Accountable Entity Program Year 3 - Feedback from Neighborhood Health Plan of Rhode Island

8-Nov-19

Implementation Manual

Page	Excerpt from EOHHS Document	Neighborhood Feedback
6	"For QPY3, AEs and MCOs must use only the AE Common Measure Slate measures to inform the distribution of any shared savings."	*Neighborhood reiterates our strong desire to have the option of additional P4P measures for QPY3, an option that was available in both QPY1 and QPY2. EOHHS has not responded to our multiple requests to reinstate this option or to provide their rationale for omitting it in QPY3.*
9	"Beginning in QPY3, all non-HEDIS measures in the Common Measure Slate are defined to only include Active Patients in their denominator. Active Patients are individuals seen by a primary care clinician associated with the AE anytime within the last 12 months."	*Neighborhood proposes that the language specify that active patients will be identified by the MCOs based on claims data using the specified CPT codes. This will be most efficient and avoid the need to audit AE data.*
10	"The value may vary from three percentage points if deemed appropriate by EOHHS."	*This important specification needs to be clarified; it does not specify what criteria EOHHS will use to identify measures where deviation from three percentage points is "appropriate" or how the determination of an alternative value will be selected. Neighborhood recommends that these decisions be made with input from and approval of the MCOs and AEs.*
11	"Improvement will not be recognized by the MCO if the rate is statistically significantly below the rate of two calendar years prior."	*It is not clear how this will work for QPY3 since QPY1 rates will not have not been audited. Please clarify.*

11	"Percentage of Quality Measures Needed to Achieve Full Shared Savings: EOHHS will define this parameter once QPY1 AE performance data and NCQA HEDIS benchmarks for CY2018 are available. It anticipates doing so and making any necessary changes to step 3 by November 30, 2019."	*Neighborhood recommends that this important decision be made with input from and approval of the MCOs and AEs.*
11	Footnote 19: "For Weight Assessment and Counseling for Children and Adolescents, statistical significance is determined using the average of numerators across component scores."	*Both numerators and denominators are needed to calculate statistical significance.*
12	"For QPY3, EOHHS will employ a combination of internal and external sources to set achievement targets."	*Neighborhood strongly recommends that these important decisions be made with input from and approval of the MCOs and AEs.*
12	"…set final Quality Performance Year 3 targets using Quality Performance Year 2 data (in conjunction with the other sources listed below) once they become available."	*QPY2 data will not be reported to EOHHS until August 31, 2020, so the MCOs and AEs will not know their final 2020 targets until late in the performance period. Neighborhood recommends that the final benchmarks be set based on QPY1 data, per item a. on page 12.*
13	"Should different data collection techniques appear to have substantive systemic effects on AE performance on some or all of those measures requiring clinical data, EOHHS will modify benchmarks for affected AEs using its best judgement."	*Neighborhood strongly recommends that these important decisions be made with input from and approval of the MCOs and AEs.*

13	To assist in achieving that end, EOHHS has offered incentive funding for AEs and MCOs during QPY2 for efforts to move towards electronic clinical data exchange for the Common Measure Slate for QPY3."	*Most of the CDE work will be done during QPY3. Neighborhood recommends that QPY2 incentive funding be carried over into QPY3 rather than lost to the MCOs and AEs.*
14	"There could be a circumstance in which an MCO does not have sufficient clinical data exchange capacity for one or more AEs. In those circumstances, MCOs must: 1) submit to EOHHS and receive approval of an action plan and timeline for clinical data exchange readiness by November 1, 2019; and 2) follow one of the methodologies identified for AEs without sufficient data exchange capacity for QPY3."	*MCOs and AEs would not have been able to determine whether their CED capacity is sufficient by this date. Neighborhood recommends that EOHHS provide MCOs and AEs flexibility to submit alternative plans and timelines at any time during QPY3.*
17	Table: "ED Utilization Among Members with Mental Illness"	*Neighborhood recommends that this measure be P4R during the first measurement year, OPY3, rather than P4P, to allow MCOs and AEs time to implement data-driven performance improvement initiatives.*
19	"Should OPY2 data deviate significantly from the OPY3 benchmarks, EOHHS will re-assess the OPY3 benchmark and notify AEs by November 30, 2020."	*The timing does not work because OPY2 ends June 30, 2020, and there is a 180-day runout period before the outcome measures are calculated and reported. EOHHS will not have data in time to re-assess the benchmarks since OPY3 ends December 31, 2020. Neighborhood recommends that this provision be deleted.*
21	"During the 2020 annual review, EOHHS shall ask AEs and MCOs to review HEDIS changes for Quality and Outcome Performance Years 3 and 4."	*This is the only mention of QPY4 in the document, and the document's title states"Requirements for Program Years 1 through 3". There have been no discussions among EOHHS, the MCOs and the AEs of the quality program requirements for QPY4. Neighborhood recommends that the reference to QPY4 be removed pending those discussions.*

