Executive Summary

After soliciting stakeholder input on the HSTP Program Year 4 Requirements for Accountable Entities, posted for public comment on October 14, 2020, EOHHS received 10 formal responses, representing Accountable Entities, Managed Care Organizations and Community-Based Organizations. Several themes emerged from stakeholder comments, and the responses contained herein reflect the edits EOHHS has made to the requirements documents to amend or clarify our approach, as summarized here:

- Broad concern for the impact of COVID-19 on performance and benchmarking;
- Mixed feedback on progression to downside (and full) risk; EOHHS will retain the requirement that AEs take on downside risk, postponed from PY3 due to COVID will not apply to FQHC-based AEs;
- Will implement a change to TCOC under which high performance on quality measures would reduce an AE's share of any losses, parallel to the way lower quality performance would reduce an AE's share of any shared savings. This will be a moderate adjustment, and will be put in place temporarily to ease AEs' transition to downside risk as they gain more experience under TCOC;
- For the OHIC Risk-Bearing Provider Organization Certification process, EOHHS and OHIC will return to a pre-qualification process that will be complete before AEs and MCOs execute contracts, followed by a final certification based on the terms of the executed contracts.;
- Mixed feedback on the proposed ROI project for FQHC-based AEs; EOHHS will allow FQHC-based AEs to use one of the AE's three other projects as the ROI project. AEs will still need to write a plan to explain how the project will reduce utilization (or otherwise reduce spending) in order to earn 5% of their Incentive Fund Pool and will still need to demonstrate savings in order to earn another 5% of their Incentive Fund Pool;
- Support for added emphasis on race/equity; mixed feedback on requirement to collect REL data; EOHHS will retain the new incentive milestone for race, ethnicity, language data collection; Technical specification for this measure will be developed in partnership with the AE/MCO quality workgroup facilitated by Bailit Health. This measure is pay for reporting in PY 4;
- Technical Assistance through CHCS will be made available to support AEs;
- Disagreement with 19% reduction in the PMPM incentive pool multiplier; Incentive PMPM will remain at $6.84 PMPM for PY 4;
- Disagreement with proposed requirement to collect Patient Literacy data; EOHHS received strong feedback on this proposal and has removed this requirement;

- Aligned SDOH screening domains w/technical specifications in quality and outcome measure implementation manual;
- Further clarified the expectation for AEs to submit EHR data of full patient panel to QRS as part of AE quality clinical data integration efforts;
- Removed proposed requirement to allow providers to be in two different AEs under different TINs; Feedback was resoundingly against this proposal;
- Attribution when a member proactively switches PCPs; past guidance required that members be re-attributed on the next attribution report that includes a quarterly reconciliation. Revised to say that members must be re-attributed at least quarterly – MCOs may switch the member immediately;
- Clarifications regarding attribution for quality and outcome measures to align with existing attribution approaches for quality measures.

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Overall Strategy	The overall strategy for this initiative continues to be built on a fee-for-service foundation when it is necessary to move to an accountable, population-based payment system (capitation) at the AE/System of Care level to accomplish the goals of all AE stakeholders. This system must be one where investment and activity are driven by goals centered around improving quality, achieving payment effectiveness, and addressing health-related social needs in the population being served by an accountable system of care, or Accountable Entity. To be clear, PCP capitation is not population-based payment and will not in any way fundamentally transform the accountability and cost structure for the AE systems of care in Rhode Island. Additionally, it is important to acknowledge there are very real limits to what can be achieved in even the highest performing, integrated healthcare/community system of care under a population based payment system without significant new government investments to address basic needs like housing and food insecurity. ...Without a fundamental change in the payment system, there will never be sufficient resources for Accountable Entities and Systems of Care to do what they can	EOHHS agrees that it is valuable for AEs and MCOs to make progress in the LAN Continuum, away from fee-for-service and toward ever more advanced types of value-based payment. Currently, it is EOHHS' understanding that the underlying fee-for-service chassis remains necessary for many providers, both for administrative and financial reasons. However, to the extent than an AE and an MCO seek to develop a capitation contract, EOHHS is open to discussing how that would work and collaborating to make it happen if appropriate in the overall context of HSTP. EOHHS strongly agrees that investment to address underlying social determinants of health is vital, and also believes that the healthcare system has a role to play in supporting community health and wellbeing - a view EOHHS knows is shared by all AEs and MCOs, who work hard to address these issues.

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	directly, or in partnership with others, to serve their population under management and improve outcomes for their members. Because of this, we urge EOHHS to adopt language that would call for developing and implementing an accountable, population-based payment system, one that that will provide the resources to begin to achieve all the goals of the AE initiative. Without delivery and financing reform, achieving equitable access for all to healthcare, behavioral, and SDOH services will remain a laudable destination without a definable pathway to get there.	
Overall Strategy	We want to recognize the additions made regarding the prioritization of health and healthcare equity for all Medicaid beneficiaries. THP, under the leadership of Juan Lopera, Chief Diversity Officer, continues to make important advances in diversity, equity and inclusion – both inside and outside The Company. We recognize that there remains much to be done and look forward to collaborating with EOHHS, our providers, CBOs and future partner AEs on this most important work.	EOHHS appreciates the support and ongoing engagement of Tufts Health Plan.
Overall Strategy	Attachment L: Accountable Entity Roadmap Document Coastal Medical remains supportive of the work that EOHHS is undertaking to address social and economic conditions that effect health as well as of the work of the Health Equity Zone (HEZ) organizations throughout the state in furthering the goals of achieving health equity for all individuals. As stated in previously submitted comments for the HSTP SDOH Investment Strategy, Coastal Medical would like to have a clearer view of how the collaboration between Accountable Entities (AEs) and HEZ organizations would be accomplished, to mitigate concerns around a narrow HEZ focus as well as difficulties inherent in collaborating across geographical locations and the addition of excessive administrative burdens for the AEs and community organizations.	EOHHS appreciates the support for EOHHS's work to address social determinants of health and for the work of the HEZ. EOHHS understands the concern about how AEs - which often serve large geographic areas - and HEZs - which are place-based - will collaborate. As discussed in the revised Social Determinants of Health Investment Strategy, EOHHS expects the Rhode to Equity to be the initial step in the that collaboration and will work with AEs and HEZs as needed to facilitate Rhode to Equity team formation.

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Overall Strategy	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. 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.	EOHHS understands that downside risk can be a concern for some AEs. After postponing the requirement to go to downside risk in PY3 due to COVID-19, EOHHS is committed to making progress toward greater accountability in PY4. While there may be financial losses under downside risk, these are mitigated by the risk exposure caps of 1% of TCOC or 3% of AE budget. In the final HSTP Social Determinants of Health Investment Strategy document, EOHHS discusses the relationship between the planned investments and the state's recognition of the impact of racial biases and inequality in health care.
PY3 Attribution	PCP Participation on Multiple AEs We urge the state to remove the new provision that would allow PCPs to participate in more than AE through different TINs. We do not believe this will serve the AE program well as it will needlessly complicate administration and quality initiatives. This will present a significant implementation challenge for AEs, and one for which there is no model or precedent as there are no other payer attribution programs in Rhode Island that allow for multiple provider affiliations. Attribution for Total Cost of Care Analysis We believe that AEs should only bear the cost of attributed members for the time following attribution. The financial exposure for AEs, under the proposed model, is particularly	Leading up to the start of PY3, EOHHS learned that MCOs had interpreted guidance on PCP participation in multiple AEs differently. In order to ensure that the same methodology is used in baseline and performance years, EOHHS revised the PY3 attribution guidance to require MCOs to use whatever methodology they used for baseline TCOC data throughout the PY3 performance year. EOHHS had proposed shifting the requirements so that all MCOs would allow PCPs to participate in multiple AEs through different TINs starting in PY4. Note that this would not have allowed members to be attributed to multiple AEs, but rather would have addressed the scenario where a PCP might have

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	acute in the fourth quarter of the year, a point at which an AE has little to no opportunity to manage newly attributed patients. There is a related impact that results from retrospective attribution. AE assignment changes every month. This can result in an AE effectively "losing" the benefit of any investment they have made in a patient – quality measures, improved utilization, savings – and taking on the "cost" for the experience of the patient for the period prior to their assignment to that AE. This is particularly relevant as the AEs, MCOs, and EOHHS work to better define our goals for "patient engagement." The monthly churn in AE enrollment is a major disincentive to sustained member engagement initiatives. Patient turnover also hinders the ability of AEs to develop action plans based on reliable data. We encourage EOHHS to engage AEs and MCOs in ways to address these issues.	separate patient panels at different practices/TINs, and these practices/TINs might participate in different AEs. The proposed change would have allowed both panels to be attributed to the respective AEs in which the PCP's two practices participated. However, EOHHS received significant concerns in public comment about this change and will therefore return in PY4 to requiring that each PCP be in only one AE, even if the PCP contracts with different TINs. The attribution methodology for TCOC in this revised PY3 guidance is not changed from the original PY3 TCOC methodology. The attribution guidance document has been updated to describe the TCOC methodology to reduce confusion regarding different uses of attribution data. EOHHS worked and communicated closely with AEs and MCOs when developing the current TCOC methodology in late 2019 and early 2020. Here, EOHHS reviews the analysis and reasoning in support of the current methodology, which was shared and discussed at that time. As AEs and MCOs are aware, MCOs conduct a quarterly reconciliation to re-attribute members to the AE from which they have received the most primary care in the previous 12 months. Therefore, the final attribution during each state fiscal year (SFY) should indicate the PCP with which each member was receiving the plurality of primary care during that SFY. EOHHS believes that for this reason, the end-of-year attribution most accurately reflects the AE most responsible for each member's care during the year. In addition, EOHHS believes that allocating costs and

