



A. Respondent Information

Prospect Health Services, RI, Inc. (PHSRI) is pleased to submit our comments on the following AE Program Year Two amended requirements documents issued April 30, 2019:

- Attachment L1: Total Cost of Care Requirements**
- Attachment L2: Incentive Program Requirements**

This document also incorporates, at the end (Section C), comments provided previously regarding the Total Cost of Care (TCOC) Requirements.

As always, PHSRI looks forward to collaborating with EOHHS. We strongly support the State of Rhode Island's Accountable Entity Program development and look forward to working with EOHHS and its Managed Care Organizations (MCOs) to make the AE initiative a success.

1. Contact Information

Garry Bliss
Medicaid AE Program Director
(401) 742-8040
Garry.Bliss@prospectmedical.com
Prospect Health Service, RI, Inc.
1301 Atwood Avenue, Suite 106N
Johnston, RI 02919

2. Organization/Organizations Represented by this response

Prospect Health Services RI, Inc. (PHSRI)

B. Comments on the Draft EOHHS Total Cost of Care (TCOC) Requirements Program Year 2

L 1: Total Cost of Care Requirements

Section C. General Requirements for Program Participants

C.4. Attribution

PHSRI recommends that the attribution methodology be standardized to attribute and/or assign members for one full year or until the beneficiary makes an election which would change their assignment or they lose eligibility, and not change assignment for each month or each quarter, which creates significant variability and has a negative impact on the coordination and cost of care.



Section D. TCOC Methodology: Required Elements

D.1.a Defining Historical Cost Data

The method of weighting by years introduces significant amount of variability and subjectivity. PHSRI recommends that a 3-year running cycle for utilization per thousand (admissions per thousand, ER admissions per thousand, SNF days per thousand, etc), and use and average of the 3-years utilization (to overcome the cyclical nature of utilization trends).

For unit cost, historical rate increases trend should be used as part of the baseline development for an average cost for members assigned to the AE. Risk scores should be used to set the baseline for the members served by each AE.

D.1.b. – Covered Services

In addition to the excluded services currently covered under stop loss provisions between EOHHS and the state, PHSRI recommends that MCO TCOC contracts with AEs exclude pharmacy (Part D) from the 3-year claims calculations. Pharmacy costs have been increasing significantly over the years, and physician groups have limited tools to overcome the increasing cost for those services. We also recommend that MCO TCOC contracts also exclude claims costs for claims above \$100,000.

D.1.b.III - Covered Services

PHSRI strongly agrees with EOHHS guidance that TCOC methodologies must include infrastructure payments made by MCOs to AEs and AE-affiliated providers, including but not limited to any Patient-Centered Medical Home (PCMH), care management and utilization management infrastructure payments.

D. 1.d. – Adjusting for Changing Risk Profile

PHSRI agrees with EOHHS that MCOs must provide a detailed description of the specific MCO risk adjustment software/methodology applied, including the underlying parameters set by the MCO.

D. 1.e- Historical Base with Required Cost Trend Assumptions



PHSRI recommends including additional guidance that MCO TCOC contracts include that trend increases for second and subsequent contract years be based on either the following at minimum: Medical Consumer Price Increase or Medicaid national average cost increase.

Section 3. Targeted Expenditures for Performance Period

3.a. – Request Cost Trend Assumptions

PHSRI recommends that the AE specific TCOC performance year budget target needs to consider the claims exclusions we recommend in our comments for section D.1.b. and the annual increase minimums we propose in our comments for section D.1.e.

Section 5. Shared Savings (Loss) Pool Calculations

5.a. – Small Sample Size Adjustment for Random Variation

PHSRI recommends that this section be removed, because shared savings percentage determinations should be left to contract negotiations between the MCO and the AE. The sliding scale method unnecessarily disadvantages AEs with smaller populations.

5.c.- Maximum Allowable Shared Savings (loss) Pool

Please refer to our comments on Section 7.

Section 7 Required Progression to Risk Based Arrangements

PHSRI recommends that the minimum withhold requirement be removed. The MCO and AE should be given the flexibility to pursue alternative approaches to assure the MCOs of an AE's financial viability to engage in downside risk arrangements.