21	Table: “Minimum Denominator Size”	*The 90% confidence interval around a rate of 75% with an N of 30 is +/- 15 percentage points, i.e., between 60% and 90%. This is not nearly sufficiently accurate for determination of quality performance determining shared savings to the AE. Neighborhood strongly recommends a much larger minimum denominator. For example, the 90% confidence interval around a rate of 75% with an N of 300 is +/- 5 percentage points, or between 70% and 80%. This is a much more acceptable level of uncertainty.*
39	“Appendix F: All-Cause Readmissions”	*It is likely that the quarterly rates produced by the MCOs using claims data will be different from the annual rate produced by EOHHS from encounter data, with concomitant problems for the AE program, including potential AE dissatisfaction. Since EOHHS is going to produce final annual rates for OPY3, there is likely to be greater alignment between the quarterly rates and the annual rate if EOHHS also produces quarterly rates.*
12	MCOs and AEs may calculate AE Overall Quality Score performance using Overall Quality Score Determinations Excel model (Current version: 9/12/19)	*12 needs a date update for the sharing of the Overall Quality Score Determination Excel model (Rebekah sent out again 10/17/19)*

12	QP3 targets (Also applicable to Outcomes (p.17) and HSTP (Attachment K))	*Consistent with PY3 Roadmap feedback provided to EOHHS on September 30, 2019, Neighborhood encourages EOHHS to consider a simplified approach to all measurement activity inclusive of quality, outcomes and HSTP incentive funding. Given the ongoing collaboration established by EOHHS with the MCOs and AEs, it seems appropriate to reconsider the program's overall approach to measurement to allow for adequate time for planning, development, and informed decision-making resulting in successful initiatives to improve quality and reduce total cost of care.*
		• *Based on input from the MCOs and AEs adopt a standard, minimal set of metrics to assess the overall performance of the AE program. Metrics should address an array of domains must relevant to the goals of the program.*
		• *Permit a standard progression to advance new quality, outcome or HSTP metrics based on the following cadence:*
		  ○ *<u>Time 0</u> = Introduction of new metrics with discussion and analysis to arrive at EOHHS/AE/MCO adoption consensus – this includes preliminary measurement to assess the measurement feasibility*
		  ○ *<u>Time 1</u> = Baseline calculation (test data methodology and validation)*
		  ○ *<u>Time 2</u> = Pay for Reporting (test data methodology and validation)*
		  ○ *<u>Time 3</u> = P for Performance*
		• *For example, applying these concepts to the new Outcome metrics associated with Emergency Department use for Mental Health reasons MH ED measure the following would occur:*
		  ○ *<u>Time 0</u> = 2019 discussion and feasibility assessment to reach consensus on adoption*
		  ○ *<u>Time 1</u> = Baseline calculation (decision specific to each measure depending on data availability or based on published Quality Compass*
		  ○ *<u>Time 2</u> = Pay for Reporting – AEs and MCOs responsible for data collection and reporting. Payments contingent on successful measurement.*
		  ○ *<u>Time 3</u> = Pay for Performance – AEs and MCOs with payment contingent on meeting targets*

17	Table: ED Utilization Among Members with Mental Illness	*Recommends adding footnote to the table of outcome measures that the ED utilization among members with mental illness measure is subject to change of targets, change in weighting, or even change in whether included in the measure slate for OPY3 dependent on OPY2 findings*
18	Table" Outcome Measures" and "Weights"	*OPY3 weights- these do not make sense. Why would ED utilization among members with mental illness weigh more than potentially avoidable ED visits? All-cause readmissions and potentially avoidable ED visits are both more whole population metrics which would demonstrate a broader impact of AE efforts. As noted in the bullet point above, we still don't really know how useful the other ED measure even is given the change from 2017 to 2018 despite AEs not knowing they should be working on this.*