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		enrollment to different AEs in different months creates a false sense of precision that EOHHS can accurately determine who was responsible for managing each patient’s care in specific months. EOHHS examined the impact of different attribution methods in early 2020 and found very minor differences between TCOC targets developed using the end-of-year attribution and month-by-month attribution. In addition, because targets and measurement year performance would be affected similarly by the methodology, EOHHS does not expect that actual AE savings would be materially affected by the TCOC methodology. Further, the end-of-year approach produced more stable per-member-per-month results for each AE between the two baseline years, which may indicate less likelihood for random fluctuations in the future. In addition, EOHHS notes that prospective attribution would create significant challenges. Medicaid members must have free choice of PCP - both in terms of which PCP the member selected and which PCP the member in fact visits for care - and may not be restricted in this choice. If EOHHS undertook prospective attribution and members then changed their PCP or used a non-assigned PCP, AEs would be accountable for the care of members that are cared for by other AEs and not be accountable for the care of some members who do receive care from the AE. This would exacerbate the concerns AEs express about the current methodology. EOHHS agrees that patient turnover when patients change their PCPs can hinder AE efforts to make plans and manage care

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		and believes that the appropriate solution is for AEs and MCOs to work closely to increase member engagement. That is, rather than locking members into an AE to obtain engagement (which is not permitted due to the necessity of patient PCP choice), EOHHS believes stronger patient engagement will reduce patient turnover, as patients are more connected to their existing PCP.
PY3 Attribution	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.	EOHHS appreciates the feedback regarding the attribution methodology and welcomes the opportunity to learn more about the issues raised related to discontinuity of care. It would be very helpful to see data identifying the numbers of members re-attributed based on reconciliation and the distribution of these members by the circumstances of the re-attribution - that is, the share of members re-attributed pursuant to each situation under section 3 of the reconciliation logic. EOHHS understands that the reference to PCP selection within the section on reconciliation may be confusing because attribution changes based on PCP selection are separate from the utilization-based reconciliation process. EOHHS will move the instructions on this point to a different section of the guidance to address this concern. Past guidance has directed MCOs to make attribution updates based on changes in PCP selection on a quarterly basis. EOHHS agrees that where possible, it would be valuable to update attribution based on such changes in the month following the change. Because it may not be feasible to make this update in attribution immediately, EOHHS has changed the language to indicate that attribution should be updated to reflect

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		changes in PCP selection no later than on the next attribution report that incorporates attribution reconciliation. EOHHS agrees that the language in the proposed guidance about a member who terms before the last day of the month is not consistent with past discussions and apologizes for the error. The final version will accurately reflect that monthly attribution will be based on the member's status on the last day of the month.
PY4 Attribution	PY4 Attribution Regarding the proposed change to PY4 attribution, we request EOHHS provide further information around their decision to allow PCPs to participate in more than one AE through different taxpayer identification numbers (TINs), specifically data supporting this change and any anticipated enrollment changes to the AE program. We are concerned that this change in methodology will add significant complexity to financial, operational, and quality reporting and may lead to confusion regarding care management responsibilities. It is not currently understood if MCOs or AEs can support this added operational complexity, prevent duplication of care management services, assure continued integrated physical and behavioral care and accurately meet the reporting requirements in the timeframes proposed. UnitedHealthcare recommends EOHHS convene a working session with all stakeholders to evaluate the proposal and determine if this attribution change adds value to the AE program.	EOHHS notes that allowing PCPs to participate in multiple AEs through different TINs would not have allowed members to be attributed to multiple AEs, but rather would have addressed the scenario where a PCP might have separate patient panels at different practices/TINs, and these practices/TINs might participate in different AEs. The proposed change would have allowed both panels to be attributed to the respective AEs in which the PCP's two practices participated. However, EOHHS received significant concerns in public comment about this change and will therefore return in PY4 to requiring that each PCP be in only one AE, even if the PCP contracts with different TINs.
PY4 Attribution	Allow PCPs to participate in more than one AE through different TINs: IHP does not agree with the methodology to allow PCPs to participate in more than one. It will become an impossibility to manage unnecessary medical spend or to understand care that	EOHHS notes that allowing PCPs to participate in multiple AEs through different TINs would not have allowed members to be attributed to multiple AEs, but rather would have addressed the scenario where a PCP might have completely separate patient panels

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	is provided or lack thereof outside of our AE. IHP strongly requests that the attribution stays the same which is that a PCP can only participate in one AE. Attribution to Inform AEs Which Patients They Are Accountable For and to Evaluate AE Performance on Outcome Metrics Measured for the Incentive Fund Pool IHP does not agree that any new attributed member identified in the monthly file has zero claims history accompanied with the file. It is best practice that if the individual was under the plan previously 36 months of claims history should accompany the file so that IHP can understand if this individual is healthy, rising risk, or high risk. IHP asks this methodology changes for PY4. Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers Assignment of Primary Care Providers (PCPs) "If a Medicaid-only member requests a change in his or her PCP, the Contractor agrees to grant the request to the extent reasonable and practical and in accordance with its policies for other enrolled groups. It is EOHHS's preference that a member's reasonable request to change his or her PCP be effective the next business day" IHP requests clarification on this statement. This document describes PCP assignment reports, including self-selection, would be updated on a quarterly basis for TCOC documentation. Are PCP changes specifically requested by the member updated 'quarterly for both Incentive Funding and TCOC calculations? For example, is the 'effective' date being utilized to calculate, or is the 'attributed file' date used to calculate Both the incentive and/or the TCOC calculations?	at different practices/TINs, and these practices/TINs might participate in different AEs. The proposed change would have allowed both panels to be attributed to the respective AEs in which the PCP's two practices participated. However, EOHHS received significant concerns in public comment about this change, and will therefore return in PY4 to requiring that each PCP be in only one AE, even if the PCP contracts with different TINs. EOHHS appreciates the recommendation that AEs receive historical claims data for newly attributed members. The attribution methodology itself does not specify what data must be provided for attributed members. The statement that ""to the extent that MCOs give AEs information about utilization patterns for attributed members, EOHHS expects MCOs will use the monthly attribution data to generate this information"" is consistent with an MCO using the monthly attribution data to identify newly-attributed members for whom the AE should receive historical claims data. EOHHS looks forward to working with AEs and MCOs on the most appropriate and helpful data for MCOs to provide to AEs. Past attribution guidance has required PCP changes requested by a member to be reflected in updated AE attribution on a quarterly basis - on the same schedule as attribution reconciliation based on utilization analysis. EOHHS considers that if an MCO is able to implement this change more quickly, that would be appropriate, and has therefore revised the Attribution Guidance to state that the attribution

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		updates should be made no later than the next monthly attribution report that includes changes from utilization analysis. The monthly attribution files are the basis of all further attribution analysis, including incentive and TCOC analysis. As described in the section of Attachment M, "" Attribution for Total Cost of Care Analysis,"" MCOs attribute member costs based on the member's attribution in their final month of enrollment in the year. The member's attribution in that final month is based on the attribution file for that month. For setting the incentive fund pool, similarly, the count of member months is based on the attribution files for the month used to estimate annual member months. The revised Attachment M now describes how attribution will work for outcome and quality measures as well; for these annual measures, attribution will be based on the final month of the measurement year, which for both quality and outcome measures is December.
PY4 Attribution	Primary Care Providers Whose Assigned Patients are Eligible for Attribution to a Comprehensive AE Integra does not believe that allowing PCPs to participate in more than one AE is advisable. We anticipate that this will create significant confusion and impede meaningful care coordination and alignment. Rhode Island has established a strong precedent for working as distinct systems of care; for a provider to participate in more than one AE would create significant operational complexity: Which care management team should be involved in each patient? How will AEs be able to ensure that their proprietary population health approaches are protected? Based on the discussion at the most recent AE Advisory Committee meeting, it does not sound as though	EOHHS notes that allowing PCPs to participate in multiple AEs through different TINs would not have allowed members to be attributed to multiple AEs, but rather would have addressed the scenario where a PCP might have completely separate patient panels at different practices/TINs, and these practices/TINs might participate in different AEs. The proposed change would have allowed both panels to be attributed to the respective AEs in which the PCP's two practices participated. However, EOHHS received significant concerns in public comment about this change, and will therefore return in PY4 to requiring that each PCP be in only one AE, even if the PCP