EOHHS Current Guidance

Should an MCO and AE wish to share risk on a more accelerated schedule than that outlined above, the MCO and AE should submit written documentation to EOHHS, including:

- *the draft contractual financial terms between the parties;*
- *a statement of why the AE is qualified to assume greater risk than that outlined above, including its infrastructure to manage clinical risk, an established record of meeting quality metrics and the likelihood that the AE will meet the quality thresholds established by EOHHS and the MCO;*
- *documentation of secured funds necessary to meet the maximum financial obligation that the AE could potentially incur under the terms of the proposed agreement.*



Following review of the aforementioned information, EOHHS will decide whether the arrangement may proceed.

PHSRI Response

PHSRI strongly supports EOHHS' TCOC guidance which would allow MCOs and AEs to enter into more accelerated risk arrangements, subject to EOHHS approval, than outlined in the schedule on page 10 of the guidance. PHSRI favors a global risk and considerable delegation based upon our competence and expertise which we have documented for EOHHS in the past.

While we would prefer that the arrangement be left to negotiations between the MCO and AE, we understand EOHHS' concern for the protection of the Rhode Island's Medicaid beneficiaries and the level of experience and comfort with arrangements where providers assume and manage a substantial portion of the medical risk for the Medicaid population it serves. We also do not want providers without the demonstrated experience and capability to assume and manage substantial risk to take on that risk and fail. We believe such failure would be a setback to the State's and EOHHS' policy objective of having providers assume accountability for the quality and cost of healthcare in order to replace the current inefficient fee for service payment model.

Therefore, we support EOHHS reviewing and approving risk arrangements beyond the thresholds established guidance in the TCOC. We would ask that the time frame for final guidance be set at 60 days for the review and action at which time the arrangement would be deemed approved if no other action is taken by EOHHS. This is simply a safeguard against delay that could extend the approval process indefinitely, delaying the ability of the AE and MCO to make timely business decisions.

In addition to EOHHS allowing more accelerated risk arrangements between MCOs and AEs, we would ask that EOHHS adopt guidance that supports a qualified AE's choice to take on more substantial risk in the case of MCOs who are unwilling to negotiate such arrangements in good faith. Again, we would prefer that this be left to negotiations between MCOs and AEs, but providers have already experienced the unwillingness of MCOs to negotiate more substantial forms of provider risk taking. Eventually, we believe the market will reward the innovative MCOs who embrace provider accountability, but in the short term there needs to be greater stimulus for qualified AEs and MCOs to negotiate these arrangements in good faith.

Therefore, we ask EOHHS to establish guidance to provide such stimulus to move the market in the direction it seeks for the state's Medicaid MCOs and the AEs who can demonstrate their experience and competence in assuming and managing greater accountability for quality and cost. We have developed draft guidance below on this subject for your consideration:

The Executive Office of Health and Human Services (EOHHS) favors and fully supports MCOs progressing to advanced forms of alternative payment methods (APMs) to fee-for-service payment for Accountable Entities (AEs) who demonstrate to the MCOs and the



EOHHS they can successfully manage such APMs in order to promote provider accountability for quality and cost in serving Medicaid beneficiaries.

In order to implement these alternative payment methods, EOHHS invites AEs to communicate their desired form of alternative payment method to the Medicaid MCOs in alternative payment Categories 2-4 as outlined below by the Health Care Payment Learning and Action Network established by the Centers for Medicare and Medicaid Services:

- Category 1: Fee-for-Service—No Link to Quality or Value
- Category 2: Fee-for-Service-Link to Quality and Value (Portion of Payments Vary with Efficiency or Quality of Health Care Delivery)
- Category 3: Alternative Payment Methods Built on Fee-for-Service Architecture (Shared Savings or Two-Sided Risk Based on Efficiency and Quality)
- Category 4: Population Based Payment (Payment Based Upon Population Outcomes and Accountability Over Time)

In order to stimulate the progression of MCOs and AEs to more advanced APMs and in particular Category 4 and ensure both parties actively participate in related negotiations, EOHHS requires Medicaid MCOs and AEs to adhere to the following process.

