TUFTS Health Plan

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September 30, 2019

VIA EMAIL

Leah DelGiudice
Executive Office of Health and Human Services
3 West Road
Cranston, RI, 02920

Re: THPP Comments on Revised Medicaid Program Accountable Entity Roadmap

Dear Ms. DelGiudice,

Tufts Health Public Plans ("THPP") appreciates the opportunity to provide comments on draft revision to the Medicaid Program Accountable Entity Roadmap ("the Roadmap"). We continue to applaud the open and collaborative process that the Executive Office of Health and Human Services ("EOHHS") has undertaken in making program design decisions.

We acknowledge and support many aspects of advancement reflected in the revised roadmap as well as the broader strategy development effort with Days Health. The refined vision appropriately emphasizes EOHHS' commitment to alternative payment models, recognizes the importance of simplifying AE and MCO administration, prioritizes the development of robust data capabilities, and raises the bar on addressing complex patient needs through the lens of integrated population health.

THPP submitted comments in 2018 on EOHHS' PY2 AE program requirements where we addressed a range of issues related to the AE program design. We continue to maintain our core perspectives incorporated in the prior comments and advocate for an AE program centered around PCP-patient relationship and strong AE-MCO partnership as pillars to deliver improvements to both patient outcomes and resource efficiency. Below we build upon our position with additional comments that specifically address newly proposed requirements in the Roadmap.

Requirement for AEs to Submit Joint Certification (Recertification) Applications and HSTP Project Plans with their MCO Partners

We appreciate EOHHS' intention to promote seamless AE-MCO collaboration. We strongly support the concept that a successful AE model requires key support functions – data analytics, network management, benefit administration, etc. – that are traditionally MCO responsibilities, which not only remain necessary but must advance in order to meet evolving AE needs. In support of our Medicaid ACO partners in Massachusetts, THPP has made substantial investment in advanced analytics with multi-source data aggregation, real time stratification and interactive performance dashboards, which significantly enhance our value beyond standard claims extracts and static reports to risk-bearing ACOs. We have also established customized referral networks and care management delegation that integrates with each ACO's unique population health management model.

However, in an environment where most AEs work with multiple MCOs concurrently, this requirement creates excessive burden on all parties which makes it unfeasible. As such we don't believe that joint application should be a mandate. However, EOHHS' recent policy statement on member assignment has given AE providers the ability to consolidate their patient panels with minimized disruption. And for AEs

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that choose to do so, leveraging MCO collaboration towards critical deliverables is likely both practical and beneficial. To solidify the process, we ask that EOHHS develop concrete guidance to operationalize the member assignment policy, which would require tight collaboration among EOHHS, the AE and the affected MCOs.

TCOC-based Alternative Payment Methodologies and Risk Adjustment

THPP supports EOHHS' TCOC vision including the expectation of a phased transition to downside risk. We encourage EOHHS to develop policies that support robust risk mitigation to help delineate insurance risk from performance variation, so that AE providers are accountable for what they can control and influence. One of the key mechanisms is risk adjustment, which has been launched for MCO capitation rates starting in FY2020. While the state does not prescribe the risk adjustment methodology applied to TCOC targets in MCO-AE contracts, from a practical standpoint it is highly compelling for the market to apply the same risk adjustment methodology for TCOC to ensure incentive alignment between AEs and MCOs, not to mention the vast benefit of simplification and consistency.

To support this effort, we ask that EOHHS maximize transparency of the risk adjustment program, sharing with not only the model name/version, but also any unique adjustments made by the state and normalization calculations. EOHHS should consider CMS's approach to risk adjustment transparency in the Medicare Advantage and ACA small and non-group programs as a best practice and benchmark.

Program Monitoring, Reporting, & Evaluation Plan

We agree with EOHHS on the notion of streamlined AE reporting through the MCO. As EOHHS has pointed out, MCOs have traditionally performed an extensive portfolio of reporting functions and expanding it to the AE level is appropriate and preferable to having AEs take on this as a new responsibility. We note, however, that proper two-way data exchange between the AE and MCO is a foundational requirement and that policy-level specifications of how the exchange shall be conducted and supported would be important. For example, a standard model of clinical data access by the MCOs should be established as a component of the AE program design.

We appreciate EOHHS' consideration of a formal program evaluation, which among other things critically informs post-demonstration strategies of the Medicaid program and its long-term sustainability post HSTP. We ask that EOHHS engage stakeholders on the design of this effort, to ensure market alignment on key metrics, thresholds, and ultimately the conclusions from the evaluation.

Specialized AE for Dually-Eligible Members

We support EOHHS' commitment to bringing the dually-eligible population into accountable care, which remains a largely untapped frontier across the nation, and would put RI in the spot light of innovation.

While we believe in the value of provider accountability in improving care for these exceptionally vulnerable individuals, we highlight that compared with the comprehensive AE model for the general Medicaid population which features a PCP-centered model; dually-eligible members must be supported by an integrated approach that covers a much broader care continuum that could be best led by MCOs. Many of these patients are home or community bound, with high dependency on social support, and require high-touch management that meets them where they are. In our recent work in Massachusetts, THPP has focused on both continued enhancement of our MCO care management program and

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discussions with ACO partners about building upon their infrastructure to support dually-eligible members, in a model that features deep and multi-channeled MCO and AE integration. We encourage EOHHS to take this into its design consideration when developing payment models over the coming years.

Other

Finally, we ask EOHHS to consider program options to strengthen members' "AE affinity" as a strategic design feature of the AE program. Development and use of an integrated provider network are essential to a high performing AE and ultimately lead to better member outcomes. Similar programs (e.g., CMS NextGen ACO program) commonly incorporate incentives or requirements that promote in-network use. In the current Medicaid AE program, the majority of members do not affirmatively select a PCP and are unaware of the value offered by an AE. Therefore, in the absence of mechanisms to encourage members to keep their care within the AE network, it is often prohibitively difficult for providers to assume effective accountability for the care of a population. Within applicable boundaries, EOHHS should consider flexibilities in benefit/network design to reinforce the use of AE providers.

We appreciate the opportunity to provide comments on the important draft Roadmap and we look forward to a continued dialogue as the Roadmap is refined and finalized.

Sincerely,

Kristin Lewis

Kristin Lewis
Senior Vice President, Chief Public Affairs Officer