

BHDDH Comments – October 16, 2018

EOHHS Medicaid Infrastructure Incentive Program:

Attachment L 2: Requirements for Medicaid Managed Care Organizations and Certified Accountable Entities – Program Year Two Requirements

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Specialized AE Pilot Program*	\$7.5 M from \$9M	25% from 35%	25 - 30%
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Lowered value of Incentive for Specialized AE yet increase in the MCO Incentives. What is the reasoning for this? Appears that there is not commitment to provide infrastructure incentive to stand up a specialized AE? However, MCO funding raised considerably.

1. Assuming satisfactory MCO performance, the MCO Incentive Management Pool that can be earned by the MCOs shall be thirteen percent (13%) from 8% of the Total Incentive Pool. However, to the degree that the MCO has more than the minimally required number of contracts with AEs, the maximum MCO-IMP shall be increased by one percent for each AE contract to a maximum of fifteen percent (15%) from 10%. These funds are intended for use toward advancing program success, including program administration and oversight, assisting with the development of the necessary infrastructure to support a new business model, and establishing shared responsibilities, information requirements and reporting between EOHHS, the MCO and the Accountable Entities.

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Developmental Milestones: Variable Percentage Allocations Based on the HSTP Project Plan	<ul style="list-style-type: none"> • Developmental milestones MCO/AE defined (at least 3 unique developmental milestones per Core Project per year) 	6/45%
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Numbers do not add up to 100%. The guidance is not clear as to what are allowable components. The row above seems particularly vague and difficult to measure with any reliability. Perhaps providing template for reporting or minimal reporting metrics would be helpful.

BHDDH Comments-Attachment L 1: Accountable Entity Total Cost of Care Requirements – Program Year Two Requirements

The section below has been deleted from the document. All references to TCOC related to Specialized AE deleted. Is Specialized AE beyond delayed and off the table? If so, why is it still in the Incentive section?

With two years expended of HSTP, very little time and funding will remain to get Specialized AEs integrated with comprehensive or off the ground independently. Specialized AEs were a core principal of the initial CMS-RI request and part of the LTSS delivery system transformation. Abandoning the AE LTSS projects and principals would be unfortunate, especially as OHHS and Governor's Office are spearheading a new LTSS Reform package – No Wrong Door.

The ongoing delay of Specialized AEs discriminates against some of the most vulnerable populations with the highest utilization of Medicaid funded services. An organized, accountable delivery system for acute and long-term care services for high-need, special (target) populations can enhance health outcomes as well as manage costs more effectively by reducing fragmentation and duplication.

Currently, most Medicaid nursing facility and home and community-based LTSS in Rhode Island are reimbursed using encounter-based and other fee-for-service payment models that do not reward quality, efficiency, or value. *EOHHS seeks to move away from fee-for-service payment models toward alternative payment models (APMs) that incentivize providers to be more accountable for Medicaid patients' care and outcomes.* EOHHS intends to pilot test APMs, including bundled payments, per member per month (PMPM) payments, episodic payments, and other value-based payment (VBP) models, on a voluntary basis with Partner and Affiliate Providers in specialized LTSS AEs. EOHHS anticipates requesting expenditure authority under Section 1115(a)(2) of the Social Security Act to implement APMs for nursing facility and home and community-based LTSS. Additional requirements around the APMs and the APM pilot opportunities will be provided separately.

BHDDH Comments - Attachment M: Accountable Entity Attribution Requirements – Program Year Two Requirements

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The population eligible for attribution to a comprehensive AE consists of all Medicaid-only beneficiaries enrolled in managed care. Rhody Health Options (RHO) members shall be included in AE attribution if the RHO member is receiving Medicaid benefits only (not Medicare). RHO and Medicare-Medicaid Plan members who have both Medicare and Medicaid coverage are not eligible for attribution to a comprehensive AE.

Is this still necessary with the implementation of the Budget Initiative eliminating RHO?