until risk adjustment is incorporated into MCO capitation rate setting, however, there is a disconnect between the capitation revenue that MCOs receive and TCOC targets that providers are held against, which could unreasonably expose MCOs to unfunded liabilities which in turn suppress AE participation by groups that care for more complex and vulnerable patient populations. As such, we ask that EOHHS work with stakeholders to develop a transitional mechanism to ensure that the capitation payments made to MCOs are not structurally below EOHHS-approved TCOC targets.

As we understand, EOHHS's future vision is that a standard risk adjustment methodology shall inform rate setting for MCOs as well as TCOC target setting for AE providers in a consistent manner. We encourage EOHHS to actively engage the market in the development and implementation of risk adjustment, including exploring leading-edge innovations that are uniquely important to Medicaid, e.g., adoption of social determinants in risk score calculation.

3) Small-cell challenges, member transition, and required number of AE contracts

As part of the TCOC methodology requirement, EOHHS has appropriately called out the importance of recognizing and managing challenges associated with small enrollment cells. We support the State's intent behind setting the 2,000 member floor as the minimum requirement underlying TCOC determination for a given MCO-AE arrangement, but believe the minimum level could be higher than 2,000 in order to have sufficient stability in the results. MCOs and AEs should be given the flexibility to determine the threshold based on their specific population mix and risk tolerance, among other factors.

More broadly, the "small cell" problem is not only a calculation challenge, it is also an impediment to moving towards a population-health-based delivery model, where scale-sensitive programs drive performance on defined populations of members. Larger populations make reporting and analytics more statistically credible, lead to higher return on fixed-cost investments, and can more easily support new platforms of capabilities such as partnering with community-based organizations (CBOs) to systematically address social determinants of health (SDOH).

We believe providers who wish to accelerate their advancement in population health, which typically benefits from strong payer-provider collaboration, would naturally want to concentrate their patient panels under preferred payer partners and seek to streamline operations. Similarly, payers that are interested in standing up new data and clinical infrastructure to support risk providers are also more willing to engage where there is membership scale.

TUFTS Health Plan

75 Fountain Street, Suite 100
Providence, RI 02903
401.272.3499
617.673.0194 Fax
tuftshealthplan.com

We anticipate a trend under which payers and providers will seek to move away from fragmentation and build more concentrated relationships featuring sophisticated collaboration. Each provider will likely choose to work with 1 or 2 preferred MCO partners, and each MCO will likely focus on a small number of providers. A three-payer market in RI allows providers to be more selective in their MCO partners, and payers shall compete with one another based on success in being a preferred MCO partner to providers.

From a design perspective, we believe the program should thoughtfully incorporate mechanisms to accommodate sensible shifts in the market and help with the necessary transition. The paramount priority, for example, is to protect members by ensuring that their access to care is not disrupted when payer-provider contracts change. This includes making sure that members are not exposed to the risk of care disruption even if they fail to take actions within set windows, which as we know is extremely difficult for any population in general, and exceptionally so for Medicaid members.

We specifically recommend that in the event a provider chooses to consolidate its patient panel to fewer payers, the affected members previously covered by the terminated MCO are allowed to stay with their PCPs by default. This would require an assignment by the State so that these members are automatically transferred to the remaining MCO(s). Member choice will be preserved by providing them with the "opt out" flexibility within a period of at least 90 days.

We acknowledge the question regarding whether reducing the number of contracted MCOs for a given provider would compromise member choice. We believe this is a tradeoff that is both defensible and manageable. A larger-scale payer-provider relationship is better-resourced to provide more sophisticated services to members, including enhancing network configuration to meet complex member needs. In other markets that have experienced similar changes, we have seen extensive network expansion efforts by MCOs as well as increasingly member-friendly out-of-network access mechanisms to minimize disruption.

In light of the above, we would also encourage EOHHS to revisit the contractual requirement on MCOs regarding the minimum number of AE contracts they must enter into. For example, currently MCOs are contractually required to subcontract with three or more AEs. While we support the notion around creating MCO incentive to participate in the program, we believe the number requirement would incentivize MCOs to focus on the quantity of relationships rather than making them successful, which in turn leads to unintended further fragmentation of the market.