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	EOHHS can articulate a compelling reason to make this change; we strongly recommend that EOHHS maintain the current requirements. Section 3.3.2 When a member is attributed to a new AE based on the quarterly attribution reconciliation, how and when will the new AE be notified, and how will the MCO determine which PCP the member will be assigned to? We encourage EOHHS to provide specific guidance. Attribution to Inform AEs Which Patients They Are Accountable For and to Evaluate AE Performance on Outcome Metrics Measure for the Incentive Fund Pool Missing from this guidance is a clear explanation of EOHHS's requirements about when and how an AE should make updates to their roster of TINs, and when those changes will take effect. We have found a confusing lack of clarity and consistency around the timelines for when roster changes are accepted, and when both "adds" and "drops" of TINs will be effective. It is crucial that AEs be able to effectively manage networks that may be participating in multiple accountable care/risk programs, with different programmatic timelines, and to ensure that our agreements and arrangements with our participating providers are structured to ensure compliance with all of our programs. It is also important to have clear guidance in place to ensure that reporting received during a performance year is accurate with respect to the practices and patients for which the AE is actually accountable. Attribution for Total Cost of Care Analysis We have concerns about the decision to assign all costs for a member during the performance year to the AE to which the member is attributed in the final quarterly update. We do not have complete confidence that attribution is being properly	contracts with different TINs. The attribution guidance reflects the current requirement that MCOs submit to AEs (and to to EOHHS) electronic lists of attributed members on a monthly basis. The updated reports must reflect changes due to reconciliation. This is documented under "Attribution to Inform AEs Which Patients They Are Accountable For and to Evaluate AE Performance on Outcome Metrics for the Incentive Pool Fund." The description of how MCOs should assign a PCP based on reconciliation will be documented in the contracts between MCOs and EOHHS. EOHHS does not limit when AEs are permitted to update their provider rosters. That is, there is no EOHHS guidance that keeps a new PCP or new practice/TIN from participating in AE activities or requires a PCP or practice/TIN to remain for any period. Rather, EOHHS sets standards for which rosters are used to measure performance for different metrics. Under Attribution for Total Cost of Care Analysis, EOHHS explains that AE TIN rosters must be held constant between baseline and measurement years. For quality and outcome measures, attribution for the (calendar) year is based on attribution in December, using the AE rosters in place in December. EOHHS understands that it was confusing to have this explained for TCOC but not for outcome measures and will add this explanation to the attribution guidance. EOHHS agrees that it is vitally important for attribution reconciliation to be done correctly and

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	updated to account for actual primary care utilization, and this approach has the potential to allocate costs to the wrong AE. Even if attribution works as designed, it will inevitably result in AEs being held accountable for costs that were incurred while a member was attributed to a different AE. Please review comment in PDF for additional information and examples provided (pg 6, box 5) Attribution for Total Cost of Care Analysis See comment above, under "Attribution to Inform AEs Which Patients They Are Accountable For and to Evaluate AE Performance on Outcome Metrics Measure for the Incentive Fund Pool."	regularly monitors this. EOHHS agrees that the nature of this system is that AEs will have costs attributed to them for TCOC purposes for members that were not part of the AE when the costs were incurred. The reverse is also true; that is, AEs will experience members "leaving" their AE so that the costs the member incurred while a member of the AE will be attributed to another AE (or no AE). EOHHS worked and communicated closely with AEs and MCOs when developing the current TCOC methodology in late 2019 and early 2020. Here, EOHHS reviews the analysis and reasoning in support of the current methodology, which was shared and discussed at that time. As AEs and MCOs are aware, MCOs conduct a quarterly reconciliation to re-attribute members to the AE from which they have received the most primary care in the previous 12 months. Therefore, the final attribution during each state fiscal year (SFY) should indicate the PCP with which each member was receiving the plurality of primary care during that SFY. EOHHS believes that for this reason, the end-of-year attribution most accurately reflects the AE most responsible for each member's care during the year. In addition, EOHHS believes that allocating costs and enrollment to different AEs in different months creates a false sense of precision that EOHHS can accurately determine who was responsible for managing each patient's care in specific months. EOHHS examined the impact of different attribution methods in early 2020 and found very minor differences between TCOC targets developed using the end-of-year attribution and month-by-month

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		attribution. In addition, because targets and measurement year performance would be affected similarly by the methodology, EOHHS does not expect that actual AE savings would be materially affected by the TCOC methodology. Further, the end-of-year approach produced more stable per-member-per-month results for each AE between the two baseline years, which may indicate less likelihood for random fluctuations in the future. EOHHS encourages AEs and MCOs to collaborate to increase member engagement so as to reduce inter-AE member churn.
PY4 Attribution	Attachment M focuses on attribution, a topic that has been scrutinized by all stakeholders since program inception. AE attribution as a whole is based on retrospective attribution. This methodology deficiencies, made evident by the ongoing need to reconcile members among EOHHS, MCOs, and AEs, inhibits care coordination among the moderate and rising risk population due to underlying discrepancies. Furthermore, the methodology prohibits meaningful review of primary care intervention on behalf of the AE. BVCHC continues to support prospective attribution in order to prevent obfuscation due to attribution influxes and churn, a component of value-based care over which providers have far less control.	EOHHS agrees that member churn among AEs (and non-AE primary care providers) is not helpful for care management or other planning work. EOHHS believes that prospective attribution would create significant challenges. Medicaid members must have free choice of PCP - both in terms of which PCP the member selected and which PCP the member in fact visits for care - and may not be restricted in this choice. If EOHHS undertook prospective attribution and members then changed their PCP or used a non-assigned PCP, AEs would be accountable for the care of members that are cared for by other AEs and not be accountable for the care of some members who do receive care from the AE. This would exacerbate the concerns AEs express about the current methodology. EOHHS agrees that patient turnover when patients change their PCPs can hinder AE efforts to make plans and manage care and believes that the appropriate solution is for AEs and MCOs to work closely to increase member engagement. That is, rather than locking members into an AE to obtain

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		engagement (which is not permitted due to the necessity of patient PCP choice), EOHHS believes stronger patient engagement will reduce patient turnover, as patients are more connected to their existing PCP.
Certification	Section 4.4.3. Provision of actionable information to providers within the system IHP continues to have concerns with access to a full member claims file that includes all claims. Absent of having all substance use disorder claims we cannot fully understand opportunities related to total cost of care. We continue to advocate that Part 2 Providers are included as part of an effort to coordinate care. Section 4.4.4. Early warning system Established methods to alert, engage the care management team to critical changes in utilization. Alerted before bearing the full burden of costs. Although these feeds are helpful, the platform still lacks a critical feature which is the outcome of the transition of care. IHP is still left waiting sometimes up to 5 days to validate an individual went to a higher level of care. There is still a significant disconnect in medical and behavioral health inpatient teams involving our care team early on in disposition planning and securing a warm hand off when possible. 5.2 Health Equity & Social Determinants of Health IHP's commitment to addressing individual SDOH needs has remained unchanged. IHP would ask for consideration for reimbursement from our MCO partners for each screening that is completed with a documented intervention when an individual screens positive. The work of addressing SDOH is a heavy lift particularly amidst the pandemic and critical workforce shortages. IHP would ask MCOs and EOHHS to consider a $15.00 reimbursement or annual funding that falls outside of HSTP funding to further address SDOH.	EOHHS will working w/ MCOS through contract amend process to provide further clarification. Behavioral Health providers can and are encouraged to be part of an AE network for care coordination purposes and managing TCOC. Certification standards require the inclusion of BH providers in the governance and breadth of participating provider network standards for this purpose. Issues specific to BH (Part 2) data exchange and information sharing have been escalated to EOHHS leadership We are working with EOHHS HIT team to formulate an approach on integration of data. The minimum set of required domains are listed in the measure specification for SDOH screening in the quality and outcome measure implementation manual and are as follows: 1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance. EOHHS notes the mis-alignment between both documents and will update the certification standards accordingly. EOHHS will be conducting an evaluation of the current the sustainability plan and potential