	Table" Outcome Measures" and "Weights"	*Neighborhood strongly recommends a more equitable and fair distribution of the proportion of funding allocated to the Outcomes proposed for OP3. Neighborhood strongly recommends a reduction in the 45% proportion to 30%. To impact Outcome metrics, demonstrative redesigns of clinical delivery systems are needed which are time-intensive activities. The outcomes associated with these efforts may take up to 24-36 months to yield demonstrable results as evidenced in a recent evaluation of the BCBSMA Alternative Quality Contract, (N Engl J Med 2019; 381:252-263). Neighborhood recommends creating a transition period in OPY3 from reporting to performance. We strongly encourage EOHHS to reduce the proportion of split the 30% allocation; allowing 15% of funds to be earned for reporting and 15% of funds to be earned based on performance for measures. Measures eligible for P4P should only be those established that fall in the Time 3 example below.*
		• *Permit a standard progression to advance new quality, outcome or HSTP metrics based on the following cadence:*
		  ○ *Time 0 = Introduction of new metrics with discussion and analysis to arrive at EOHHS/AE/MCO adoption consensus – this includes preliminary measurement to assess the measurement feasibility*
		  ○ *Time 1 = Baseline calculation (test data methodology and validation)*
		  ○ *Time 2 = Pay for Reporting (test data methodology and validation)*
		  ○ *Time 3 = P for Performance*
		EOHHS needs to establish a progression to Pay for Performance, instead of the current proposal which moves too quickly and put the incentive funding at too much risk.

18 and 23	P., 18 “For OPY2” second bullet states AEs should provide MCO with documentation of both continuing and new processes implemented in PY2 to reduce a) avoidable inpatient admissions and b) avoidable ER Visits.p.23 Table, 4th Row.	*Only Avoidable ER visits is applicable as it is an outcome metric. Avoidable inpatient admissions should not be required as it is not an outcome for PY2. Outcomes are defined on p. 17*

ATTACHMENT J - ACCOUNTABLE ENTITY TOTAL COST OF CARE REQUIREMENTS

Page	Excerpt from EOHHS Document	Neighborhood Feedback
5	The Total Shared Savings Pool (inclusive of both the AE and MCO portions) must be adjusted by the Overall Quality Score as detailed in Attachment A.”	*It is not clear how the quality multiplier affects the MCO “portion” of shared savings. EOHHS should clarify with an example where the multiplier is less than 1.00.*
3	Attribution - Calculation of final TCOC performance is to bas3ed solely on the final quarterly update of attribution for the performance year. All costs associated with a member for the entire performance year shall be allocated to the AE to which the member is attributed in the final quarterly updates as specified in Attachment M.	*Attribution based on the final quarter’s attribution does not fairly distribute the accountability of expense. Each AE should be held accountable for their membership while they hold the membership. If the model was based on monthly rate cells and premium risk, it could be apportioned to account for expenses incurred while under the attribution of the AE during the time periods as appropriate.*
3 thru 7	All TCOC Methodology Descriptions	*Neighborhood strongly recommends adoption of TCOC model changes only after EOHHS has thoroughly tested and demonstrated the results of the new model to the AEs and MCOs. EOHHS is putting the AEs at risk by allowing for such dramatic and profound changes to the foundation of the program in a rapid and seemingly hasty timeframe. EOHHS needs to provide evidence of impact, attest to feasibility and provide time for meaningful feedback from the AEs and MCOs. We encourage EOHHS to recognize that a change of this magnitude, requires measured and careful consideration and strongly recommend providing the time to carry out a deliberate and fair process.*

6	Provider Revenue	*Please clarify what is counted as Provider Revenue for network hospital-based AEs.*
7	FQHCs may remain in shared savings only contract but must demonstrate a progression to value based care. Such progression may include the development of evidence based processes, incentives for cost reduction, and the establishment of sustainability for interventions currently funded by grants.	*More clarity is needed to understand the shaping of the progression identified. As written, it is unclear what additional items are required given the AE Agreement is already a value-based arrangement. Neighborhood welcomes the opportunity to work with EOHHS on examples to fulfill this requirement.*

