

To: Libby Bunzli, 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 PY4 Requirements Draft Comment Request

Date: November 17, 2020

Neighborhood Health Plan of Rhode Island is pleased to respond to the Executive Office of Health and Human Services (EOHHS) Proposed Accountable Entity Program Year 4 Draft Requirements Documents that were distributed by EOHHS on October 14, 2020.

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

**General Observations and Comments:**

Program Year 4 is pivotal to the ongoing viability of the AE program. The direction and requirements put forth by EOHHS in PY 4 will determine the AE and MCO's success in bending the cost curve and delivery system and care transformation. The comments that follow are based on Neighborhood's absolute commitment to the AE's program success and our experience as administrators of value based contracts and champions of system reform.

Program Year 4 is highly dependent on the performance and benchmarking during the COVID 19 Public Health Emergency. As such, we caution EOHHS throughout our comments to allow programmatic flexibility and most importantly consider revisions to these requirements once actual performance is realized and the course of the COVID crisis has subsided.

**In light of the ongoing upheaval of the health care environment we strongly recommend down-side risk as an option and not a requirement.**

The AEs are at the center of an impossible convergence of responding to a nation-wide health care emergency while responsible for keeping all Rhode Islanders healthy. The PY 4 requirements need to recognize our Medicaid health care heroes. EOHHS needs to allow the AE program to adapt to the tremendous strain and expectations placed on health care system.

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The PY4 requirements and the state's vision and approach to SDOH continues to lack recognition of the impact of racial biases and inequality in health care. Neighborhood encourages EOHHS to clearly state intentions to address health disparities and by adapting its approach to SDOH. The current proposal of data exchange is inadequate and puts additional administrative burdens on the AEs. To make progress in eliminating health disparities and systemic racism in health care EOHHS will need a determined and focused effort that could benefit from the HSTP resources earmarked under this initiative.

Throughout this response we will identify suggested corrections as well as inconsistencies between documents within the PY4 Requirements and between Program Years.

The PY4 Requirements documents are listed individually below with the Neighborhood Comments bulleted below.

#### **Attachment J – Total Cost of Care Requirements**

- **Downside risk-** Neighborhood strongly recommends the removal of required risk PY4 and instead allow AEs to opt-in to risk. By providing an option it allows the AE to: 1. assess the impact of the newly changed TCOC model; 2. assess the impact COVID on the benchmark period and changes in risk scores due to decreases in utilization. EOHHS does not know the full impact of COVID on PY3 performance and has not issued any changes to the model. Given this programmatic and extraordinary environmental uncertainty, we request EOHHS' seriously consider relieving the AEs from required exposure to downside risk.
- **State Quality Reporting** – Neighborhood requests the addition of language stating the Quality System (QRS) is required to release CDE data to the MCOs. The clinical data is critically important data for MCO accreditation and HEDIS data collection and needs to be a part of EOHHS' QRS business processes. Further, Neighborhood recommends edits to the document to recognize the MCOs as central to the quality reporting process, as this is a core function of the MCOs, which have effective and accurate processes in place for quality measurement, reporting, and improvement. Neighborhood has been a state-wide leader in the QRS development and has worked with each AE to ensure a robust CDE process and has invested extensively in the success in the EOHHS' QRS.
- **New participants in the AE program** - Neighborhood requests a meeting with EOHHS to better understand potential new program entrants and any program modifications. The MCO will have considerable report and data preparation to be ready for possible new entrants.
- **Statistical significance** - EOHHS should be more specific when referring to statistical significance, Neighborhood recommends using a specific level of statistical significance such as using  $p < 0.05$
- **Inconsistency between Attachment J and the Implementation Manual** - Attachment J identifies that it will define the percentage of quality measures from the common measure slate needed to achieve full shared savings. The Implementation Manual states, The overall quality multiplier shall be adjusted upwards by 0.10 for each AE contract, with a cap at 1. Attachment J should be consistent with the Implementation Manual guidance.

