Neighborhood Health Plan OF RHODE ISLAND™

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To: Debbie Correia Morales
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From: Jay Buechner, PhD
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Re: Neighborhood's Response to the Proposed "Quality Framework and Methodology" for Accountable Entities

Thank you for the opportunity to review the proposed quality guidance prepared by EOHHS for use in contracts between the Medicaid MCOs and the Accountable Entities in the next phase of the AE program. Clearly, much work has gone into preparing a proposal at the level of detail seen in the guidance document. After review of the proposal, our response and recommendations are as follows.

Neighborhood finds the proposed methodology to be complex, prescriptive, and limiting, and we have made general recommendations concerning the changes we would want to see in the final guidance to address a number of serious reservations on our part. These concerns derive from our experience with the AE pilot program and with quality improvement incentive programs with providers over many years. Our primary objective is that the quality incentive on shared savings be structured so that MCOs and AEs have the flexibility needed to maximize the full spectrum of clinical quality of care for Medicaid managed care members who are treated by AE providers. We are requesting a meeting with the appropriate EOHHS staff and consultants to review and expand on our written recommendations, and we will gladly collaborate with you and our colleagues at United and Tufts and in the AEs to define and implement such a system.

Major responses and recommendations

1. **Data-driven Measurement Selection**

   The proposed incentive program covers only 12 performance measures. This limitation is extreme and is counterproductive. Accountable care organizations are responsible for the entire spectrum of care for their patients, and the SIM/OHIC aligned measure set for ACOs, which includes 11 core measures and 57 menu measures, reflects this spectrum. Accordingly, Neighborhood's current quality incentive for the AE pilot program includes an index composed of 35 HEDIS measures. For comparison, EOHHS' Performance Goal Program for Medicaid health plans included 28 HEDIS measures (45 specific rates), 3 CAHPS measures, and 7 non-HEDIS, non-CAHPS measures in 2017.

   Recommendation: Place no limit on the number of ACO menu measures that can be included in the AE/MCO contracts. This will allow the flexibility for the quality incentive to be directed toward

those areas where quality improvement is most needed, based on analysis of performance data. In addition, support the collection and analysis of data on AE performance on the full range of ACO measures, insofar as possible and practical, so that opportunities for improvement can be identified for inclusion in the quality incentive. Using data to drive improvement is consistent with EOHHS' approach under the AE Incentive Guidance.

2. Ensure Data Integrity

The proposed incentive program allows AEs to be measured for their entire Medicaid AE population, rather than for each MCO population. This is unacceptable to Neighborhood, as it will make it impossible for us to audit the reported rates (due to HIPAA privacy protections) and to analyze the data to support targeted interventions. Moreover, this proposal does not recognize the fact that measurement of most or all of the quality metrics will almost certainly be done by the MCOs rather than the AEs, as the AEs will not have access to claims and other data from multiple providers. This is particularly true for the many HEDIS measures that are included in the core and menu measure sets for ACOs. It would be redundant and a significant burden on the resources of the AEs to require them to implement HEDIS measurement in parallel with the MCOs.

Recommendation: Remove this specification from the proposal. MCOs and AEs may still agree to measurement at the all-payer level for specific measures, as appropriate. In addition, the guidance should strongly support the submission of extract files from provider EMRs to enable accurate measurement of clinical quality measures. Neighborhood is currently negotiating the submission of such extracts from a number of AE-affiliated providers.

3. Simplify Quality Score

The formula for the Quality Score is opaque and has many elements that are not well constructed to support quality improvement. The tiered measure score is awkward and appears to have been created just for this proposal, and the underlying rationale is not presented. Payment to AEs for reporting is not acceptable to Neighborhood, in great part because the plan will likely be doing the work of measurement, not the AEs. The formulas with sharp cutoffs (e.g., +/- 5%) are inefficient as incentives for continuous improvement. The use of statistical significance tests is cumbersome and penalizes small AEs with small measure denominators. Comparisons of AE performance to the overall MCO rate does not allow for risk adjustment, and our experience with the pilot program has demonstrated that the AEs have substantially different patient mixes.

Recommendation: The Quality Score should be simply constructed and designed so that it provides an incentive for continuous quality improvement at all levels of current performance among the AEs. Neighborhood supports the use of a risk-adjusted index of multiple measures coupled with a combination of the level of performance and relative improvement by the AEs in the determination of the level of shared savings awarded to the AEs.

Other specific recommendations

4. **Eliminate the comparison of AE performance to MCO performance** in computing the quality score. This comparison would require the MCOs to extend the measurement of all non-HEDIS/non-health plan measures to include their non-AE members/providers, which will be administratively burdensome and costly to both the health plans and non-AE providers. There are five such measures in the proposed measure slate: Developmental Screening in the First Three Years of Life; Tobacco Use: Screening and Cessation Intervention; Screening for Clinical Depression and Follow-up Plan; Social Determinants of Health (SDOH) Screen; and Self-assessed Health Status. Among the 57 ACO Menu measures there are an additional 29 non-HEDIS/non-health plan measures

5. **Do not include the "home-grown" measures** for social determinants of health and self-assessed health status. Although of great interest, these measures will be difficult and costly for the AEs to collect and there is no evidence supporting the use of either of these measures for improvement of clinical quality. Especially note that any direct data collection from Medicaid members typically results in high rates of non-response, even with the resources available to MCOs, such as staff supporting member services. Without those resources, AEs will like have even larger rates of non-response. Instead, continue to focus on SDOH measurement and collection under the Incentive program and allow time for the formulation of consensus and collaboration on the measurement of SDOH across the state inclusive of SIM, EOHHS, health plans and AEs. We believe a widely implemented and well supported system will prove a better choice for SDOH data collection than a system developed only for use in Rhode Island.