Memo

To: Debbie Correia Morales, Senior Consulting Manager, Conduent/EOHHS

From: Patrice Cooper, CEO, UnitedHealthcare Community Plan of Rhode Island

CC: Renee Rulin, MD; Leslie Percy, UHC

Date: September 12, 2017

RE: EOHHS Guidance TCOC Guidance for the AE program dated August 18, 2017

UnitedHealthcare (UHC) is committed to work towards the success of the EOHHS Accountable Entity (AE) program and has reviewed the Total Cost of Care (TCOC) guidance document. Nationally, UHC has created accountable care shared savings and shared risk models that have been used and tested within multiple markets for the Medicaid population. Our TCOC methodology, previously approved by EOHHS for the AE pilot program, aligns with the goals of the AE program, however does have distinct differences. It is UHC's intention to work with EOHHS to gain approval to continue to use our TCOC methodology within our AE contracts.

Minimum Membership and Population Size: UHC believes that populations of at least 5,000 assigned members allows for a minimum level of membership in order to feel relatively confident that the actions of the AE are able to directly influence the overall Benefit Cost Ratio (BCR). Currently a handful of AEs serve at least 5,000 members, however, there are a few which do not. The introduction of a third MCO into the market leaves each MCO with a smaller potential share of the Medicaid population. MCOs with smaller shares will be at a disadvantage in being able to move forward with contracting with some AEs as the AEs will not meet the minimum population size. UHC requests that EOHHS revisit the APM and AE contract requirements to reflect more reasonable goals, lowering the target threshold and eliminating the 1% withhold.

Although UHC does not believe we will have sufficient membership for LTSS AE arrangements, the vast difference of minimum membership requirements between comprehensive AEs and LTSS AEs, from a statistical perspective, is challenging to understand. AEs with as few as 500 attributed members has the potential to see vast fluctuations from period to period, regardless of the influence of the AE providers.

Historical Cost Data: EOHHS has suggested that three years of data be used to establish a historical baseline for each respective AE. Benefit changes between 2014 and 2017, as well as the tracking of the IHH population beginning in 2016, do not allow for an accurate comparison between years. UHC suggests using the most recent 12 month period to establish a baseline for contract targets.

Claims Threshold for High Cost Claims: The UHC TCOC methodology incorporates a TCOC cap of $100,000 for each member per 12 month measurement period. This has been used across all UHC Medicaid ACO arrangements. We feel that this stabilizes the data period over period, reducing fluctuation of high dollar cases. There are scenarios in which costs over $100,000 are unable to be influenced by the AE. UHC requests that this threshold be approved for all UHC AE contracts.

Historical Base with Required Cost Trend Assumptions: UHC does not trend costs forward due to the BCR methodology. Our methodology incorporates the capitation rates set by the state. The State's actuarial trends in those rates are passed through our model. The BCR model provides for a more direct alignment between State guidance of expected Medicaid program cost and desired AE performance. Developing a target based on revenue is less subjective and more transparent to the AE.

BCR helps account for items where PMPM cost-only model would not:

- Member mix changes
- State MCO rate adjustments
- Aligns with State MCO Risk Sharing

- Covered Benefit changes
- Changes to Provider Payment Methodology

Adjustments for Prior Year Savings: The UHC methodology does not directly charge back each respective AE for the payments made to such AE for shared savings or other incentives, therefore our model would not require this suggested upward adjustment.

Adjustments for Historically Low-cost AEs: While the UHC methodology allows for first dollar savings on lower cost AEs with over 5,000 Members, we do not upward adjust targets. The overarching goal of the AE program is to reduce overall costs and, all else being equal, allowing savings for degrading performance is counter-intuitive.

TCOC Expenditure Target: UHC is willing to align the AE measurement periods with the State fiscal year, however, requests that we are able to use a HEDIS calendar year to measure the quality gate. The HEDIS gap reports generated on a monthly basis are based on calendar year, and as such, the efforts of the AE for meeting their quality targets in order to achieve shared savings will be better supported and more transparent.

Small Sample Size Adjustment for Random Variation: The methodology suggested by EOHHS is complex and difficult to administer. We believe an adjustment for random variation due to smaller populations can be addressed in a more straight forward and consistent methodology. UHC methodology incorporates a confidence adjustment into our model to account for random variation. Smaller populations would drive confidence adjustments up to 3%, while larger populations allow for 1% or 0% adjustment. The inclusion of a claims threshold also helps to adjust for random variation.

Impact of Quality and Outcomes: The UHC methodology includes a quality gate. A set of HEDIS measures, along with targets would be included in the contract. The more quality targets the AE achieves, the higher their percentage of share.

Maximum Allowable Shared Savings (Loss) Pool: The UHC methodology includes a payment cap based on the size of the population. For AEs greater than 5,000 Members, the maximum payout is equal to 5% of the total cost of care. UHC recommends that the downside risk be capped at the same (5%) level.

AE Shared Savings (Loss) Pool: UHC standard methodology limits upside only ACO contracts at 40%. However, it has been our experience that other MCOs are sharing 50%, which has driven UHC to move this direction in RI. More clarification is needed regarding the 'minimum withhold' statement for downside risk arrangements – UHC does not believe this can be operationalized.

Required Progression to Risk Based Arrangements: Although moving to a risk-based arrangement is reflective of a higher degree of integration and accountability, based on UHC experience, not all providers or AEs are going to be able to ultimately take on risk. UHC has an extensive internal review process with any prospective ACO prior to agreeing to enter into shared risk. We believe EOHHS should review and ultimately approve an AE's capacity to take on risk; however that process and approval will not circumvent UHC's internal process and approval.

Attached to this Memo are the overview documents submitted to EOHHS in 2016 for TCOC approval during the AE pilot. There are a number of memos subsequent to these submissions answering questions from EOHHS about the programs which can be resubmitted by request. UHC requests approval to proceed with using our national models, which allows for support from our national ACO team, in moving forward with the AE contract in Rhode Island.