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Via Email To leah.delgiudice@ohhs.ri.gov

November 5, 2019

Re: **Certification Standards**
TCOC Requirements
Incentive Program Requirements
Attribution Guidance

Dear Leah:

Thank you for the opportunity to submit these comments concerning the proposed standards and requirements for Accountable Entity (AE) Program Year 3. The Rhode Island Parent Information Network (RIPIN) helps thousands of Rhode Islanders to navigate the healthcare system every year. We operate an all-payer consumer assistance program (in partnership with OHIC) that helped clients save $2.25 million in 2018. We also operate numerous other programs that help Rhode Islanders, especially those with disabilities and special needs, to access the care they need.

The Rhode Island (and American) health care systems generally face crises in both spending and outcomes, but the Rhode Island Medicaid program has controlled spending for the past decade. In Rhode Island, per-member per-month (PMPM) Medicaid spending decreased every fiscal year from 2010 ($814 PMPM) to 2017 ($690 PMPM), and stayed virtually unchanged in 2018 ($691 PMPM). PMPM spending in FY 2018 is more than 15% lower than it was in 2010.

Nonetheless, the United States ranks 44th in life expectancy at birth, 55th in maternal mortality, and 55th in infant mortality. Among disadvantaged racial and socioeconomic subgroups, the numbers are far worse. If African American infants were looked at as their own country, they would rank 98th in the world; African American mothers would rank 90th in maternal mortality, worse than El Salvador and Vietnam. On these types of outcomes, Rhode Island has made far less progress.

Payment and delivery system reform efforts in Rhode Island, including the AE program, have focused too heavily on reducing spending and too little on improving outcomes. While attention to spending is important and necessary, we believe that EOHHS has the opportunity to increase the emphasis on outcomes. Our recommendations to that end, as well as others, follow.

Alternative Payment Models Should Prioritize Improved Outcomes

Cost-savings and improved outcomes are often held out as equally important priorities of the AE program, but the financial model proves otherwise. In the current proposed plan, AEs that show savings will likely recoup some portion of those savings even if quality and outcomes performance is mediocre. However, even the best performing AE on quality and outcomes (whether in absolute or improvement terms) will receive no bonus if its cost performance is flat. That same "high quality" AE could even be penalized if its cost performance is above trend. These types of disparities, prioritizing cost savings over quality and outcomes, should be eliminated. They are particularly inappropriate in the RI Medicaid context where, as mentioned above, cost control does not stand out as the primary challenge.

To start, RIPIN recommends funding bonuses for high-performing AEs, including those that do not achieve savings, using the withheld Shared Savings Pool bonuses from AEs that fail to meet outcome targets. Alternatively, RIPIN recommends utilizing withheld shared savings bonuses to create public health funds to be invested in initiatives likely to improve public health outcomes.

Thank You for Exempting FQHCs from Risk; Definition of "Value-Based" Contracting Uncertain

RIPIN appreciates EOHHS' determination to exempt FQHCs from the Program Year 3 requirement that AEs enter into a risk-based contract in order to qualify for the entire incentive pool. However, the alternative requirements for FQHCs to participate in the incentive pool use the vague term "value-based," a term without a clear definition.

A payment program that disadvantages FQHCs would run counter to the important role that FQHCs play in serving the needs of Rhode Island's Medicaid-enrolled population. However, it is not entirely clear as to what is meant by a value-based payment contract, and RIPIN would recommend providing clearer guidance on that front in advance of establishing such a requirement. Particularly, it should be clarified how that term differs from current AE contracts, which already include shared savings bonuses and quality targets.

Comprehensive Risk-Readiness Evaluation is an Important Prerequisite to AE Risk-Bearing

RIPIN supports the requirement that AEs meet risk-readiness criteria in order to participate as risk-bearing provider organizations (RBPOs) in the expanded Incentive Program. RIPIN thanks EOHHS and OHIC for their efforts to develop a program by which AEs may be evaluated to determine their readiness to bear risk in their contracts with MCOs.

However, we believe that having this evaluation apply only to the potential RBPO's Medicaid line-of-business is unduly narrowly focused. Many of the Medicaid AEs that will negotiate RBPO contracts with Medicaid MCOs also participate in risk-based contracts as ACOs in other lines of business, and their overall risk portfolio is impacted by their risk-based contracts across all of these lines of business. We perceive no legal barrier to a more comprehensive review.

For that reason, RIPIN would recommend that EOHHS and OHIC examine a potential RBPO's risk-readiness across their entire business in determining whether their absolute risk-readiness is sufficient to bear additional risk through a RBPO contract with a Medicaid MCO.

EOHHS Should Establish Low Introductory Risk Ceilings in an Immature RBPO System

RIPIN supports EOHHS' establishment of a reduced risk ceiling of 3% of provider revenue, as compared to an originally-proposed risk *floor* of 2% of total cost of care. While 2% (or even 1%) of TCOC may sound low, the low-sounding number obscures a very high level of absolute risk, as many PCP-based AEs could be risking up to 20% of their revenue in such a system. Very few AEs could confidently risk such a significant portion of their income. Establishing an absolute risk ceiling can be an important tool to moderate the level of acceptable risk to a more tenable level.

Nonetheless, for AEs not used to bearing negative risk, and who are frequently operating on razor-thin margins, even 3% of revenue may be overly burdensome. RIPIN would recommend establishing a lower risk ceiling, or at least phasing in the 3% provider revenue ceiling over several years, so as to allow AEs to adjust to negative risk without potentially enduring an existential threat to their business viability.

We also recommend clarifying that the 3% of revenue ceiling preempts the 1% of TCOC floor. In other words, for an AE where 3% of revenue (the supposed ceiling) is less than 1% of TCOC (the supposed floor), then the ceiling is the binding constraint. This circumstance will likely be frequent.

Additional Reasons to Go Slowly on Risk: Small AE Panels and a Changing TCOC Model

There are a series of additional concerns that militate toward Rhode Island taking a slower transition into risk-based contracting. As RIPIN has stated repeatedly, we remain concerned about the inherent volatility in AEs of less than about 25,000 lives, where the state's minimum AE-MCO contract size is set at only 2,000 lives. RIPIN is also concerned that the State's decision to recalibrate the calculation of TCOC and the issuance of new TCOC targets will decrease predictability, which is concerning as it coincides with the beginning of AEs assuming downside risk.

Thank you again for the opportunity to provide these comments. Should you have any further comments, please feel free to contact us.

Sincerely,

/s/

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