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	Additionally, IHP seeks clarification on the domains used for SDOH. EOHHS has previously listed 6 Domains as it relates to SDOH Screening: Housing Insecurity, Transportation, Interpersonal Violence and Utilities Assistance. "Connectivity with internet and digital services to enable tele-health capacity" has not been planned for in the overall SDOH screening measure or processes. Section 1.1.2 specifically causes a divide in housing "Housing stabilization and support services and, Housing search and placement". IHP seeks clarification on the expectation of reporting, as not all AE's are screening the same questions, which, leads to the need for clarification on the implementation of the 6 domains listed above. 6. Integrated Care Management IHP continues to request that sunsetting care management reimbursement through the state and CTC puts us in a financially difficult position particularly as this service is a critical and fundamental element to the ongoing efforts to improve health outcomes and drive down unnecessary spend as an AE. In Addition, NHPRI reimburses Care Management services (T1016/T1017 As of July 2020, whereas UHC does not). This practice was in existence before CTC, during CTC and after CTC. IHP is not sure where the bulk NCM funding from NHPRI/UHC stands in relation to CTC/OHIC. 6.2. Defined Care Management Team with Specialized Expertise Pertinent to Characteristics of Rising Risk and High-Risk Target population IHP continues to escalate to NHPRI senior leadership our request to remove any duplicative claims from the member claim files. Absent of NHPRI correcting this error within their claims adjudication system, our ability to hone in on specific populations that appear to be high risk or rising risk may be	enhancements of VBP requirements/program beyond HSTP. EOHHS will consider opportunities as it relates to SDOH screening and related topics as part of that process. Medicaid has been committed to supporting practices for transformation efforts. Due to budget restrains over the years, EOHHS does not require the Medicaid MCO to pay certified PCMH practices for perpetuity. This does not preclude a Medicaid MCO from engaging in a contractual arrangement with a PCMH for this purpose.

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	misguided. IHP has concern due to the flaw in their system, our utilization is grossly overestimated across all points of care. Furthermore, this flaw is completely constraining our ability to participate in shared savings. This also impacts TCOC, its calculation and the audit process. If the MCO gives the AE an incomplete claim file the AE cannot be confident in the ability to calculate TCOC. These claim files are also used as a guide to the AE in population management.	
Certification	The AE Certification Standards document does not specify whether AEs must submit data for patient populations outside of Medicaid. We recommend that the AE Certification Standards be revised to state that QRS data submission be required to include the AE's full patient panel, rather than be limited to the Medicaid patient base. Medicaid providers frequently serve as safety-net providers for a broader population in need, who often are not covered under Medicaid. Patient data that is more inclusive of all Rhode Islanders served by AEs will allow for more robust evaluation. This is particularly important for programs like Upstream who rely on the full patient panel to generate evidence of effectiveness in order to improve work with agencies and better serve Rhode Island patients. A clearer picture of all patient data can help AEs be better partners for the community they serve and for all Rhode Islanders, not solely for Medicaid patients. In addition to including all patient populations in the QRS, the Aligned Measures Set should include a measure related to contraceptive care. This would enable AEs to set measures and standards to ensure that all patients are able to access contraception. To avoid coercion, and since many people choose not to use a contraceptive method, we would encourage that any contraceptive care measure set pay-for-reporting targets rather than pay-for-performance targets.	EOHHS appreciates this comment and will provide further clarification in the certification standards of the expectation for full patient panels to be submitted to the States quality reporting system. EOHHS appreciate this recommendation being brought forth and encourages Upstream and other organizations to participate in the state's annual statewide measure review and public comment process via OHIC. This annual review process is where stakeholder (providers, MCO, and other organizations) can discuss and present formal recommendation to the State's quality measure slate and process.

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Certification	Breadth and Characteristics of Participating Providers Behavioral health capacity shall be commensurate with the size and needs of the attributed population…" Behavioral health capacity is the responsibility of the MCO, who establishes and manages the network of behavioral health providers who are available to provide services to enroll members. It is not clear what the requirement on the AE is. EOHHS should remove this section, clarify the requirement, or permit AEs to meet the requirement through executing an AE agreement with a Medicaid MCO (as suggested at the top of page 6). Breadth and Characteristics of Participating Providers Direct service capacity within the AE shall be evidenced by the participation of Rhode Island licensed providers. MCOs, not AEs, have the responsibility to credential providers based on licensure and other factors, so it is not clear what the requirement on the AE is. EOHHS should remove this section, clarify the requirement, or permit AEs to deem the requirement as met through executing an AE agreement with a Medicaid MCO (as suggested at the bottom of page 5).	EOHHS acknowledges it is the responsibility of the MCOs as it relates to their provider network contracting and credentialing. The Medicaid AE certification standards are specific to AEs requirement to include both in governance and as part of an AE network behavioral health providers and contracts with BH providers that is commensurate with size and needs of the AEs specific population. A critical component of an AE network and management of TCOC and care coordination is the identification and inclusion of Behavioral Health and Social Services providers.
Certification	Collecting Patient Literacy Page 16 of Attachment H mentions collection of patient literacy as part of demographic capture. Subsequent follow-up confirmed this requirement to be reading literacy, not health literacy. This requirement is wholly inappropriate and does not meaningfully contribute to care. It is not a provider's place to ask this of a patient, especially in a vulnerable area where cultural differences and immigration status persistently place patient engagement in a tenuous position. The AEs are not data collection conduits and BVCHC will not collect this data. Social Determinant Z-Codes	Based on feedback received EOHHS will remove literacy from section 4.1 Core Data infrastructure. As part of the development of electronic reporting, the use of Z codes is not required, but an option. This will be re-evaluated over time.

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	Page 20 of Attachment H added a new requirement of ICD-10 Z-Code coding to augment recognition of social determinant of health (SDOH) components in encounters. Although BVCHC does not oppose this requirement, we remind EOHHS that provider coding practices are slow to change even absent ongoing clinic transformation due to COVID-19. Other AEs who use multiple EMRs are at an additional disadvantage. BVCHC hopes EOHHS can confirm this requirement will not be subject to strict implementation dates and be left between AE and MCO dyads.	
Certification	Health Equity The PHSRI-AE welcomes the way the PY4 Certification Standards incorporate and formalize Health Equity as a priority for the AE program. We look forward to working with EOHHS, RI Medicaid, our MCO partners, community-organizations, AE members, and our front-line care providers to address health equity. AE/HEZ Collaboration While there is a natural affinity between Accountable Entities and the HEZ, it is important to remember there is not complete alignment. A fundamental tenant of the HEZ initiative is that residents, and the organizations that serve residents, set the priorities for each HEZ. These priorities may not necessarily align with the priorities of the AE initiative. To the degree that AEs and HEZ coordinate and collaborate, this work should be focused around the priorities of the AE initiative. AEs face many demands related to quality, performance outcomes, utilization, and care coordination. AE/HEZ collaboration should advance these priorities. This is the way to realize the greatest positive impact – as the work will align with our strategic plans and the initiatives we are implementing – and guard against AEs diverting limited resources away from where they would have the greatest impact. Race, Ethnicity, and Language Data	HSTP funds have been allocated to support integration of SDOH Screening into EHRs. Capturing SDOH Screening results in an EHR allows for the ability to collect, exchange data files via the QRS and ultimately aggregate SDOH data by payer, provider etc. An E-referral system would essentially communicate with EHR, whether screening is done via EMR or e-referral it should ultimately make its ways to QRS as this is the state's uniform way of collecting and calculating EHR based metrics. EOHHS will remove literacy under Section 4.1 Data Infrastructure.

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	The PHSRI-AE certainly recognizes the intersection of health status and REL. However, we do not believe this is the most efficient or effective way to begin collecting this data in a way that will truly inform AE policy and practice. We urge EOHHS to reconsider the implementation of this requirement – working collaboratively with AEs, MCOs, and other key stakeholders – in order to find the most efficient, least burdensome, and most effective way to collect this data. As a multi-TIN, multi-EHR Accountable Entity, we do not currently collect this data in a uniform way across all practices. There are varying degrees of specificity and ways of classifying some of this data. Establishing a uniform standard for collecting and coding this data would require a transition period – one which we cannot, at this time, estimate. We would be reluctant to do this unless such an effort were aligned with any potential reporting requirements that could be imposed outside of the Medicaid population. Until common standards are established and implemented, AEs should be permitted to report data in a way that reflects the variety in implementation across practices and EHRs – if this requirement is imposed and/or it remains an AE obligation. we encourage EOHHS to consider whether this data collection and reporting requirement would be more efficiently implemented as part of the enrollment/re-enrollment process. In this way, data could be collected in a uniform way through a single point of entry. By centralizing, and not dispersing, this process the data collection and reporting process would be streamlined and made more efficient. This would also spare AEs and primary care providers a reporting burden when time and effort would be better deployed to patient care and care management initiatives. Literacy The state also proposes that AEs collect and report on the “literacy” level of AE members. While we are well-aware of the	

