Rhode Island Executive Office of Health and Human Services (EOHHS)
Response to Comments on Accountable Entity TCOC Technical Guidance 01/31/2020

Commenting Entity	Topic	Comment	Response
Neighborhood Health Plan RI	**New Repricing Methodology for PPS**	The PY3 TCOC model includes an adjustment applied to reprice claims at FQHC's to their PPS rates. Commenter requested more information around the methodology and value.	Using the encounter data, EOHHS will identify FQHC using the billing provider federal employer identification number. Once identified, EOHHS will reprice each claim to the PPS rate applicable to the provider at the date of service. Still using the encounter data, EOHHS will then compare estimated TCOC by year, AE, MCO, and rate cell before and after this repricing. EOHHS will calculate a multiplicative adjustment factor by year, AE, MCO, and rate cell and apply these adjustment factors to the TCOC values provided by the MCOs. Note that this adjustment is the responsibility of EOHHS. MCOs should not apply this adjustment to the claims for their summarized TCOC reporting. EOHHS will show the value of this adjustment by year and rate cell in each AE's TCOC target calculations.
Neighborhood Health Plan RI	**Missing Data Adjustment**	Commenter requested that, if a missing data adjustment will be part of the calculation going forward, that EOHHS provide AEs and MCOs with specific details around that adjustment.	A missing data adjustment will not be part of the calculation for PY3. This adjustment was only required for the simulations, because encounter data was the source of all TCOC values. This adjustment is not required when MCOs provide summarized TCOC values.
Neighborhood Health Plan RI	**Attribution for Members Switching AE's**	Commenter requested documentation regarding how EOHHS will manage attribution for Members that change from one AE to another during the year.	For purposes of TCOC calculations, each member will be attributed to a single AE in each year (Baseline Year 1, Baseline Year 2, and Performance Period), regardless of movement between AEs throughout the year. The member's AE will be based on their final available monthly attribution in that year. All claims and enrollment for that year will apply to the TCOC calculations for the final attributed AE. Note that attribution for TCOC purposes is performed separately for each year, so it is possible for

			members to be attributed to one AE in Baseline Year 1 and a different AE in Baseline Year 2 or the Performance Period.
Neighborhood Health Plan	**MCO Data Requirements**	Commenter requested the methodology and timeline of EOHHS's data needs from the MCOs.	EOHHS has scheduled meetings with each MCO in the first half of February 2020 to discuss the data requirements. A detailed data request will be provided in advance of those meetings. EOHHS is requesting that MCOs complete the data request by March 31, 2020 in order to allow EOHHS and Milliman to review and complete the remaining calculations and provide preliminary AE-specific TCOC targets to AEs and MCOs by June 1, 2020.
Neighborhood Health Plan	**MCO Roles and Responsibilities**	Commenter requested a delineation of the roles and responsibilities of EOHHS and the MCOs regarding communicating the TCOC performance.	MCOs will be responsible for providing quarterly estimates of Performance Period TCOC expenditures and enrollment by rate cell to each AE. MCOs are not expected to provide quarterly estimates of risk scores. MCOs should be prepared to address questions directly related to TCOC expenditure and enrollment values, as these are to be calculated by MCOs. All questions on other topics (for instance, risk scores) will be addressed by EOHHS. In general, MCOs will respond to questions on the data and calculations developed by the MCOs, and EOHHS will respond to questions on the data and calculations developed by EOHHS. EOHHS encourages stakeholders to review the 'Division of responsibilities between MCOs and EOHHS' subsection in the Program Year 3: Total Cost of Care Technical Guidance document.
Neighborhood Health Plan	**Milliman Availability for Support**	Commenter requested a description of the access and availability of EOHHS' actuarial vendor to both AEs and MCOs on an ongoing basis and requested inclusion in any meetings between AEs and EOHHS reviewing TCOC methodology and or performance.	EOHHS will be available to support MCO and AE discussions and will directly address questions related to items other than TCOC expenditure and enrollment values. As the vendor is a subcontractor to EOHHS, EOHHS will determine when it is necessary to consult with the vendor.
FQHC AEs	**Rate Development Methodology to Deliver to AE's**	Commenter requested that EOHHS make available to each AE participant the methodology of calculating MCO premiums.	The TCOC appendices will break down trends between inflationary trend and adjustments for program and policy changes (such as new benefits).
FQHC AEs	**Diagnosis Codes Utilized in Risk Adjustment**	Commenter stated that there is concern that data submitted by the FQHC entities is not accurately captured in the risk adjustment calculations and	For purposes of risk adjustment, EOHHS is working with the MCOs to ensure the encounter data appropriately includes relevant diagnosis code information. EOHHS intends to use

