



A. Respondent Information

Prospect Health Services, RI, Inc. (PHSRI) is pleased to submit our comments on the RI Medicaid Accountable Entity Roadmap Document (Draft for Public Comment August 30, 2019).

1. Contact Information

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2. Organization/Organizations Represented by this response

Prospect Health Services RI, Inc. (PHSRI)

B. Comments on Draft Medicaid Program Accountable Entity Roadmap Document

Overview

To begin with, we would like to thank EOHHS for the robust engagement of AEs and other stakeholders in developing the AE Blueprint and related AE planning documents.

The AE Open Discussions were a particularly welcome addition to the process this year. These meetings provided a forum for the free exchange of information and ideas on how to improve the design and implementation of the AE program.

As was discussed at those meetings, AEs welcome more forums where AEs, MCOs, and the state could collaboratively address issues that need to be resolved. Some specific examples are discussed below.

Risk-Based Arrangements

Prospect continues to support the overall goals of the AE initiative. In particular, Prospect supports moving away from traditional fee-for-service payment in favor of alternative payment methods.

At many meetings, a request was made to accommodate AEs not prepared to move at the pace set by EOHHS for adopting down-side risk. We would like to repeat the point we made in every meeting where this was raised – accommodating those AEs that wish to proceed slowly should not delay those that are prepared to move more quickly toward downside risk and capitation.



Social Determinants of Health

We support the continued focus on “orienting the health care delivery system to respond to upstream determinants of health to address individual’s health-related social needs and consider community factors that impact population health, with an emphasis on housing and homelessness.”

This will require building partnerships between the large health systems that operate AEs and the community-based organizations that address the social needs we will be identifying. The state could play a critical role by taking the lead in advocating for, developing, and investing in common platforms and mechanisms to facilitate partnerships between these two very different cultures and systems.

The AE initiative would benefit greatly from a common IT platform for managing all activities and functions related to SODH Screening, Referral, Navigation, and Closing-the-Loop. With a single referral and SDOH management platform in place, CBOs will be more likely to engage with the AEs knowing they will not face the challenge of navigating different systems implemented by each AE. AEs, MCOs, EOHHs, and other stakeholders would also benefit from having a single source of aggregated data regarding SDOH needs and the success/gaps in addressing those.

However, this is not purely an IT challenge. While a comprehensive platform (e.g. UniteUS, demonstrated at the United Way) is essential, the effective integration of community organizations and health care systems likely requires an intermediary that can bridge these two sectors and develop systems, protocols, policies, and tools that connect the dynamic energy and capacity of CBOs into large health systems.

As the AEs more deeply engage in addressing the social needs of their patients, we will, surely, find a significant disconnect between the scope of need we are identifying and the community-based capacity to address that need. Gathering the data on this gap is valuable in and of itself, but its real value lies in the degree to which it can inform and guide policy and investment decisions.

Given that, the AE initiative is now at the point that new sectors should be brought to the table.

A good place to start would be housing. The Housing Resources Commission, the state’s Office of Community Development, and Rhode Island Housing (RI’s FHA) would be valuable additions as AEs endeavor to respond to the housing and supportive housing needs of their patients. Beyond these entities which are sources of financing, community development corporations (CDCs) would also be a valuable addition – either select individuals CDCs or sectoral representation. Other potential additions include education, corrections, DCYF, human services, veterans’ affairs, labor & training (beyond the current engagement around healthcare sector employment), and municipalities (consider prioritizing the urban core).

The state could also play a catalytic role encouraging and fostering innovative investments to address the social needs of AE patients. The engagement of philanthropy, to date, has been minimal, but at this point it could be critically valuable to future progress.



Expansion

We support the decision of EOHHS to include the dual eligible population into the AE program. This population includes those patients with the highest levels of need who stand to realize the greatest benefit of improved care, improved health, and smarter spending through comprehensive accountable care.

AE/MCO Collaboration

The AE Open Discussion meetings provided a forum where there was a robust discussion of several proposals from EOHHS designed to encourage greater AE/MCO collaboration and to streamline the overall implementation of the AE initiative.

With these proposals, EOHHS is seeking to respond to issues identified in the interviews conducted by Day Health Strategies. We support the goal of EOHHS to reduce the administrative complexity of the AE program. However, as was discussed at the Open Discussion meetings, some of the mechanisms proposed may not achieve their intended goal.

For example, requiring AEs and MCOs to apply *together* for recertification would add another layer of complication to a process that is already very demanding. The final arbiter for Certification is EOHHS. The most efficient way to manage this process is for AEs to apply to EOHHS, with any issues or gaps, resolved between the AEs and EOHHS directly. Inserting a layer of MCO review and approval would result in AE certification applications reflecting differing interpretations of the respective MCOs and not the state of the AEs as they present themselves vis-à-vis the Certification standards.

As we have all along, we support the idea that AEs can pursue a single HSTP Plan covering all attributed patients. EOHHS has been clear in their support of this and that clarity is greatly appreciated.

The proposal that AEs develop and submit HSTP plans in partnership with each MCO, however, would not necessarily advance/support this. It would merely move the opportunity for variation in the HSTP to an earlier stage in the process. What is needed is a single, unified review and approval process.

A core challenge to the AE initiative lies in the “delegated” and “divided” authority under the program. Certain roles and responsibilities are the responsibility of MCOs. They must carry these out based upon the guidance and regulations of EOHHS. EOHHS seeks to make its guidance as clear and precise as possible, however there is inevitably variation – and sometimes significant variation – in how the MCOs implement this guidance.

The most valuable contribution EOHHS could make to resolving this would be to take steps to decrease the variation in administration by MCOs. As was discussed in the Open Discussion meetings, this could include more forums where AEs, MCOs, and EOHHS together review significant documents, policies, and issues and resolve any differences in interpretation or implementation in an efficient manner.

Rule Changes to Achieve Desired Goals

During the Open Meetings, EOHHS shared some insights regarding the degree to which EOHHS believes the AE program is falling short of its intended goals. In response to perceived shortcomings, the state



proposed several rule/regulatory changes to more clearly guide the work of AEs and MCOS to achieve the desired goals.

While we understand, and sometimes share, the frustration of EOHHS, we urge EOHHS to impose new/revised rules sparingly. Rather than rule changes, simply giving more time for all parties involved to achieve our shared goals might be more effective.

Conclusion

Again, thank you very much for the opportunity to comment on the AE Roadmap. We look forward to working with EOHHS and other stakeholders to achieve the long-term goals of the AE initiative.