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	intersection between literacy/education level and patient health, we are very troubled by this proposal. Requiring practices to ask about, or to assess, patient literacy could seriously undermine the doctor/patient relationship. We do not see how this could be implemented within practices without significant disruption. Front-line healthcare professionals are not trained in this field and requiring them to pose questions that could make patients extremely uncomfortable will not benefit patients or patient care. SDOH Data Reporting We believe the proposed requirement for AEs to report SDOH data in EHRs to the state's Quality Reporting System (QRS) is premature, particularly given the prospect of the state adopting an SDOH platform for the AE program. This platform, rather than EHRs, might be the better source of this data given the fact such platforms are specifically built to collect, store, and report SDOH information. This is not a core function/role of EHRs and pursuing this path may not be the most efficient or effective route to collecting this data from AEs. This is a premature decision that will limit the future flexibility of EOHHS, AEs, and MCOs that does not need to be – and should not be – made at this time. Instead, this decision should be postponed until after the state makes a decision about an SDOH platform. We have similar concerns about the proposal to require the collection of Z-Codes for health-related social needs. We believe any decision regarding this should be made after any decision is made regarding an SDOH platform.	
Incentive Program	AEs shall be required to demonstrate that at least 10% of Program Year 4 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants.	The HSTP program was developed and approved by CMS based on the concept that majority of dollars would be invested upfront for capacity building and enhancement upfront as MCO/AE enter into risk-based arrangements etc... and sustainability path is implemented. EOHHS appreciates the transparent

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	IHP agrees to demonstrating at least 10% of incentive funds for PY4 are allocated to partners as defined above. However, IHP is curious as to why such a significant reduction in the PMPM for AE's from $8.44 PMPM to $6.84 PMPM. Lastly, from an IHP perspective due to the claims files issues and what is reportedly a significant overage in our pmpm, IHP has not been able to find a financial sustainability path forward even in our current framework. With the new attribution methodology now live, our IHH population continues to grow and with that comes rising costs. Although we are trying to change course to intervene with evidence based and meaningful interventions it is almost an impossible needle to move on TCOC. Therefore, IHP has no ability to participate in downside risk as to date we have to protect what little reserves we already have in place particularly with no reassurance HSTP incentive funding will be renewed after PY4.	and candid feedback and will continue to work with stakeholder to define a path to sustainability moving forward. EOHHS will provide an HSTP budget and timeline at a future AE Advisory Committee meeting. Please note that HSTP extend into PY 6. EOHHS appreciates the transparent and candid feedback and will continue to work with stakeholder to define a path to sustainability moving forward. Based on federal requirements, FQHC-based AEs will not participate in downside risk. To continue to promote the transition to value-based care, FQHC-based AEs will be required to demonstrate a return on investment/savings from a project conducted through the Incentive Program. FQHC-based AEs will be able to earn up to 5% of their Incentive Fund Pool through this project, which may consist of the same activities pursued for another AE project. That is, instead of downside risk, FQHC-based AEs will need to demonstrate savings in order to earn that 5% of Incentive Funds.
Incentive Program	AEIP Integra recognizes the necessity for the HSTP funding to gradually decrease over time. We would appreciate EOHHS's best estimate of what the intended HSTP PMPM for PY5 will be, to support longer-term planning around sustainability. AEIP Funding Requirements We strongly recommend that EOHHS develop a "model amendment" for MCOs and AEs to use to memorialize the incentive program arrangements. Having to separately negotiate	EOHHS appreciate the question and hopes to provide a budget update and timeline as part of an AE advisory committee. EOHHS is requesting further clarity on the request to create a model contract or amendment. Currently the HSTP/AE program requirements are the method by which program standardization is achieved. EOHHS welcomes stakeholder engagement and feedback on this topic as we move forward.

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	two different amendments to achieve the same requirement has been frustrating. We have significant concerns with the requirement that AEs spend at least 10 percent of their incentive funding on partnerships with CBOs to address SDOH. We want to reiterate that we share the goal of addressing SDOH, and that we agree that partnerships with CBOs are the best way to achieve this. However, the minimum expenditure requirement is problematic for several reasons: Given EOHHS's announced plan to make statewide investments in community-based organizations to address the social determinants of health, it seems reasonable to eliminate or reduce the requirement that individual AEs make investments in CBOs. Given the size of Integra's membership, 10 percent of our HSTP funding is a significant amount of money. We have concerns that although we can establish contracts with CBOs under which we spend nearly $0.5M, we may not be able to get that much value out of the contracts. In other words, it's not clear that our potential CBO partners can provide services which meaningfully impact the health outcomes and TME for our members such that those services are worth $500,000. This requirement is an outlier, and is inconsistent with the overall HSTP structure. The HSTP program is organized around establishing milestones at which AEs earn payments. In other words, the entire plan and structure are about determining how and when funds flow to an AE from the MCO. With the exception of this requirement, there is no explicit expectation that an MCO must monitor how an AE spends its HSTP funds. The 10 percent expenditure requirement implies a robust system for an AE to be accountable to the MCO for how funds flow out of the AE. However, no such process is described in state guidance, and no process is defined in our contractual arrangements with the MCOs. Despite repeated	EOHHS views the SDOH Investment Strategy as a way to support current AE efforts to engage with community organizations and address social determinants of health, not as a replacement for these efforts. EOHHS understands that it may be complex to identify projects with CBOs that can create an amount of value that is measurably commensurate with the 10% of incentive funds that must to go these (and behavioral health) efforts. EOHHS notes that the Rhode to Equity may offer opportunities to work through this complexity in a team environment with support from facilitators.

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	conversations, neither of our MCO partners has been able to articulate how they will operationalize this requirement, which creates considerable uncertainty.	
Incentive Program	FQHC ROI Project Attachment K described a portion (10%) of the AE incentive pool (AEIP) for federally qualified health centers (FQHCs) focused on demonstrating "return on investment" (ROI) utilization-based measure interventions and the consequent savings. The first 5% of this incentive relies on execution of a meaningful plan. The second 5%, however, corresponds to the lesser of savings generated or 5% total AEIP. The advent of COVID-19 introduced unprecedented changes to hospital utilization patterns and access. In all likelihood, the deferred care of CY 2020 will spill over into CY 2021 as access-deferred demand increases hospital utilization. In this case, attaining savings on utilization-based occurrences approaches $0, which would represent the lesser of the aforementioned figures. The concept stems from FQHCs' inability to assume downside financial risk, but it neglects the operational risk FQHCs have assumed these past several years in striving to earn steadily diminishing shared savings. This requirement represents another activity that distracts from ongoing efforts to provide value-based care by FQHCs. BVCHC proposes reducing further administrative burden by removing this component and restoring the Health System Transformation Project's (HSTP) apportionment to 45% of AEIP.	EOHHS appreciates the importance of minimizing administrative burden and has therefore revised the requirements for the ROI project to explicitly permit FQHC-based AEs to designate their work under another project as their ROI project intervention. AEs and MCOs will still need to produce a plan that indicates how the project will generate a return on investment to earn the 5% of Incentive Funds associated with producing the written plan for the ROI project and will still need to produce that return on investment in order to earn 5% of Incentive Funds. However, AEs but will no longer need to conduct a separate fourth project in addition to the other three projects. EOHHS is highly aware of the ways in which COVID-19 may affect measurement of utilization and spending, and the guidance for the ROI project specifically asks MCOs to design targets with this in mind. For example, MCOs and AEs may consider using a baseline year that is further in the past (pre-COVID). EOHHS is available to discuss options.
Incentive Program	Infrastructure Incentive PM/PM We understand that funding realities require EOHHS to decrease the Infrastructure Incentive PM/PM, however we believe that a cut of nearly 20% is excessively steep. While we have realized some shared savings, the AE program is still in an early, developmental phase. At this point, AEs require continued investment that exceeds the gains AEs could realistically expect	EOHHS plans to continue to work with stakeholders over the course of the HSTP program to identify a solid path of sustainability moving forward. REL data collection is critical to population health management, reducing disparities of care and creating equity in the health care system. EOHHS will

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	to achieve in shared savings. On top of this, AEs – like the healthcare system as a whole – are wrestling with the enduring impact of once-in-a-lifetime pandemic. REL Reporting Please see our comments above regarding the proposed requirement for AEs to collect Race, Ethnicity, and Language data. We do not believe imposing this requirement on AEs and primary care practices is the best path forward. Should the state retain this requirement, we would like clarification of the REL reporting requirement. In this section AEs are required to report on the percentage of AE members with a PCP visit in the last two years for whom AEs have collected REL data. It would appear this is a retrospective requirement – with AEs expected to report data they were not, at that prior point in time, required to collect and not expected to report. Material Change in Population As we have in previous years, we urge the state to include a provision for a "material increase" in AE population to match the language accounting for a "material reduction." We continue to believe that, just as it is reasonable to make an adjustment should an AE experience a significant decrease in population, AEs should be protected from a potential spike in attribution. Language like this is even more important in the current economic climate where Medicaid enrollment is rising, and likely will continue to increase, due to the COVID pandemic.	seek this data through several mechanisms/ pathways, including in partnership with AEs. EOHHS notes that for AEs to engage in their own population health management, having this information internally should be highly valuable. Technical specification for this measure will be done via the AE/MCO quality workgroup facilitated by Bailit Health. This measure is pay for reporting in PY 4. EOHHS is purposefully implementing this as a pay for reporting measure because it is a new measure and to provide AE and MCO collectively with time needed to implement a robust data collection process. With regard to material increase/decrease, attribution has remained relatively steady and has not decreased or increased significantly. If it increases, we are unable to apply an increase because of HSTP budget allocation.
Incentive Program	Based on the technical guidance the AEIP PMPM will be reduced 19% over the previous year's rate ($8.44 vs. $6.84). Coastal has invested significantly to develop and enhance our population health management programs. These costs are predominately in staffing for positions such as pharmacists, nurse care managers, nurses, and behavioral health navigators that take part in the care delivery process for our patients. These costs	EOHHS appreciates your feedback and will continue to work diligently with stakeholder to identify and implement a path for sustainability beyond HSTP.

