RHODE ISLAND PARENT INFORMATION NETWORK
RIPIN
1210 Pontiac Avenue Cranston, RI 02920 CALL 401.270.0101 800.464.3399 (in RI) FAX 401.270.7049 VISIT www.ripin.org

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EOHHS Accountable Entity Team
By Email To: Deborah.Morales@ohhs.ri.gov

Re: Comments on TCOC Guidance for LTSS AEs

Dear EOHHS AE Team,

Thank you for the opportunity to comment on the total cost of care (TCOC) model for the specialized LTSS AEs. As you know, RIPIN is generally supportive of the AE initiative. Transitioning away from fee-for-service has the potential to promote coordination amongst providers, lower costs for payers, and intent better quality, outcomes, and satisfaction for patients. Our Medicaid program and our State also stand to benefit greatly from transitioning more LTSS care out of nursing homes and into the community.

Unfortunately, we do not believe that the AE and TCOC model is an appropriate tool to promote LTSS rebalancing.

Populations Too Small for AE Model

First, the attributed population sizes are too small to make the math work. TCOC models have been developed to work with ACOs that have at least 5,000 to 10,000 patients, if not more. The TCOC model for "standard" AEs correctly recognizes that even 5,000 patients can be too small, and (also correctly) expresses a preference for AEs with at least 10,000 patients. By comparison, the proposed minimum size of size of the LTSS AEs is far lower: 500 patients.

The guidance recognizes the "methodological challenge" presented by these small numbers, but makes no serious attempt to resolve it. We have not consulted with an actuary, but it is hard to believe that the proposal's requirement of a 4% Minimum Savings Rate (Section 5(a)) is adequate with attributed populations of this size. (The Health Affairs article cited in the guidance doesn't even examine ACOs smaller than 5,000 patients. But even at 5,000 patients it found that a 4% savings would occur by chance 5% of the time.)

To be clear, this potentially creates a serious fiscal risk for the State, the Medicaid program, LTSS providers, and patients. If organizations are achieving shared savings bonuses simply by an accident of probability, that is not a good investment of scarce program dollars. To the extent these organizations move to two-sided risk models, the State's stated goal, the same

problem exposes the LTSS AEs to risks that would probably be inappropriate for the State to encourage.

At the very least, the State should not be moving forward without conducting, and sharing with the public, its own actuarial analysis of the implications of using an AE/TCOC model on this patient population with these population sizes.

Other More Direct Ways to Improve Access to Community-Based LTSS

Second, the critical goals of this program (reducing nursing home use and increasing availability of home- and community-based care) can be achieved through far more obvious means. The difficulty of accessing home and community-based care in this State is no secret, and it has two main drivers:

1. The DHS application and approval process is slow and extremely difficult to navigate.
2. Even after home care hours are approved, the shortage of home care workers in the State makes it very difficult to fill the approved hours.

It is not apparent how the LTSS AE proposal will have anything more than the most tangential impact on these problems.

It is difficult to understand investing in this type of initiative while the State's LTSS application process is clearly not working as it should. In our consumer assistance program, we have served numerous clients and families who have spent more than six months (some more than a year) attempting to secure home-based LTSS services, even with us offering professional support. These have been clients with serious needs and deteriorating health, including ailments like MS and ALS. And the delays in accessing services have been impactful, with at least one of these clients now residing in Elanor Slater.

Fixing the LTSS application and approval process is the low-hanging fruit of this important public policy problem and should be a priority at this point. Led by EOHHS, the State should consider some sort of presumptive eligibility as part of the solution, so that home care providers can start services quickly and have financial protection during the period of delayed application processing. (NHPRI is currently operating in a similar manner in its product lines for duals.)

Conclusion

RIPIN is fully supportive of the State's goal to "rebalance" long term care out of institutional settings and into the community. We appreciate the effort to incorporate this important goal into the new AE program. Unfortunately, we believe that the AE model is not the best fit solution to address this particular problem.

First, the small attributed population sizes make the AE model unlikely to bear significant fruit. Second, we believe that the State's resources could be better invested into alleviating the

most obvious barriers to Rhode Islanders accessing home-based services, including the application and approval process.

Thank you again for the opportunity to comment. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

/s/

Samuel Salganik
Attorney / Health Policy Analyst
401-270-0101, ext. 131
Salganik@ripin.org

Copy: Patrick Tigue, Director, RI Medicaid
Stephen Brunero, Executive Director, RIPIN
Linda Katz, Policy Director, Economic Progress Institute