Within 30 days of the receipt by the MCO of an AE's desired form of APM, the MCO will respond to the AE their willingness to enter negotiations on that form of APM. If the MCO is unwilling to negotiate with the AE on the AE's preferred form of APM, the MCO's written response must include: 1) an explanation of the reason they decline to negotiate on the AE's preferred APM and 2) a detailed alternative proposal regarding the APM they will be willing to negotiate. A copy of both the AE's proposal letter and the MCO's response must also be provided to the Secretary of Health and Human Services (Secretary) by the respective parties at the time of issuance.

The AE may accept the MCOs alternative APM method or appeal in writing to the Secretary, describing the reasons the AE does not accept the MCO's refusal to negotiate with the AE on their preferred APM model or their offer of an alternative APM model. . The Secretary will accept written responses from both parties supporting their position and make a determination within 30 days as to the appeal and notify the MCO and AE of the determination.

If the AE has reason to believe, at any time during the communication or negotiations that the MCO is not negotiating in good faith toward the agreed upon APM, the AE may appeal to the Secretary with the reason they believe that the MCO is not negotiating in good faith. The Secretary will review the appeal within 30 days and provide the



determination to both the MCO and the AE, along with further instructions on further negotiations.

EOHHS Guidance

Additionally, if an AE enters into an arrangement that provides for shared losses with a total potential risk that equals or exceeds 10% of expected expenditures, the AE must meet all of the financial reserve and risk-based capital requirements required of a Managed Care Organization, with oversight by the Department of Business Regulation.¹

EOHHS anticipates that any AEs taking on such risk must, at a minimum, demonstrate adequate capitalization to cover three (3) months of claims.² In order to monitor AE financial performance, AEs and MCOs will be required to furnish financial reports regarding risk performance on a semi-annual basis to EOHHS.

PHSRI Response

As we have said, we support EOHHS' encouragement of MCOs and AEs to enter into APMs that replace the inefficient and fragmented fee for service reimbursement method. We also understand EOHHS' desire and need to protect the Rhode Island's Medicaid beneficiaries and the State from AEs who are unable to manage the contractual risk they assume. However, we are concerned that the guidance outlined above will have unintended consequences, which we outline below. Further, we also provide our recommendations to avoid the unintended consequences and at the same time adequately protect Medicaid beneficiaries.

The guidance above requires AEs who enter into an arrangement with risk greater than 10% of expected expenditures to meet all of the financial reserve requirements of an MCO and be further be subjected to oversight by the Department of Business and Regulation (DBR). We believe that this level of financial reserve requirement and DBR oversight imposed on AEs is excessive, unnecessary and counter-productive, and will have significant and unintended consequences as follow:

- **The requirements duplicate the financial reserves required of MCOs for the protection of beneficiaries and will increase the cost of health care for Rhode Island and its beneficiaries.** Under this requirement, not only will the State's premium paid to MCOs need to cover the reserve formation of the MCO, but it will now have to cover the additional reserves required of the AE. As an example, if 5% of the current Medicaid premium is required for the MCOs risk formation, this requirement would require the State to add another 5% for the AE's risk formation. At a time when the State's budget is challenged and we are trying to use the AEs to bend the cost curve, this requirement would add new and unnecessary cost;
- **The MCOs must reserve for insurance risk, whereas the AEs must have the financial wherewithal to manage contractual risk which is far less than insurance risk.** MCOs



do not provide care—they contract with providers and pay claims. The greatest insurance risk for MCOs is for incurred but not reported claims (IBNR). The risk of variation in the cost of care beyond the historically established IBNR is substantial due to the lag between the delivery of care and when the claim for service is submitted and then paid. Literally, 100% of the MCOs' medical costs are subject to this variability and insurance risk. On the other hand, a capitated AE provides care to beneficiaries in its own facilities and offices and can easily match the expense of that delivery for 50-70% of the care provided to its population under management. This eliminates most of the time lag of claims and only exposes the AE to the variable cost of its services. In addition, as providers, the AE has a much closer connection with patient than does the MCO. Due to that relationship, the AE is better able to manage the care and the cost of the care of the patient who is treated by a non-owned provider than the MCO. Therefore, the insurance risk for an AE is only 15-30% of the MCO and so requiring similar reserves of an AE is unduly excessive and cost increasing;