## Quality Measure Grid

Adolescent Well Care measure	This measure has been retired by NCQA for MY2020 (QPY3), so it is not produced by the HEDIS software system and cannot be reported. Recommend replacing with the new measure Child and Adolescent Well Care Visits (adolescent age groups) as Reporting Only for QPY3
Child and Adolescent Well Care Visits	Add <u>Child and Adolescent Well Care Visits</u> (all ages combined) to QPY3 as Reporting Only. Note that this item is not consistent with the Implementation Manual, which states, “ <i>Child and Adolescent Well-Care Visits (2 components: 3-11 years and total).</i> ” Recommend reporting both components as specified in the Implementation Manual, as Reporting Only for QPY3
Comprehensive Diabetes Care	Eye Exam was selected as an optional P4P measure for QPY2 by four Accountable Entities and will continue as P4P for those AEs in QPY3. This should be acknowledged in the grid by identifying the measure as P4P/P4R in the column “QPY2 Reporting and Incentive Use and QPY3 Incentive Use Per 5/8/20 EOHHS Memo.”
Social Determinants of Health (SDOH) measure	Does not appear in the QPY4 column. SDOH (original methodology) for QPY1 and QPY2 is also missing from the grid, although it was reported as P4R for all AEs. Note that SDOH for QPY1 and QPY2 is identified correctly in the grid in the Implementation Manual.

### Total Cost of Care Technical Guidance

- **TCOC Historical Base calculation** is not consistent with instructions previously provided to the MCOs. We recommend adding language that clarifies that claims and enrollment in each year will be limited to members attributed to an AE as of their last eligibility segment with Medicaid with the 12 months of that year.
- **Market Average Adjustment** – Neighborhood strongly recommends a unique adjustment for and recognition of historically efficient AEs. The proposed market average adjustment will have a negative impact on historically efficient AEs putting shared savings out of reach and making sustainability much for difficult to ever attain.
- **Solvency Review Process:** Neighborhood requests use of the prequalification. The proposed process to conduct a review and deem solvency *after* the contract enforce has been signed puts the MCO and AE at risk of implementing an inappropriate contractual commitment. The requirement unnecessarily delays the AEs notification and potential need for mitigation. We recommend retaining the current process of a pre-qualification in the spring prior to contracting allowing approval prior to entering the downside agreement.

### Attachment K – Infrastructure Incentive Program

- **FQHC ROI Project** – The Centers for Medicare and Medicaid Services prohibit FQHC exposure to down-side risk. The directive eliminates the FQHCs option to select down-side risk. The CMS decision protects the FQHC PPS payments and recognizes the importance of the FQHCs as safety net

providers. As such, the FQHCs should not be penalized by meeting additional requirements to access 100% of their incentive pool. Neighborhood recommends removal of the separate FQHC ROI Project and apply the 10% allocation to the FQHCs participation in a value-based contract.

- **New Pay for Reporting Measures** – Neighborhood requests a meeting to discuss alternatives to the proposed collection of race and ethnicity data. The administrative burden on the AEs and their primary care providers along with the MCO is considerable and is not a “fast” solution to address health disparities. Neighborhood has evaluated alternative methods for populating missing race and ethnicity data.
- **PY 4 Incentive Pool** - Please include the amount of funds remaining in the Incentive Pool. It would be helpful to provide ongoing reporting on the details of available and spent amounts associated with the Incentive Pool overall size of the Incentive Pool.
- **Weighting of Outcome Measures** – consider equal weighting of outcome metrics allowing for greater weight to measures impacting more members such as avoidable ED and Readmissions. Please note, the percentages are inconsistent between documents
- **SDOH** – the program direction outlined in the SDOH Investment Strategy is not reflected in the document. Will future guidance be provided to set the SDOH requirements in PY4?
- **Behavioral Health Admissions Alerts:** The system of alerts covering discharges from hospital inpatient settings and emergency rooms does not cover discharges from behavioral health facilities. Neighborhood strongly encourages EOHHS to facilitate discussions with RI Quality Institute to overcome the deficit of program-critical BH data sharing. EOHHS leadership is needed to help define and mitigate the overly cautious restrictions surrounding the sharing of behavioral health data carried out across the state.