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	carry a significant level of investment risk where just the infrastructure and quality incentives provided under risk contracts alone do not cover these costs. We must generate shared savings across our contracts in order to fund our investment risk. Any change in funding from infrastructure, shared savings or quality incentives requires us to re-evaluate our investments. Reducing the AEIP PMPM will require Coastal to re-evaluate our investments and make changes in our population health management programs so that our resources are properly allocated.	
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.	EOHHS appreciates the importance of minimizing administrative burden and has therefore revised the requirements for the ROI project to explicitly permit FQHC-based AEs to designate their work under another project as their ROI project intervention. AEs and MCOs will still need to produce a plan that indicates how the project will generate a return on investment to earn the 5% of Incentive Funds associated with producing the written plan for the ROI project and will still need to produce that return on investment in order to earn 5% of Incentive Funds. However, AEs will no longer need to conduct a separate fourth project in addition to the other three projects. EOHHS notes that FQHC-based AEs will have access to the full Incentive Pool but must earn this 10% of the Pool through making a plan to achieve a return on investment and then demonstrating a return on investment, rather than only by meeting self-designed measures. EOHHS believes that it is appropriate for the State to use only self-reported REL data and will not, for State purposes, pursue any imputation methodology. EOHHS is seeking to complete REL data through

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	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.	several different pathways, including in partnership with AEs, for whom this data should play a significant role in population health management. As described in the SDOH Investment Strategy document, EOHHS has not made participation in any aspect of the SDOH Investment Strategy mandatory. Therefore, EOHHS does not expect to set PY4 requirements tied to this Strategy. However, EOHHS does expect that AEs that do engage with the Strategy may leverage their work there to meet program requirements. EOHHS plans at a future HSTP AE Advisory Committee to provide an update on the HSTP budget and incentive program payouts since the inception of the program. EOHHS has been discussing the BH admission alerts topic/issue with EOHHS HIT team and understand this to be addressed as part of the HIT Governance structure moving forward.
Quality Program	Quality Implementation Manual •Page 6, Adolescent Well Child (AWC) Measure: The National Committee for Quality Assurance (NCQA) retired the AWC measure for QPY3; therefore, the health plan cannot report a hybrid rate. The health plan can report an administrative rate, which would align with the change to Well-Care Visit (WCV) administrative rate in QPY4. •Page 6, Tobacco Use: Screening and Cessation Intervention Measure: It looks like the Health Insurance Commissioner (OHIC) Common Measure Slate removed this measure from the Common Measure Slate. If that is accurate and given the health plan's understanding that AE Quality Measures were to align	Page 6: Per the 9/25/20 memo, EOHHS is replacing the AWC measures with the adolescent age stratification for the new Child and AWC measure for PY 4. This measure will be reporting only in PY 3. EOHHS will adjust the target for PY 4 to account for the change from hybrid reporting to admin reporting method. In addition, AEs and MCOs will be required to report the full Child and AWC as a reporting- only measure in PY4 due to dropping pediatric utilization as a result of COVID-19. EOHHS is adopting the revised specification for the remaining six HEDIS measures in the AE common measure slate for PY 4.

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	with the OHIC Common Measure Slate, the health plan would recommend this measure be removed from QPY4. •Page 10, Selection of P4P Measures: The minimum # P4P Measures under QPY4 is listed as 11. This should be edited to 12. •Page 12, Overall Quality Score Calculation: The sentence that reads “the MCO should sum the scores for each of the ten measures and divide the result by 10” should be edited to read “the MCO should sum the scores for each of the twelve measures and divide the result by 12.” •Page 18 Timing: The bullet reading “MCOs shall calculate and report AE performance on the Common Measure Slate for the QPY3 measures using (a) the clinical data exchange and (b) the QPY1 and QPY2 method by September 30, 2021” should be edited to “MCOs shall calculate and report AE performance on the Common Measure Slate for the QPY3 measures using (a) the clinical data exchange and (b) the QPY1 and QPY2 method by October 30, 2021” •Page 18, Timing: Regarding systematic variation in performance, the health plan will not be able to re-report CY2019 in CY2021 as the health plan will no longer have the version of software that was available when original reporting was completed. There are further complications due to file format changes in term of data preparation •Page 23, For OPY3: Regarding “AEs will need to submit Outcome performance improvement reports by December 31, 2020 and participate in an interview with EOHHS to discuss Outcome performance improvement efforts by February 15, 2021.” Will the health plan also be involved in the interview as well? •Page 29, TCOC Quality and Outcome Measures Reporting Timeline: Regarding “EOHHS provides first semi-annual OPY3 measure performance report to AEs.” Will the health plan also receive this report as well?	Page 6: Tobacco Use Screening measure will be retained as a reporting-only measure. Page 10: The minimum # of P4P measures for QPY4 should be 10 (1. Breast Cancer Screening, 2. Child and Adolescent Well-Care Visits, 3. Diabetes Eye Exam, 4. Diabetes HbA1c Control, 5. Controlling High Blood Pressure, 6. Follow-up After Hospitalization for Mental Illness, 7. Weight Assessment and Counseling, 8. Developmental Screening, 9. Screening for Clinical Depression and Follow-up Plan and 10. SDOH Screening). Page 12: This language should remain as "divide the result by 10" for the reason explained above. Page 18: This language does need to be modified. Page 18: This language does need to be modified. Per the June and July AE/MCO Work Group meetings, the systematic variation analysis should be conducted only for QPY3, not QPY2. Page 23: The Outcome Measure milestones/deliverables are for both the AE and MCO. MCOs should be partnering and assisting the AEs with their plans and their incentive opportunity is linked and evaluated directly with that of the AE. Yes, the MCOs will need to participate if they want to also earn the incentive funds linked to this measure. Page 29: The EOHHS outcome measure reports will be provided to both the AEs and MCOs.

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Quality Program	Quality and Outcome Measures Implementation Manual Calculation of the Overall Quality Score Integra enthusiastically supports the 0.10 adjustment to the quality multiplier. TCOC Quality Benchmarks We would like to emphasize how important it is to get our PY4 targets as early as possible, especially for new measures. Calculation of the Outcome Measure Performance Area Milestones The description of the weighting of the outcome measures for PY4 is inconsistent and confusing. The text indicates that 35% of the incentive pool will be based on outcome measures; however, the table totals to 45%, and says “OPY3” in the heading. We recommend that these measures account for 35% of the incentive pool, not 45%, and that the measure weights should be as follows: Outcome measure OPY4 Weight All-cause readmissions 25% Emergency department utilization for individuals experiencing mental illness 5% Potentially avoidable ED visits 5% Appendix C. SDOH Screening Measure Specifications We believe that it is premature to use the Social Determinants of Health Screening measure as P4P in PY4, especially since we have not yet seen what current performance looks like, and do not have a sense of what the targets will be. We recommend moving very deliberately when it comes to custom-designed measures We also recommend further discussion around the application of the SDOH screening measure to children 12 and under. The requirement that the screening appear in each	Calculation of Overall Quality Score EOHHS appreciates the support for this adjustment. TCOC Quality Benchmarks The targets will be finalized shortly after the AE/MCO Work Group meeting on 12/14. Calculation of the Outcome Measure Performance Area Milestones The table column does need to be re-worded to read "OPY4" not "OPY3." The weights for the measures will remain as 15%, 20% and 10%. The language about the measure weights will be re-worded to sum to 45%. Appendix C. SDOH Screening Measure Specifications EOHHS's two-year plan has been to promote SDOH Screening measure to P4P after AE practices implemented the measure as reporting-only in QPY3. Given the importance of SDOH screening, the measure will remain P4P in QPY4 and will be applicable for patients of all ages. The limited availability of current AE performance information will be taken into consideration when setting targets for the measure for QPY4. AEs and MCOs will have an opportunity to weigh in on the EOHHS' proposed targets on 12/14.