ATTACHMENT M - ACCOUNTABLE ENTITY- ATTRIBUTION GUIDANCE

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4	"If an AE has the highest number of visits, the member will be attributed to that AE, even if it does not align with their PCP assignment of record."	*The situation where the member's attribution to an AE does not align with the assigned PCP is a significant challenge for calculating HEDIS. Please clarify that changes in attribution also mean a change to the member's PCP assignment.*
5	"All costs associated with a member for the entire performance year shall be allocated to the AE to which the member is attributed in the final attribution report."	*As proposed, attribution does not fairly distribute the accountability of expense. Each AE should be held accountable for their membership while they hold the membership. If the model was based on monthly rate cells and premium risk, it could be apportioned to account for expenses incurred while under the attribution of the AE during the time periods as appropriate.*

Attachment H Accountable Entities Certification Standards - Comprehensive AE

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5	"EOHHS application will demonstrate an effective and robust partnership between the AE and MCO to leverage the capabilities that each brings to the relationship and to avoid duplication."	*Neighborhood strongly recommends MCO review and preapproval of the certification prior to state submission. This is particularly important if the HSTP Plan is to be a component of the Certification. The MCOs must review the HSTP Plan prior to submission to ensure adequate measures can be established keeping in mind that MCO incentive funding is tied to AE performance. Please modify the proposal to describe the MCO participation in the Certification and HSTP review process.*

Attachment K- Infrastructure Incentive Program

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7	Table, 45% of AE and MCO Infrastructure funding for Outcomes	*Neighborhood strongly recommends a more equitable and fair distribution of the proportion of funding allocated to the Outcomes proposed for OP3. Neighborhood strongly recommends a reduction in the 45% proportion to 30%.* *The proposed 20% weight for ED visits for patients with mental illness is particularly high and the measure is methodologically flawed because it does not take into account "valid" reasons for ED use.* *Neighborhood recommends that HSTP metric performance should be weighted at 50% because it directly assesses the work of the AE.*
6	The MCO IMP shall be awarded from EOHHS to MCO based on the same set of performance areas and metrics.	*It is understood that the intent is to ensure that there is collaboration between MCO and AE. However this may unfairly impact the MCO if the AE fails to deliver on a metric that is beyond the control of the MCO.* ○ *The MCO payment should pay the MCO 50% of the available funds for management and* ○ *50% of available funds tied to the delivery on the project plan metrics by the AE.*

7	HSTP Project Plans will be submitted as part of the PY3 Certification Application. EOHHS will review and approve each HSTP Project plan as part of the certification process. Further detail regarding the HSTP project plan is in the Medicaid Accountable Entity Application for Certification.	*2.4 of Certification document referred to the requirement of a contract between MCO and AE for HSTP Plan funding. More specifics are needed to fully understand this process. Since the incentive funding is split between AE and MCO, it is important that the MCO provide oversight and pre approval for the project plans prior to EOHHS submission. Guidance for acceptable projects has been a role of the MCO and should continue. Reporting capabilities and support is a critical function to the success of project plans and the MCO. MCO funding should include a payment for the management role of the MCO.*
8	First Sentence…"Incentive funding must be earned and awarded to the AE via a Contract Amendment between the MCO and the AE."	*Clarify that a mutually agreed upon core contract exhibit and/or an executed HSTP Project Plan would satisfy the requirement for the Incentive Funding Contract Amendment.*
8	3rd bullet, The AEs failure to fully meet a performance metric under its HSTP Project Plan within the timeframe will result in forfeiture of the associated incentive payment. There will be no payment for partial fulfillment.	*The MCO is unfairly impacted here if the AE fails to deliver through no fault of the MCO. Same as p.6 concern.*
8	"In advance of the MCOs payments to AEs the MCO shall receive payment from EOHHS in the amount and schedule agreed upon with EOHHS. AEIP and MCO IP milestones will be paid on a quarterly basis."	*Could more clarity be provided as to how this might differ from current payments of fixed milestones paid as approved and quarterly advances based on targeted milestone completions?*