		suggested that the MCOs be required to report the relevant diagnoses along with the spending data as part of the TCOC data submission process to properly capture the diagnoses necessary for the CDPS+Rx model. Commenter further suggested that the data should be shared with each AE to confirm it matches internal tracking, to ensure there are no biases in the final risk adjustment calculation.	the encounters, supplemented by ad-hoc MCO diagnosis information if needed, to perform the TCOC risk adjustment. EOHHS encourages any known diagnosis submission or encounter submission issues disproportionately affecting an AE to be reported to EOHHS and/or the MCOs.
FQHC AEs	**Attribution Methodology**	Commenter requested that EOHHS shift to a prospective attribution process for PY3.	EOHHS reviewed the PY3 attribution methodology (attributing each member to only a single AE in each year, consistent with the final available attribution month in the year), as well as an alternative method in which claims and enrollment are attributed to AEs separately in each month. EOHHS found that targets were largely consistent between the two methods. Further, if the attribution method is applied consistently in both the Baseline Years and Performance Period, prospective and retrospective attribution methods should each produce similar trends in aggregate. EOHHS recognizes that there are pros and cons to each attribution methodology and that some other models use a prospective approach. EOHHS will maintain the proposed attribution methodology for PY3 and will continue to evaluate the need for an alternative methodology in the future.
FQHC AEs	**Market Efficiency Adjustment for FQHC's**	Commenter stated that there is concern that there does not seem to be a planned adjustment to the market efficiency process to account for the change in the PPS methodology and suggested an additional step taken with the market efficiency adjustment to ensure that the FQHC AEs are measured against a comparable market average by creating separate market efficiency measures for the FQHC AEs and non-FQHC AEs.	The current methodology incorporates the full cost of FQHC services into the TCOC for both the AEs and the MCO average. Whether the FQHC claims are reimbursed at a physician fee schedule with a wrap payment or directly at the PPS rate, the PPS rate is ultimately incurred by the state. Therefore, EOHHS will apply the adjustment as have described in PY3 requirements in order to ensure alignment with capitation rate setting, which is a goal for PY3. This adjustment also protects the AEs from receiving an artificially low target that will not be achievable when

			MCOs begin reimbursing directly at the PPS rate in the future.
FQHC AEs	**IHH Adjustment to TCOC**	Commenter stated that although they agree with the changes to the process to align individuals who are part of an Integrated Health Home (IHH) to an AE for TCOC purposes, there is a concern that there will not be appropriate adjustments to the baseline cost calculations. Commenter suggested that EOHHS work with MOCs to determine the best process to realign historical spending of IHH members with their new AE, rather than relying solely on the historical attribution of each AE.	EOHHS is working with the MCOs to recast attribution for historical years with the attribution guidance applicable to PY3. In the event this is not possible, EOHHS will look into modifications to the risk score algorithm to fully account for costs associated with IHH members.
Tufts Health Plan	**TCOC Target Consistency with MCO Capitation Rate Setting**	Commenter requested continued consideration of the PY3 guidance comments relative to TCOC program elements, specifically underscoring the objective of having the TCOC target uniformly developed to align with MCO capitation.	The proposed methodology for establishing TCOC targets aligns with the methodology used to develop managed care capitation rates. The key difference is that managed care capitation rates are established using base experience from all MCOs, rather than experience specific to each entity. EOHHS believes that such an approach is not appropriate for establishing targets for AEs, which each have distinct attributed populations due to the nature of the services they provide and communities they serve. The current methodology is intended to create a target that represents a cost estimate for a given population in absence of intervention by the AE; as a result, any shared savings achieved by the AEs should be the result of actual cost reductions realized by the MCOs.
Tufts Health Plan	**Removal of Risk Exposure Cap**	Commenter stated that the current proposed risk share arrangement outlined in the guidance creates limitations to the AE program objective of establishing higher degrees of accountability and suggested that there not be a risk exposure cap, in order to allow AEs and MCO flexibility to establish desired levels of risk share.	The revised TCOC program requirements and technical guidance remove the 10% limit on shared savings as a percent of TCOC as well as the 10% risk exposure cap. Savings or losses that exceed 10% in any program year will trigger a review by EOHHS to determine if all Performance Period TCOC and target TCOC calculations are accurate. EOHHS reserves the right to revise any errors and adjust for unforeseen programmatic or data issues that may be contributing to overstated losses or savings.