- **Requiring excessive reserves will exclude many providers from moving to Category 4 APMs.** The only APM that replaces the fee for service system is Category 4 Population-Based Payment. All others continue to rely on the fee for service chassis that rewards volume over value. The declining reimbursement or reimbursement that does not keep pace with increasing medical costs, particularly for Medicaid and Medicare, means that providers have less margin than in the past. The excess reserves required of AEs by the current guidance to match MCO reserve requirements will keep most providers, if not all, in Rhode Island from being able to move to Category 4 APMs—and unnecessarily. Additionally, low cost providers are rewarded in Category 4 APMs—and are significantly disadvantaged in the current Rhode Island fee for service system. This hardly seems consistent with State's and EOHHS' policy intention to move AEs to greater levels of provider accountability to replace the fee for service system and to reward lower cost, high quality providers.
- **Providers who can meet Category 4 reserve requirements and be subject to oversight by DBR could likely conclude that there is no reason not to become an MCO.** Some providers have moved into becoming MCOs themselves. But many of us do not want to become MCOs, unless forced to do so due to MCOs unwillingness to move to Category 4 APMs. Having to meet MCO reserve requirements and becoming subject to oversight by DBR removes nearly all the impediments to becoming an MCO. While this could be an objective of EOHHS in establishing the proposed financial reserve requirement, it is our understanding that EOHHS has always been clear that it wanted to work through its partner MCOs and move the market to greater risk APMs with AEs rather than stimulate more competition to the existing MCOs.

Given these unintended consequences, PHSRI asks that EOHHS consider the following principles in establishing reserve requirements which will encourage AEs to move to greater risk forms of



APMs and at the same time provide adequate financial protection to the State and its Medicaid beneficiaries:

1. AEs who demonstrate their experience, capability and expertise to assume and manage accountability for the quality and cost should be encouraged to do so immediately as a positive example to the rest of the provider community and reserve requirements should not be a barrier to that accountability.
2. Supporting and encouraging all AEs to assume and manage greater accountability for quality and cost of care early is necessary to achieve the State's goal of sustainability after five years, when development and implementation funding will end and AEs are expected to be self-sustaining based on their successful performance.
3. Risk based capital requirements for AEs should only be tied to the portion of TCOC that the AE is under contract to manage with an MCO and only those uncovered expenditures which are not capitated and paid on a fee for service basis in non-owned facilities.
4. Since AEs do not hold IBNR underwriting risk, a substantial discount factor to reserve requirements should be applied to reflect that the AE is not an insurer. Unlike insurers, AEs do not price and cover policies on an annual basis but provide and manage the care of their patients.

In order to achieve these principles, we recommend that the AE who assumes global risk on a percentage of premiums must demonstrate to its contracting MCO that it has the minimum of the following in financial reserves:

- A minimum of \$500,000; or
- 6% of the annualized health care expenditures, except those paid on a capitated basis.

The financial reserves must be evidenced by a restricted account; a letter of credit; a surety bond; or a combination of the three.

Attachment A: Quality Framework and Methodology

PHSRI supports the clinical data exchange goals of EOHHS (page 16), and has made and will continue to make significant investments to meet those expectations, however given the fact this is a new requirement – and one that requires coordination of multiple partners (providers, the AE, and the MCOs) – would strongly suggest that EOHHS consider providing flexibility in this area.

We would encourage EOHHS to allow AEs to develop plans for collecting, validating, and submitting data that meet the overall objectives of EOHHS. In this instance, EOHHS should prescribe the final goal – submission of quality/clinical data – but allow AE/MCO partnerships to define the most efficient and effective method for realizing that goal.



Comments on the Draft EOHHS Incentive Program Requirements Program Year 2

L 2: Incentive Program Requirements

- PHSRI support the increased funding made available in PY2 to support Clinical Data Exchange and Validation Activities, however – in line with our comments above about Attachment A to L1, we encourage greater flexibility related to Clinical Data Exchange in recognition of the complexity of this new process and the long-term benefit of allowing and encouraging AEs to move in the direction EOHHS has set.
- PHSRI believe the new language (page 11) regarding the fact that “failure to fully meet a performance metric under its AE Health System Transformation Plan within the timeframe specified will result in forfeiture of the associated incentive payment (i.e. there will be no payment for partial fulfillment)” is overly restrictive and punitive.

PHSRI recognize this language is somewhat modified in the following bullet (page 11) that states MCOs must develop “a process by which an AE that fails to meet a performance metric in a timely manner (thereby forfeiting the associated Health System Transformation Project Plan Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric.”

