

To: Melody Lawrence, Director of Policy and Delivery System Reform, Rhode Island Executive Office of Health and Human Services

From: Beth Marootian, Director, Strategy and Business Development

Cc: Nancy R. Hermiz, VP Medicaid; David Burnett, Chief Growth Officer

Re: Response to Public Comment Request: Medicaid Accountable Entity Program Road Map

Date: September 30, 2019

Neighborhood Health Plan of Rhode Island is pleased to respond to the Executive Office of Health and Human Services (EOHHS) Proposed Medicaid Accountable Entity Program Road Map Document.

We look forward to discussing our comments with EOHHS to answer any questions and clarify our recommendations.

Overall Comments

Although not defined in this document but, consistent with recommendations from Day Health, Neighborhood recommends the elimination of the “Type 2” AE category and allow the attribution to align with the members assigned primary care provider. Reference to Type 2 and Specialized AE to be removed from the document on Page 24, H.

Specific Comments

1. Joint AE/MCO Application

Neighborhood does not recommend the inclusion of the MCOs in the Certification Application process. As written, the joint MCO/AE Application seems to lend itself to exclusive MCO/AE arrangements which EOHHS has clarified in public meetings is no longer being contemplated. In the absence of these arrangements, an AE will need to collaborate with 2-3 MCOs on their Application submission and will incur a substantial administrative burden increase compared to the current process.

Neighborhood’s Recommendation

- Continuation of EOHHS independent Certification process directly with the AEs.

2. Total Cost of Care Model and Progression to Down-Side Risk

Neighborhood does not concur with EOHHS’s recommendation to require AEs to assume meaningful downside shared risk or full risk. If any AE opts to assume down-side risk, an actuarial review of the AE’s financial readiness to assume risk needs to be conducted. EOHHS needs to ensure any risk arrangement does not jeopardize RI’s Medicaid primary care infrastructure comprised of both FQHCs and non-FQHCs.

Neighborhood's Recommendation

To ensure the future success of the AE program, please consider allowing changes to an MCO's shared savings model. Specifically, consider allowing the use of EOHHS-established MCO risk-adjusted rates to be used to establish performance targets.

3. **Specialized AE**

Neighborhood looks forward to collaborating with EOHHS and the LTSS provider community to develop the foundation of the Specialized AE program.

Neighborhood's Recommendation

- **Leverage Health System Transformation Program funding to support LTSS** provider infrastructure for 3 purposes: promote rebalancing, further quality measurement, and prepare for APM/AE partnerships. Promote opportunities for primary care and LTSS to work together.
- **Consider future MMP/APM Pilot** to create shared savings program with Medicare and Medicaid revenue using AE program as the foundation. Current AE providers are highly engaged and understand clinical transformation needed to benefit from shared savings but, MMP financial and utilization experience is still evolving and needs careful assessment prior to engaging in shared savings.

4. **HSTP Measures**

Neighborhood encourages EOHHS to consider a simplified approach to all measurement activity inclusive of quality, outcomes and HSTP incentive funding. Given the ongoing collaboration established by EOHHS with the MCOs and AEs, it seems appropriate to reconsider the program's overall approach to measurement to allow for adequate time for planning, development, and informed decision-making resulting in successful initiatives to improve quality and reduce total cost of care.

Neighborhood's Recommendation

- Consider adopting input from the MCOs and AEs to use a standard, minimal set of metrics to assess the overall performance of the AE program. Metrics should address an array of domains most relevant to the goals of the program.
- Consider creating a standard progression to advance new quality, outcome or HSTP metrics based on the following cadence:
 - Time 0 = Introduction of new metrics with discussion and analysis to arrive at EOHHS/AE/MCO adoption consensus – this includes preliminary measurement to assess the measurement feasibility
 - Time 1 = Baseline calculation (test data methodology and validation)

Time 2 = Pay for Reporting (test data methodology and validation)
Time 3 = P for Performance

For example, to apply these concepts to the new Outcome metrics associated with Emergency Department use for Mental Health reasons MH ED measure the following would occur:

Time 0 = 2019 discussion and feasibility assessment to reach consensus on adoption

Time 1 = Baseline calculation (decision specific to each measure depending on data availability or based on published Quality Compass

Time 2 = Pay for Reporting – AEs and MCOs responsible for data collection and reporting. Payments contingent on successful measurement.

Time 3 = Pay for Performance – AEs and MCOs with payment contingent on meeting targets

We look forward to discussing our comments with EOHHS to clarify our recommendations.

Sincerely,

Beth Marootian
Director, Strategy and Business Development