Tufts Health Plan	**Grandfathering of Previous AE Contracts**	Commenter requested that existing contractual arrangements that contain higher levels of upside/downside risk be allowed to continue.	EOHHS is moving to uniform TCOC and expects all MCO-AE contracts to follow the PY3 guidance. As specified in the guidance, EOHHS will evaluate whether alternative TCOC methodologies may be used for contracts with less than 2,000 members attributed during each of the two historical baseline years on a case-by-case basis.
Tufts Health Plan	**Inverse Adjustment for Quality**	Commenter requested that EOHHS consider quality as an inverse adjustment to shared losses – such that suboptimal quality would increase the share and excellent quality would decrease the share.	No inverse quality adjustment will be applied for shared losses in PY3. EOHHS will continue to evaluate the need for an alternative methodology in the future.
Tufts Health Plan	**Clarification of Shared Savings**	Commenter requested that EOHHS clarify the terms of a minimum savings threshold, specifically requesting whether the AE gets to share in all the savings once the target minimum has been exceeded or only the amount in excess of the threshold.	If the AE exceeds the minimum savings rate (MSR), the Shared Savings Pool is equal to the difference between the Actual Expenditures and the TCOC Expenditure Target. The Shared Savings Pool is <u>not</u> limited to the amount above the MSR.
Tufts Health Plan	**IBNR Estimates from MCO's**	Commenter requested that EOHHS explicitly request IBNR estimates from MCOs and include these estimates in the final settlement calculations, regardless of the claims-runout period selected. As a less optimal alternative to including IBNR, commenter recommended that EOHHS require that any claims paid after settlement be reflected as expense in the following year's calculation.	EOHHS prefers not to require IBNR estimates from the MCOs, as this creates an adjustment that can be disputed by the AEs. It has been clarified in section 1.f of the TCOC technical guidance that EOHHS could determine an IBNR adjustment is needed in specific circumstances where the claims completion was estimated to vary significantly between the Baseline Years and the Performance Period for a given MCO.
Tufts Health Plan	**Clarification of Adjustment of Historical Data for Mid-Year Changes**	Commenter requested that EOHHS further define how adjustments will be made to the historical base for partial year changes such as the new MCO wrap payments due to the FQHCs.	In section 1.f of the TCOC technical guidance, special adjustments to changes in payment mechanisms or reporting are allowed. The FQHC adjustment is an example of such an adjustment. In that case, since all FQHC claims will be repriced, the adjustment will reflect only the impact to the portion of the year in which claims were paid at the physician fee schedule. If there are other major changes that occur in the middle of a year and which could disproportionately affect certain AEs, EOHHS may consider

			other adjustments. Any adjustments will be clearly explained and quantified by EOHHS.
Tufts Health Plan	**Flexible Risk Sharing Rates for FQHC's**	Commenter requested that the program provide flexibility to FQHCs that choose to participate in more meaningful risk sharing arrangements.	EOHHS encourages FQHCs that are interested in taking on downside risk to pursue opportunities and arrangements that would allow them to do so without putting the PPS rates at risk. CMS has provided that FQHCs are not able to put their PPS at risk. EOHHS also encourages value-based MCO/FQHC AE partnerships that do not require state or federal approval, particularly if those partnerships involve meaningful risk arrangements.
General	**Risk Adjusted Targets During Performance Period**	Commenter requested interim estimates of each AE's final risk adjusted TCOC target before issuing the final savings estimates.	EOHHS will not be providing interim estimates of each AE's final risk-adjusted TCOC target before issuing the final savings estimates. It is not feasible to estimate Performance Period risk scores with a reasonable degree of precision until the year is complete. However, EOHHS does recommend that AEs review the mix of attributed members by rate cell on the quarterly reports provided by the MCOs. The mix of rate cells is a key driver of risk adjustment.