Ms. Libby Bunzli
Special Assistant to the Medicaid Program Director
By Email To: Libby.Bunzli@ohhs.ri.gov

March 28, 2019

Re: **Care Management Delegation to AEs**
Risk Adjustment for MCOs and AEs
Assignment of AE Members to MCOs

Dear Libby:

Thank you for the opportunity to submit these comments. RIPIN has long supported the Accountable Entity (AE) initiative. More important than saving money – even before the AE program, RI Medicaid saw consistent reductions in per-member-per-month spending – the program has the potential to promote coordination amongst providers, and improve quality, outcomes, and the patient experience of care. It is through these types of improvements that the AE program has the potential to have a lasting, positive, sustainable impact on Rhode Island's health care system.

RIPIN **strongly supports** the policy to promote the delegation of care management functions to AEs, **supports** the use of risk adjustment, especially the use of methodologies that include social and economic risk factors; and has some **concern and questions** about the proposal to move an AE's patients out of their MCO if the AE's contract with that MCO is terminated.

Delegation of Care Management to AEs

For many years and in many fora, RIPIN has long supported the vision of a health care system where most care management activity happens at the provider level, primarily in the primary care setting. Primary care providers generally have a well-earned relationship of trust with patients, one that is necessary for care management activities to be successful. The AE program's strongest potential lies in creating a business case for providers to make these care management services available.

RIPIN recognizes that this type of policy will not always be simple to execute at the technical level. That said, we are strongly supportive of this directional shift in thinking.

Other delegated functions: As EOHHS reviews other ideas and proposals for delegation of functions to AEs, the function of network management should be explicitly off the table for now. Patients must continue to be allowed to see any provider within their MCO's network under the same terms and conditions as apply today. Any shift away from that bedrock is entirely premature, given the current status and makeup of AEs, and would raise dozens of serious and

complicated problems and questions. RIPIN thanks EOHHS for their consistent commitment to this principle so far.

Risk Adjustment

Risk Adjustment for MCO Capitation: RIPIN supports the use of risk adjustment in setting MCO capitation rates to ensure that MCOs are adequately compensated for seeking out the patients who need the most help. RIPIN also strongly supports the inclusion of social and economic factors into the risk adjustment formula. Research has shown that social and economic factors can be just as strong predictors of health and cost outcomes (e.g. readmissions) as are clinical factors. These factors therefore need to be part of the formula, or else MCOs and providers may not seek out the neediest populations.

Risk Adjustment for AE TCOC Calculations: Risk adjustment is also a critical tool in determining whether an AE's performance was caused by their interventions or simply by changing patient risk profiles. RIPIN recognizes the tension between wanting a uniform system and wanting to allow the MCOs and AEs to bring their experience to bear in developing their own systems. The State must be very careful, however, in examining the relationship between the risk adjustment tool being used for MCO rates and the risk adjustment tool being used for AE TCOC calculations. If those tools are not properly aligned, it can expose the State to financial liability unrelated to program improvement.

Risk Adjustment for Quality Measures: When money is attached to a measure, risk adjustment should almost always be used. Failing to use risk adjustment leads to penalizing those providers who take on the most challenging cases. The only potential exception could be when the focus is on quality *improvement* within an AE, rather than comparisons to other AEs.

Reassignment of AE Members to Other MCOs

RIPIN would like to express **concern** about this proposal. First, it should be made very clear that this policy is designed only to deal with the circumstance where an AE becomes non-participating with an MCO, not where the AE merely terminates its AE relationship with the MCO. (Our understanding is that this was already the intention.)

In addition, RIPIN believes that this policy should focus on the notice and assistance that would be made available to patients under these circumstances. EOHHS has already recognized that these patients would have a choice of staying with or changing their MCO, a choice they already have today. This proposal would merely change the default rule, but does nothing to help patients make an informed decision.

Our health care system is extremely complicated to navigate, and many factors would go into a patient's decision about the MCO if their AE became non-participating. While the AE relationship is very important, some patients are more connected to certain specialists who do not participate in other MCOs. Some rely on medications that are not on other MCO formularies.

Rather than merely changing the default rules, RIPIN would propose that these circumstances (an AE leaving an MCO) trigger notice requirements from both the AE and MCO. That notice should be in plain language, no more than 5th grade reading level, no more than one page,

available in multiple common languages (and with a "babel page"). The notice should explain that their primary care doctor no longer accepts the MCO, and that the patient now has a choice of changing MCOs or changing primary care doctors. The notices should be approved by EOHHS in advance, mailed at least 60 days prior to the AE leaving the network, and made broadly available to the public on the websites of EOHHS, the MCO, and the AE. The notices should also identify phone numbers of unbiased resources who can help walk the patient through their options. MCOs and AEs should be required to train and inform their staff (inducing call centers, reception, bill collectors, etc.) about the changes and how to answer patients' questions.

We, as a society and as a State, have set up this complex healthcare system. There are advantages to having multiple insurance companies and providers and freedom of contracting, but there are disadvantages too. When those disadvantages arise, such as the disruption that would follow an AE becoming non-participating with an MCO, we need to provide the information and support that patients need. AEs, MCOs, and the State share this obligation. Merely changing the default rules is not enough.

With a strong notice and support structure in place, the default rule becomes less important. That said, RIPIN would still have concerns about the operational challenges of moving people between MCOs with little or no notice. RIPIN would not feel comfortable supporting that type of proposal without those operational concerns addressed in detail.

Conclusion

Thank you very much again for the opportunity to submit these comments. If you have any questions, please do not hesitate to contact me.

Sincerely,

/s/

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