PHSRI encourage EOHHS to remove the reference to automatic forfeiture of HSTP funds for a missed deadline. The projects and tasks EOHHS is asking AEs to take on are complex, requiring collaboration of multiple partners. Given this, it is possible that, even with the best of intentions, an AE could miss a deadline due to unforeseen circumstances. Language triggering an automatic forfeiture seems contrary to the collaborative nature of the AE initiative while failing to account for the complex nature of these projects.

- PHSRI have concerns about the impact of the footnote (#6) on page 15 that states “AEs cannot submit the same agreement as evidence of milestone achievement under



multiple MCO contracts.” This footnote references the required “Execution of an agreement with SDOH, BH, and/or SUD Provider by the end of the calendar year.”

AEs, like all health care providers, seek to treat all members in a similar manner, regardless of the member’s provider. This is a matter of equity and efficiency. It is not right for patients covered by one MCO to receive a notably different suite of services from the PHSRI-AE than those of another MCO. This is also the most efficient way to operate the AE and provide care across our population. For this reason, PHSRI set identical projects and milestones for our PY1 HSTP Plans. Our approach is to build one AE that serves patients who happen to be covered by different MCOs.

PHSRI would like to continue this approach in PY2 and therefore would suggest that EOHHS allow AEs to submit the same contract/contracts in satisfaction of this requirement.

Finally, requiring separate SDOH/BH/SUD contracts for each MCO dilutes the potential impact of this funding by spreading a limited amount of funding over more than one contract, rather than allowing AEs to focus investment and make a greater impact.

- A similar restriction is included in the language, on page 10, related to the “AE Specific Core Projects: Workplan and Budget.”

In this section, the guidance states: “To avoid duplication, each core project must include MCO specific milestones...”

As stated above, our goal is to create a unified AE program that serves all attributed members in a similar manner. PHSRI has designed our program based upon our direct experience providing accountable care and best-practices. Coverage by one MCO versus another should define neither the care we provide nor the developmental goals we set for our Accountable Entity.

PHSRI understands the desire – in fact, the need – to avoid redundancy and the appearance of “double dipping,” receiving payment twice for the same activity. However, there should be a provision to allow AEs to create a single, unified development plan and allocate the investments related to that across its population per MCO.

The more that guidelines require divergence between what is done for one MCO vs another MCO, the effectiveness of AEs will be undermined.



PHSRI recommends carrying forward the PY1 approach that aligned with this unified AE development approach.

- On page 11, EOHHS makes clear that for AEs will be required to develop a PY2 budget that is closely tied to the PY2 workplan:

The AE must develop a multi-year workplan and budget to address these priorities over the course of the program. A more detailed workplan and budget must be developed for Program Year 2 that identifies a requested set of core projects in the pertinent Domains needed to address the Shared MCO/AE Priorities.

And

The funding request must be reasonable for the project identified, with funds clearly dedicated to this project. The level and apportionment of the incentive funding request must be commensurate with value and level of effort required.

While PHSRI recognizes EOHHS's obligation to account for the expenditure of federal funds, it is important to recognize that much of what the AEs are charged with accomplishing is practice transformation, fundamental reform of the delivery of healthcare in order to achieve the goals of the AE initiative.

Change management does not come with a discrete cost that can be cataloged in an invoice or an accounting ledger. PHSRI urges EOHHS to find a way to meet your need for accountability while also recognizing the nature of the work AEs are being asked to undertake.

Perhaps, Center for Health Care Strategies (CHCS) could provide some guidance based upon successful models from other states.

The flexibility of the PY1 approach has been beneficial in that it has provided necessary resources to the AEs without excessive burdens and has provided funds upfront rather than on a reimbursement basis, an approach that would severely constrain the ability of AEs to invest in program/capacity development.

PHSRI appreciates the opportunity to provide input into the guidance provided by EOHHS on the operation of the AE program. It is an important effort to be able to afford covering citizens of Rhode Island who need Medicaid assistance.



**PROSPECT HEALTH
SERVICES RI, INC.**
Quality Service – Quality Care

**RI Medicaid EOHHS Draft
AE PY2 Documents
L1: Total Cost of Care Requirements
L2: Incentive Program Requirements**