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	child's record may present additional technical implementation complexities. It may be simpler to apply the quality measure only to adult patients for QPY4.	
Quality Program	Quality Reporting System (QRS) Implementing and validating the QRS continues to add extreme burden to analytic and (H)IT staff. The value added to AEs is quality measure calculation inclusive of external EMR data. Still, a limitation exists in the absence of MCO claims data to help AEs continuously monitor quality measures at a pace that matches MCOs as a means of supporting self-sufficiency. BVCHC requests EOHHS require MCOs to contribute claims data to QRS to better justify the immense effort AEs must undertake to operationalize data exchange.	The purpose of the QRS is to collect, calculate, and aggregate clinical EHR measures in an efficient manner. The system is capable of calculating claim-based measures as well. This is a topic of discussion to be furthered by the EOHHS HIT governance committee.
Quality Program	Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual Outcome Scoring We encourage the state to consider allowing AEs to earn "partial credit" on outcomes performance. As it is now, the state proposes that AEs will earn either "no credit or full credit." We believe, in recognition of the developmental nature of the AE program, that AEs should be recognized for progress improving outcome performance. Note: We believe there is a typo in the section describing the weighting of measures. The text on page 20 (non-redline version) states that "35% of the AE Incentive Pool allocation and 35% of the MCO Incentive Management Pool allocation will be determined by Outcome measure performance." The table, however, indicates that 45% will be allocated. ED Use for Individuals Experiencing Mental Illness The outcome measure that presents some of the greatest implementation challenges, ED Utilization for Individuals Experiencing Mental Illness, has the greatest weighting. One significant implementation challenge is the fact that the daily ED	TCOC Quality and Outcome Per the STCs and HSTP authority partial credit is not allowed. EOHHS agrees that there is a typo on page 20, which EOHHS will revise to 45% in the next version of the IM. ED for MI EOHHS will support the inclusion of a flag for patients "experiencing mental illness" in the RIQI CM dashboards. Regarding the 36-month lookback - MCOs should use any utilization data they have for the patient, up to 36 months, to identify two or more visits with specific mental health diagnoses for inclusion in the denominator. For example, if MCOs only have data for a 24-month lookback for a specific patient, they should use the 24 months. EOHHS is modifying its calculation to ensure that it is using the same claims data available to MCOs (i.e., it will only utilize claims for the MCO to which the member is attributed when

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	reports AEs rely on do not identify ED visitors who meet the "experiencing mental illness" criteria. This requires AEs to review daily ED reports to identify qualifying patients. This is made slightly easier for our AE members with NHP-RI insurance as NHP-RI provides a quarterly report flagging such patients. We will be identifying AE members with UHC insurance who meet these criteria by analyzing claim data. We have approached RIQI and begun conversations about the benefit to AEs if their reports could be modified to include a flag for patients "experiencing mental illness." We urge the state to actively support this request as this would be a significant benefit for AEs. We would like a clarification regarding the new language for this measure referencing a 36-month lookback. How will this be implemented in instances when a patient's current MCO does not have utilization data for this period? Will AEs still be measured for patients for whom their current MCO cannot provide this data? Note: If EOHHS will be evaluating AEs for patients who might not be identified as "experiencing mental illness" based on MCO data – by using three year data available to EOHHS – this could be corrected for through the RIQI ED reports if those reports drew on three years of data. Finally, the documents state there are two ways to calculate performance for this measure. It is not clear how the decision regarding which method will be used will be made.	identifying mental health diagnoses in the 36-month lookback period). This ensures that denominators for this measure are consistent across MCO quarterly reports and EOHHS annual reports. Finally, EOHHS is using the revenue codes in the numerator 1 option to identify ED visits (i.e., 0450, 0451, 0452, 0456, 0459, 0981).
Quality Program	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	Reference response to UHC above for Adolescent Well Care. Per response to UHC I believe the recent memo address this question or item. Comprehensive Diabetes Care

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	Child and Adolescent Well Care Visits: Add Child and Adolescent Well Care Visits (all ages combined) to QPY3 as Reporting Only. Note that this item is not consistent with the Implementation Manual, which states, "Child and Adolescent Well-Care Visits (2 components: 3-11 years and total)." 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. 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 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,	EOHHS did not specify that Eye Exam had to be either a P4P/P4R measure for PY2, which is why it is not included in the column "QPY2 reporting...". NHP's inclusion of this measure with 4 AEs falls under the P4P/P4R notation for the "OHIC Aligned Measure Set Menu" under Optional Measure Slates (for QPY1 and QPY2). SDOH Screening This measure does appear at the bottom of page 7 in the redlined version of the IM. There are two references for the specifications - one for QPY1/QPY2 and a second for QPY3/QPY4. Follow-up After Hospitalization for MI The "QPY2 reporting... QPY3 incentive use" column indicates that either the 7 day or 30 day component could be P4P in QPY2, and therefore QPY3. Unavailable Benchmark Data EOHHS selects measures for the AE program on the premise that it is confident in its ability to set benchmarks. Should EOHHS change its assessment at any point in time, it will discuss the topic with the AE/MCO Work Group. Self-report data MCOs per the manual are required to calculate and report AE performance for PY 3 using a two-prong approach 1) CDE and 2) QPY 1 and 2 methods. MCOs shall analyze any systematic variation in performance between QPY3 data using (a) the clinical data exchange and (b) the QPY1 and QPY2 method by October 31, 2021. In each year, AEs will self-report

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	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 do 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.	positive results for all hybrid measures after MCOs identify all positive results from administrative data, including through clinical data exchange. MCOs will then compare the ratio of self-reported positives to administrative positives for each measure for QPY2 and QPY3, separating AEs with clinical data exchanges in place for QPY3 from those without. The changes in ratios for the AEs between QPY2 and QPY3 will identify the contributions of the clinical data exchange data. The ratios for AEs without clinical data exchanges in place will serve as a "control group." This systematic variation assessment is parallel to the data validation performed by AEs, MCOs and IMAT and will allow AEs/MCOs to verify whether performance generated via CDE (after undergoing several rounds of data validation) is comparable to the QPY1 and QPY2 method. Outcome performance Yes, MCO are to generate the All Cause Re-admission measure and provide data to EOHHS, which will aggregate data across MCOs to calculate AE-specific performance. All-Cause Readmission EOHHS is aware of MCOs' limitations in reporting quarterly data for this measure and has therefore included it as a topic for discussion during the 12/14 AE/MCO Work Group meeting. It will update the Implementation Manual with more specific language for what MCOs will report following that meeting.
TCOC	Risk Arrangements To achieve improved outcomes and reduced costs, EOHHS must continue to move providers along the spectrum towards	EOHHS appreciates the support for continuing the progression toward downside risk and agrees that it

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	accepting downside risk. The most successful accountable care systems are able to customize engagement at the individual practice level as provider capabilities vary, especially for smaller, independent or individual providers. Additionally, providers are more likely to participate in increasing levels of performance compensation or risk if MCOs have the flexibility to use their tools and expertise to inform agreements on an individual basis based upon provider readiness. Given these factors, EOHHS should continue to provide flexibility to both AEs and MCOs to support AEs in meeting their clinical and business goals. As EOHHS continues to shift away from volume and towards value, the lessons learned from years of value-based payment development and operation should be leveraged. We encourage EOHHS to engage MCOs in programmatic decisions moving forward. Creating a sustainable Medicaid program requires engagement from all participants in Rhode Island's delivery of Medicaid services, from MCOs to AEs. As mentioned in our comments to the AE Roadmap (submitted on October 13, 2020), we recommend EOHHS consider implementing parity among MCOs and AEs in terms of assessing penalties and earning rewards for meeting or not meeting the State's goals. While there are incentives and penalties for MCOs to work with providers and shift contracts from volume to value, this is not the case for AEs. EOHHS should consider allowing MCOs to pass on incentives and/or penalties to AEs to promote participation and make certain AEs are held accountable. For example, New York allows MCOs to pass on incurred penalties to providers if penalties stemmed from providers refusing to participate in VBP arrangements. We appreciate EOHHS taking the first steps to propose the Return on Investment Projects for federally qualified health	is vital to engage MCOs in ongoing development of value-based payment. EOHHS notes that AEs do bear some accountability for participating in value-based contracts, because a portion of AE incentive funds are tied to participating in these contracts. To the extent that new data indicates that MCOs may incur penalties due to AE refusal to participate in value-based contracts, EOHHS will consider possible approaches to address the problem. EOHHS appreciates the support for a Return on Investment project for FQHC-based AEs and agrees that input from MCOs and FQHC-based AEs will be important to fully develop the program structure. EOHHS looks forward to working with stakeholders to ensure that the projects work as intended, to enhance accountability for these AEs in an appropriate manner.