### **Attachment M – Accountable Entity Attribution Guidance**

- **PCP Reconciliation** - Neighborhood recommends that EOHHS, Neighborhood and UHC review the impacts of the lowered minimum qualifying threshold of visits determine the need for potential changes. Neighborhood remains concerned with the potential for discontinuity of care resulting from the reconciliation methodology.  
Neighborhood recommends removing reference to PCP selection in the reconciliation process. The member's ability to select a PCP is available at any time and the reconciliation process evaluates utilization and makes adjustments based on that utilization.
- **Monthly Attribution and TCOC Attribution methodologies** - as written are not consistent with previous decisions shared by EOHHS and Neighborhood requests correction.  
According to EOHHS: 1. Monthly attribution is based solely on last day of the month eligibility and 2. TCOC attribution is based on most current eligibility segment as of the last day of the reporting month, even if a member termed prior to the last day of the month.

### **Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies: Implementation Manual**

Neighborhood is providing extensive comments to the Implementation Manual and requests a meeting with EOHHS and the Bailit Team to review our concerns.

- **Adolescent Well Care** has been retired by NCQA and should be removed
- Add **Comprehensive Diabetes Control – Eye Exam** and **Follow-up after Hospitalization for Mental Illness within 30 Days**, as both were P4P measures for some AEs in QPY2 and will therefore will be P4P in QPY3
- **Unavailable Benchmark Data**- Neighborhood recommends adding the option to declare a measure “P4R” or “Reporting Only” if appropriate benchmarks cannot be determined.
- **Self-report Data** – Neighborhood recommends requiring self-report for QPY3 even if the AE has submitted CDE files for QPY3, both to obtain the most accurate rates as well as to be able to evaluate the completeness of CDE to identify measure compliance.
- It is not clear how the requirement of **verifying the accuracy of data reported using ECDE** aligns with the CDE Evaluation Plans established by the AEs and MCOs and submitted to EOHHS. AEs, MCOs, and IMAT have performed and/or will perform several rounds of data validation before CDE files are accepted for regular submission to IMAT and the MCOs.
  - Neighborhood's CDE Evaluation Plan, approved by EOHHS, makes clear the final authority on the inclusion of CDE files as supplemental data files for HEDIS measurement rests with each MCO's NCQA-certified HEDIS auditor.
  - If the files does not pass HEDIS audit, they cannot be used in HEDIS measurement, and in Neighborhood's case, our HEDIS vendor will not allow us to upload files that have failed HEDIS audit for use in measurement of non-HEDIS AE quality rates.

- **Outcome Performance:** EOHHS states that it shall generate AE Outcome measure performance rates for each AE for OPY3. Our understanding is that the MCOs will generate the HEDIS measure Plan All-Cause Readmissions for OPY3.
- **All-Cause Readmission** - MCOs are constrained in their ability to report the HEDIS measure for time periods other than the calendar year. This has been discussed previously and is not reflected in the current All Cause calculation language. The final reporting requirements for this measure need to reflect those limitations.
- **Corrections and Inconsistencies between documents**
  - **Inconsistency:** The entry in the grid for P4R states, “Reporting of any performance rate in QPY2 will result in full credit towards the Overall Quality Score for QPY3.” This appears to be inconsistent with the statement on page 5, “EOHHS expects that performance on each Common Measure Slate measure be reported annually for the full Quality Measures Performance Year.” Recommend that the inconsistency be removed by making clear that the use of QPY2 rates to calculate the QPY3 Overall Quality Score does not remove the requirement on MCOs and AEs to report all rates for QPY3.
  - Replace QPY2 with QPY3 (2020) in the following statement: “Submission of QPY2 clinical measure data to IMAT and United Healthcare, per MCO clinical data exchange operational plans previously submitted to EOHHS, for testing purposes.”
  - **Social Determinants of Health (SDOH) Infrastructure Development** - The measure specification does not align with the measure specification for SDOH Screening, as it does not require the EHR to include defined fields corresponding to the exclusions allowed under the SDOH Screening measure. If the EHR lacks that information, it will not be possible to produce rates for the SDOH Screening measure without chart review.

We would be happy to discuss any of the above comments/recommendations/questions with you and look forward to continued engagement in the progression of the AE program.

Thank you for your review and consideration.

Beth

Beth Ann Marootian, M.P.H  
 Director, Strategy and Business Development