4) Attribution

We generally support the design of the attribution requirement, which combines PCP records with actual utilization history of the patient. We recommend that over time, instead of relying on MCOs to perform the attribution and associated record keeping, the State should develop centralized capabilities and processes to manage attribution.

Specifically, we recommend that the state maintain a reliable "source of truth" of PCP records of all enrolled members, which requires that EOHHS collect, extract and scrub the information from MCOs' monthly data submission, as well as supplementing it with encounter analysis and applying the defined attribution algorithm. Proper mechanisms to maintain data integrity will be important.

Similar to TCOC and risk adjustment as referenced earlier, we believe attribution is another "technical" component of the program where the benefit of consistency, transparency and rigor outweigh that of flexibility. We encourage EOHHS to closely engage stakeholders in the methodology development, and maintain a high degree of transparency throughout the implementation process, which can be lengthy and complex. We believe the end result, where the State provides strong oversight on the attribution process and maintains a valuable dataset that can support a host of reporting at the market-wide level, is well worth the effort.

TUFTS Health Plan

75 Fountain Street, Suite 100
Providence, RI 02903
401.272.3499
617.673.0194 Fax
tuftshealthplan.com

5) Infrastructure incentive funding _ allocation

THPP firmly believes in the value of payer-provider collaboration and strongly supports the notion of encouraging the MCO and the AE to share responsibilities in performing AE-related functions, supported by appropriate allocation of infrastructure incentive funding.

We ask EOHHS to consider flexibilities around the parameters of Total Incentive Pool (TIP) allocation, which currently are overly-prescriptive. For example, it is specified that for an MCO with five or more AE contracts, the MCO share of the pool shall be 15% depending on satisfactory performance. We believe that funding allocation should be a function of underlying responsibilities which could vary substantially by circumstance given the vast differences in organizations' capabilities and constraints, and will likely evolve over the course of the program. For instance, for MCOs that have participated in similar programs in other products or markets, certain key infrastructure could be redeployed with a relatively light lift, which may justify a greater share of the TIP being directed to the AEs to support agreed-upon new capabilities. In another situation, a provider that is new to the AE model might rely on the MCO to assume most of the responsibilities in initial years, and gradually take on functions as the organization matures; funding should follow the resources and therefore change in its allocation. The MCO-AE partnership should be allowed to negotiate funding allocation based on characteristics and stages of their collaboration.

6) Length of contract

We ask EOHHS to consider allowing longer-term contracts beyond one year. This would allow the AEs and MCOs to negotiate agreements that entail deeper integration activities and investments, which allow the new care models to progress on their multi-year trajectories. This will also make planning easier for both MCOs and AEs, by providing an avenue for increased predictability related to the program and help move towards stability for all participants.

7) Broader pursuit of Alternative Payment Models (APM)

Moving a market towards value-based payment is an ambitious and complex endeavor, where policies and rules will inevitably impact stakeholders in different ways and therefore face varying levels of receptivity. We believe EOHHS has done a commendable job balancing between consistency and practicality, and that progress will continue to be made as market inputs are carefully absorbed.

We believe that some market participants, particularly provider organizations, might be strategically committed to pursuing value-based care and APM but not able to meet all AE requirements in the short term due to organizational or business constraints. From a policy perspective, we think EOHHS, in collaboration with OHIC and other agencies, should be broadly supportive of APM efforts and allow these organizations to innovate and build capabilities that are consistent with AE principles, while giving them more time to evaluate whether and when they are able to come into full compliance with the program. We believe this more "inclusive" approach to supporting delivery system reform will ultimately deliver broader, more systematic success in the market and provide more value to the members we serve.

Thank you again for the opportunity to provide feedback on this important program. We welcome the opportunity to answer any questions or discuss any of our comment in more detail.

Regards,

Helene Forte, RN, MS, PAHM
Vice President, Emerging Markets
Tufts Health Plan