



May 31, 2019

Ms. Christine Dadali
Executive Office of Health and Human Services
By Email To: Christine.Dadali@eohhs.ri.gov

Re: **Draft Accountable Entity (AE) Total Cost of Care (TCOC) and Incentive Program Requirements**

To Whom It May Concern:

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

The healthcare system in America and Rhode Island faces two crises. First, spending has grown far faster than GDP for decades, leaving the nation with the most expensive healthcare system in the world by far, nearly double the per-capita cost of the OECD average. Second, health outcomes lag. The United States, with its advanced economy and high healthcare spending, ranks 31st in life expectancy (with consecutive annual declines not seen since 1915-1918), 46th in maternal mortality, and 56th in infant mortality. Among certain racial and socioeconomic subgroups, the numbers are far worse.

In the Rhode Island Medicaid program, cost growth should be less of a concern. Per-member-per-month (PMPM) Medicaid spending has decreased for seven consecutive years. PMPM spending in fiscal year 2017 (\$690) is 15% lower than it was in 2010 (\$814).*

Payment and delivery system reform efforts to date, including the Accountable Entity program, have focused too heavily on spending and too little on outcomes. While the attention on spending is important and necessary, we believe that EOHHS has the opportunity to increase the emphasis on outcomes, even if subtly. Recommendations to advance that and other goals provided below:

Comments on TCOC Document

- ✓ Total Cost of Care methodologies should always place equal emphasis on quality and outcome improves as they do on cost trend reductions. For example:

* See EOHHS Annual Expenditure Reports for SFY 2014 through 2017. Even removing the impact of the expansion, the reductions have been consistent.

- Bonuses should be available to AEs that perform exceptionally on quality and outcomes, even if they do not achieve savings (just as AEs that perform on average for quality can receive a shared savings bonus if they achieve savings). These bonuses can be funded using portions of shared savings payments that are withheld after an AE misses quality targets.
 - Alternatively, withheld shared savings bonuses could be used to create public health funds, to be invested on initiatives likely to improve public health outcomes.
 - To the extent there is movement to risk because of a belief that risk a great motivator (discussed below), that risk should also extend to quality and outcome goals.
- ✓ EOHHS should encourage the development of new ways to tie payments to improvements in critical public health outcomes.
 - For example, Kids Count recently release data on childhood obesity that was based on healthcare claims and clinical data linkable back to a primary care provider. This type of data could be used to develop a new measure to reward providers with success addressing childhood obesity, a critical public health problem strongly associated with future healthcare spending.
 - Current quality metrics typically used in AE (and broader ACO) contracting do not appear likely to generate significant improvements in public health outcomes.
- ✓ The minimum contract size for an AE (2,000 lives) is far lower than suggested in the literature for a stable actuarial base (see below). The adjustment factors for small AEs, while noble in purpose, do little to mitigate the concern over random fluctuation, especially as the system moves towards risk. We recommend the minimum AE-MCO contract size cover at least 5,000 lives, or potentially 10,000 lives.
- ✓ As stated in many other fora, we remain concerned about the movement towards risk-based contracting, for many reasons. First, very few providers in Rhode Island are large enough to have sufficient lives in any single risk-based contract to avoid high natural volatility risks. Recent research indicates high natural cost volatility even in very large Medicare ACOs (by RI standards), and that achieving 90% confidence that measured spending is within 1% of true performance requires an ACO to have 100,000 lives (achieving 99% confidence requires 250,000 lives).[†] There is also currently no system in place to monitor whether entities have the capacity to bear risks, and no clear policy path has been set for AEs for whom risk at that level might not be appropriate. We recommend that risk-based contracting not be encouraged before the proper oversight is in place, and never be encouraged for contracts with fewer than about 50,000 lives.
- ✓ Also with respect to risk-based contracting:
 - In its last round of APM meetings, OHIC moved to a new framework for measuring downside risk that does not exactly correspond to this on proposed. The OHIC 2019 APM plan is available for review at www.ohic.ri.gov/documents/2019-Alternative-Payment-Methodology-Plan.pdf.
 - The levels of risk proposed are extremely high, especially for PCP-based AEs. The minimum proposed risk cap is 2% of TCOC. For a PCP-based AE whose revenue would be roughly 10% of TCOC, that minimum risk cap accounts for 20% of their

[†] Barr, Lynn, Anna Loengard, LeeAnne Hastings and Tim Gronniger "Payment Reform in Transition – Scaling ACOs For Success." Health Affairs, May 11, 2018.

revenue. Very few, if any, AEs are in a position to take that level of risk today or will be in a few years.

- The OHIC standards recognize a difference in risk for PCPs, whose revenue makes up a small share of TCOC, and hospital-based ACOs. EOHHS should consider that as well. Just applying a flat % of TCOC is not appropriate.
- Even with the 75% withhold, imagine a PCP-based AE with risk capped at 2% of TCOC. The withhold would be 15% of their regular revenue. It is unlikely that many AEs can continue to provide high quality accessible services with a 15% reduction to cash flow.
- There has been public discussion of an MOU between EOHHS and OHIC allowing OHIC to confirm whether AEs can bear the risks they are taking. RIPIN supports that arrangement. This guidance document should start to lay out how that process will interact with AE program. For example, what happens to AEs who cannot reasonably assume risks at the levels required by EOHHS?

Comments to Incentive Program Document

- Page 12 - As an HSTP/AE priority we recommend adding a goal of measuring and rewarding improvements in key public health priority outcomes, e.g. obesity, infant mortality, maternal mortality.
- Page 12 – The requirement that 10% of the incentive funds be allocated to BH, SUD, and SDOH partners feels out of proportion to the statement that these items are high priorities. At the same time, AEs should have the option of tackling some of these priorities with their own staff. We would propose a balance to ensure that investments are made in these priorities (far more than 10% of funds, maybe 50%?) and also that some funded partnerships are formed (10% minimum may be adequate for that).
- Page 15 – footnote 6 – This note states that AEs cannot submit the same BH, SUD, or SDOH partnership agreement as evidence of a milestone achievement under multiple MCO contracts. That raises a concern that AEs will view these partnerships through the lens of their MCO relationships, which is probably suboptimal. If an AE forms a relationship with a community partner, it will likely work best if the community partner can work with all patients that need the support on all-payer basis. That's the only way that partnerships can really become part of the regular workflow of everyone involved.
- (The document also appears outdated in parts. Page 4 mentions the 1115 Waiver expiring Dec. 31, 2018, and says that an HSTP AE Advisory Committee "shall be" established.)

Thank you again for the opportunity to submit these comments. Should you have any further questions, please feel free to contact me.

Sincerely,

/s/

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