

Comments on Year 2 AE Certification Requirements

Attachment L1

D.1(b)l. The benchmark should be adjusted if Long Term Care, Transplants, Early Intervention and Hep C costs will now be included in the TCOC.

D.1 (d) It would be helpful if the clinical risk adjustment methodology was defined and standardized so that all AE's are subject to the same adjustment. It would also be helpful if either the MCO's risk-adjustment methodology including underlying software parameters set by the MCOs was disclosed to the contracting AEs or, if opting for Rate Cell Adjustments, the calculations were shared with the AEs.

D.1 (e) Not sure what is meant by "final cumulative trends" or "state budgetary savings assumptions".

D.2 (a) A desired methodology for adjusting Prior Year Savings would be one that rewards only the AEs. As presently structured, Prior Year Savings would have been shared 50/50 with the MCO in the Prior Year. When Prior Year Savings are factored into the Shared Savings for the Current Year, the additional benefit is again shared 50/50 with the MCO. It would be helpful to the AEs if this Prior Year Savings Adjustment could be isolated and paid only to the AE.

D.2 (b) The comment made above in D. 2 (a) applies here as well. The benefit of the Adjustment for Historically Low-Cost AEs is again split 50/50 with the MCO. It would be helpful if this Adjustment could be made directly to the AE and not become comingled with the Shared Savings generated in any subsequent performance year. The TCOC model proposed by EOHHS is distinct in identifying the upward Adjustments identified in D.2 (a) and D.2 (b), and could therefore be easily separated from a current performance year's shared savings pool, and paid to the AE. Some MCO TCOC models obfuscate the presence of these adjustments that make them difficult to identify for payment to the AEs.

The guidance for D.2 (b) should describe what "significantly above" means in the statement "This adjustment shall not be applied to entities with a historically attributed patient population for TCOC covered services that was significantly above the MCO average".

D.3 (a) and D.3 (b) The MCOs should be required to share the information used to adjust the cost trend as well as reveal the risk adjustment methodology used to assess any changes in an attributed population's risk profile from the risk-adjusted historical base to the contractual performance period.

D.5 (a) Does the MCO or AE get to choose whether to use the small sample size? What happens to the portion of the shared savings pool that gets eliminated by the small sample size adjustment? Does this amount stay with the MCO or is it reverted to the state?

D. 7 If you want to incent AE's to take downside risk, the AE % share of savings needs to be more than 10% higher. Additionally in D.7, the Chart column labeled **Loss Cap** contains a Definition that continues to include "contract revenue" rather than "expenditure target, as has been corrected elsewhere. Also in the **Loss Cap** column, do the percentages given for Years 3-5 make sense if the definition changes by substitution of "expenditure target" for "contract revenue"?

D.7 Continued.

It is unclear, in the event of a shared risk arrangement, how would a withhold be accomplished? If there is a shared loss, there would be no payment. How would a withhold be accomplished, i.e. withheld from what payment stream? Capitation payments?

Attachment A

We continue to be concerned with the measure regarding follow-up after hospitalization for mental illness. The limitations placed by 42CFR Part 2 combined with Lifespan and Care New England unwillingness to develop ADT feeds directly to AEs will make measurement difficult. EOHHS needs to help with solving the issue for the AEs. BVCHC is totally committed to the needed follow-up if we have the needed data available in a timely manner.

Additionally, we are concerned with the varied approaches for measuring the data. Each MCO is planning on implementing a data warehouse of EHR data and the SIM group has contracted for an IMAT solution. BVCHC has had a solution in place for two years. There is a lot of redundancy and each system will need to be reconciled with the other solutions. This adds a lot of cost to the AE system.

Although BVCHC can report on the majority of the quality measures in Years 1 and 2, we do have some concerns about the plans for the MCO's and others to develop reporting tools. BVCHC is favor of using a population based approach to quality reporting but have some reservations related to the planned proposed systems to report in the future. If the MCOs invest in data warehouse tools in order to compute quality measures, and if the AEs are expected to build interfaces between their EMRs and the MCOs date warehouse tools through which clinical data will flow to the MCOs, as the AE EMR data is necessary to compute certain hybrid measures, we see no reason that the clinical quality measures have to remain on a HEDIS-defined calendar year basis. As it stands right now, the HEDIS measurement year is a calendar year, and the AE Performance Year is on a state fiscal year basis. AEs are now advised on their HEDIS performance halfway through a performance year, leaving very little time for course correction (less than six months usually). The data warehouse tools being envisioned by the MCOs could easily be programmed to calculate clinical quality measures to be coincident with the state fiscal year. These date-modified HEDIS measures could be produced in near real-time, allowing for month - to - month course correction by the AEs. The fact that MCOs have to produce HEDIS measures to satisfy NCQA should not create a burden on AEs, as described above. In fact, if the MCOs design their data warehouse tools properly, these tools could be used to produce both the standard HEDIS measures for NCQA reporting by the MCOs and date-modified HEDIS measures for AE performance evaluation.

It would be helpful to know what happens to the portion of shared savings pool that is eliminated by the quality multiplier. Are these fund kept by the MCOs or are they returned to the state via the calculus of the risk share/gain share arrangement.