



March 26, 2019

TO: Libby Bünzli, Special Assistant to the Medicaid Program Director
Executive Office of Health and Human Services

FROM: Matthew Harvey, Sr. Director of Government Programs,
Integra Community Care Network

RE: Comments on March 2019 managed care strategic goal setting policy statements

Integra appreciates the opportunity to provide public comment on the draft policy statements released on March 7, 2019. We support each of the proposed policies, and look forward to working closely with EOHHS to ensure they are successfully implemented.

Member Assignment

Integra supports the intent of this policy, and appreciates EOHHS's commitment to maintaining the member/PCP relationship. We agree that members should remain assigned to their AE where possible if an AE terminates its contract with an MCO. We would like to offer some suggestions as EOHHS considers how to implement this policy.

- The draft policy statement suggests that "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 that EOHHS consider flexibility in the ratio of assignment in cases where more than one AE/MCO contract remains, to ensure that each AE/MCO contract covers a reasonable minimum number of members.
- EOHHS should consider ways to promote and make explicit a member's connection and identification with their AE. Historically, most enrollees identify their Medicaid enrollment through their selected MCO; in fact, many enrollees may not realize that they are part of an AE. Encouraging a member to maintain their clinical relationship with their provider may require a rebalancing of the roles of the MCO and the AE regarding member enrollment and communication.
- EOHHS should encourage the MCOs and the AEs to make every effort to avoid a termination.

Risk Adjustment

Integra strongly supports the addition of risk adjustment to the Medicaid capitation methodology. We recommend EOHHS consider the following:

- MCOs and AEs should have the opportunity to provide comments and feedback on the details of the methodology and its application to capitation payments and AE TCOC measurement.
- Adding risk adjustment to the AE TCOC model should happen concurrently with applying it to MCO capitation, and should be implemented as soon as possible (i.e., for PY2).
- In selecting a diagnostic-based risk adjustment algorithm, EOHHS should consider publicly or commercially available tools that are appropriate for the Medicaid population (including the

pediatric population) and that are reasonably priced for AEs who will need to make an investment in data systems.

- We encourage EOHHS to look closely at the UMMS SDOH risk adjustment model used by MassHealth as a starting point for including social determinants of health in a member's risk score, and should consider enhancing the UMMS model to include additional ICD-10 codes.
- EOHHS should consider applying different risk adjustment approaches to MCO capitation (where a concurrent/prospective risk adjustment algorithm would be appropriate) and AE TCOC reconciliation (where a 12-month retrospective risk score may be more effective) to ensure that AEs are not disadvantaged by efforts to reduce hospitalizations (since inpatient stays are often the source of diagnostic codes with a significant effect on clinical risk scores).

Delegation

Integra strongly supports EOHHS's intent to give AEs a larger role to play in care management of the populations for which they are accountable. As AEs take on financial risk for our attributed members, it is critical that we have as much flexibility, visibility, and participation as possible in the care management activities that affect their health.

There are a number of important considerations as EOHHS rolls out this initiative.

- Our existing program plans, and our existing HSTP budget, assumed the status quo. As additional functions are delegated to AEs, EOHHS must ensure that there is a sustainable funding stream for these activities. Following the example of MassHealth's approach to their ACO program, EOHHS should consider diverting a portion of the administrative capitation that MCOs receive for care management and other activities. This could be accomplished through a direct PMPM administrative payment to AEs, or by requiring a pass-through of funds from MCOs to AEs.
- For AEs to effectively manage cost and utilization, it will be critical for MCOs to be collaborative and transparent with AEs about UM/UR policies and decisions. We encourage EOHHS to clarify expectations about how MCOs and AEs should participate in these processes.
- EOHHS should carefully consider whether "delegation" is the appropriate model to expand the role of AEs in care management. The delegated care management model adds an entirely new and different level of responsibility and burden upon the AEs.
- EOHHS should facilitate a transparent discussion about the appropriate role for the AE and the MCO across all the typical MCO functions (member engagement, care management, analytics, wellness, etc.), and establish a timeline and expectations about which functions an AE can or should take on.