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	centers (FQHCs). UnitedHealthcare is exploring utilization oversight initiatives with FQHCs and other AEs. We believe the proposal would benefit from the engagement of MCOs and FQHCs on how to structure this program for successful outcomes. We agree that any additional incentives should be tied to successful outcomes and associated returns on investment. We are, however, concerned that it may be challenging to track outcomes to a specific initiative or separate this work from the ongoing Total Cost of Care work.	
TCOC	The Overall Quality Score will be used as a multiplier to determine the percentage of the Shared Savings Pool the AE and MCO are eligible to receive. IHP continues to escalate to NHPRI senior leadership our request to remove any duplicative claims from the member claim files. Absent of NHPRI correcting this error within their claims adjudication system, our ability to hone in on specific populations that appear to be high risk or rising risk may be misguided. IHP has concerns due to the flaw in their system, our utilization is grossly overestimated across all points of care. Furthermore, this flaw is completely constraining our ability to participate in shared savings as the TCOC may be overstated.	EOHHS agrees that duplicative claims are a concern and will engage as needed to ensure that the problem is addressed.
TCOC	Required Progression to Risk-Based and Value-Based Integra has shared previously our concerns with moving too quickly to downside risk. We do not have sufficient data or experience with the new TCOC model to project our performance under a downside risk arrangement, and therefore cannot analyze and assess our likelihood of success in the program. It would be irresponsible to commit and expose our primary care network to an unknown level of financial risk.	EOHHS understands that downside risk can be a concern for some AEs. After postponing the requirement to go to downside risk in PY3 due to COVID-19, EOHHS is committed to making progress toward greater accountability in PY4. While there may be financial losses under downside risk, these are mitigated by the risk exposure caps of 1% of TCOC or 3% of AE budget. EOHHS understands that there is uncertainty regarding what the results will be using the new TCOC model, given that PY3 is the first year it will be in use. EOHHS does not expect the TCOC

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	Furthermore, we have not yet seen that our MCO partners have the technical ability or the demonstrated commitment to work closely with us to monitor financial performance and collaboratively develop strategies to improve our performance. While this has been acceptable when we were in an upside-only arrangement, we have serious concerns about how these partnerships will function when downside risk is on the table. Most importantly, the COVID-19 pandemic has created significant financial strain for the health care system. In addition to the uncertainty around how the state and the country will fare over the next twelve months, many of our primary care practices are under severe financial strain. EOHHS should permit AEs to continue in upside-only arrangements until PY5, when we will have more meaningful experience with the model, and, hopefully, the impact of the pandemic will be reduced.	methodology to disadvantage AEs relative to previous approaches, and it is not clear in what way having a full year of experience with this model would affect AE planning or program development, insofar as the activities that would improve outcomes would be the same for this model as for others. Further, while the final results will, of course, not yet be available by the beginning of PY4, AEs will have received two quarterly reports by that time. The first report, covering costs incurred through September 2020, will be available in March 2021, and the second, covering costs incurred through December 2020, will be available in May 2021. These reports will not be exact predictions of final results but are expected to give AEs information to form directional expectations. EOHHS expects to work with AEs and MCOs to ensure that partnerships to monitor performance and develop improvement strategies are working well. EOHHS also notes that AEs will receive quarterly TCOC reports developed jointly by the MCOs and EOHHS. EOHHS agrees that neither the State nor stakeholders have a perfect sense of how COVID-19 will affect total cost of care. Information from PY2 indicates that utilization fell considerably in the spring and summer. To the extent that utilization is depressed through any part of PY3, the directional effect will be to increase AEs' potential for shared savings. To the extent that EOHHS adjusts MCO capitation rates during PY3 to account for generally depressed utilization, the potential for shared savings due to this low utilization will be reduced through the

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		associated TCOC target adjustments, as TCOC targets are adjusted for changes in MCO capitation. However, EOHHS does not currently anticipate a capitation rate adjustment for depressed utilization. EOHHS understands that it will be important not to count periods of pandemic-depressed utilization in developing TCOC targets, since these periods would not be appropriate comparisons to "normal" years. EOHHS will use the same baseline years for developing TCOC targets as are used for MCO capitation rate-setting and expects to use time periods that precede the pandemic to prevent unfair comparisons to a time with unusually low utilization. Finally, EOHHS understands that when patients are not seen by providers due to COVID-19, and particularly if they are not seen for a full 12 months, average risk scores in the Medicaid population will decline. This could make it appear that an AE's members are healthier, when actually they just have not received care due to the pandemic. EOHHS resolves this problem by using a "budget neutral" risk adjustment methodology, where what matters is each AE's change in risk score relative to the statewide managed care average. Because all AEs are expected to experience similar drops in risk scores due to the pandemic, no AE should face an adverse risk adjustment due to the pandemic.
TCOC	QPY4 (2021) Quality Targets We have two concerns about the proposed method for setting QPY4 targets. the state proposes using QPY2 performance data. We understand the logic behind not using QPY3 data given the impact of the COVID pandemic, however this seems to assume that 2021 will not be dominated by the pandemic as has the	EOHHS agrees that it is valuable for AEs and MCOs to make progress in the LAN Continuum, away from fee-for-service and toward ever more advanced types of value-based payment. Currently, it is EOHHS' understanding that the underlying fee-for-service chassis remains necessary for many providers, both

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	current year. At this point in time, we see no reason for making that assumption. The most optimistic forecasts for a vaccine do not foresee one being available until about halfway through next year. Additionally, there is no indication how widely any vaccine will be available. We applaud EOHHS for its responsiveness and flexibility over the past year relative to the COVID pandemic, and we have confidence that EOHHS will be similarly responsive and flexible in 2021 as the COVID pandemic plays out. However, it would be helpful if EOHHS were to formally acknowledge in this document that plans may need to be revised depending on the future pandemic-related developments. Second, we are troubled by the short time between when the state will share proposed targets, mid-December, and when the state will finalize them, December 31, 2020. This is a very short time for AEs to analyze and comment on the proposed targets. We urge EOHHS to provide more time for AEs to engage in a collaborative process of setting QPY4 targets. Pre-Qualification of Accountable Entities Bearing Financial Risk In Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk The state adds a new requirement for evidence that “secured liquid assets and reinsurance to cover maximum potential losses” are “secured in a controlled or custodial account.” We believe this requirement is overly prescriptive and encourage EOHHS to remove this new, additional requirement.	for administrative and financial reasons. However, to the extent than an AE and an MCO seek to develop a capitation contract, EOHHS is open to discussing how that would work and collaborating to make it happen if appropriate in the overall context of HSTP. EOHHS strongly agrees that investment to address underlying social determinants of health is vital, and also believes that the healthcare system has a role to play in supporting community health and wellbeing - a view EOHHS knows is shared by all AEs and MCOs, who work hard to address these issues.
TCOC	We want to recognize the additions made regarding the prioritization of health and healthcare equity for all Medicaid beneficiaries. THP, under the leadership of Juan Lopera, Chief Diversity Officer, continues to make important advances in diversity, equity and inclusion – both inside and outside The Company. We recognize that there remains much to be done and look forward to collaborating with EOHHS, our	EOHHS appreciates the support and ongoing engagement of Tufts Health Plan.

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	providers, CBOs and future partner AEs on this most important work.	
TCOC	Attachment L: Accountable Entity Roadmap Document Coastal Medical remains supportive of the work that EOHHS is undertaking to address social and economic conditions that effect health as well as of the work of the Health Equity Zone (HEZ) organizations throughout the state in furthering the goals of achieving health equity for all individuals. As stated in previously submitted comments for the HSTP SDOH Investment Strategy, Coastal Medical would like to have a clearer view of how the collaboration between Accountable Entities (AEs) and HEZ organizations would be accomplished, to mitigate concerns around a narrow HEZ focus as well as difficulties inherent in collaborating across geographical locations and the addition of excessive administrative burdens for the AEs and community organizations.	EOHHS appreciates the support for EOHHS's work to address social determinants of health and for the work of the HEZ. EOHHS understands the concern about how AEs - which often serve large geographic areas - and HEZs - which are place-based - will collaborate. As discussed in the revised Social Determinants of Health Investment Strategy, EOHHS expects the Rhode to Equity to be the initial step in the that collaboration and will work with AEs and HEZs as needed to facilitate Rhode to Equity team formation.
TCOC	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. 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	EOHHS understands that downside risk can be a concern for some AEs. After postponing the requirement to go to downside risk in PY3 due to COVID-19, EOHHS is committed to making progress toward greater accountability in PY4. While there may be financial losses under downside risk, these are mitigated by the risk exposure caps of 1% of TCOC or 3% of AE budget. In the final HSTP Social Determinants of Health Investment Strategy document, EOHHS discusses the relationship between the planned investments and the state's recognition of the impact of racial biases and inequality in health care.

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	determined and focused effort that could benefit from the HSTP resources earmarked under this initiative.	
TCOC Technical Guidance	Mitigation of Impact of Outliers: Claims threshold for high cost claims: Integra recommends that the claims threshold for high-cost claims be applied at the member level, not at the member-rate cell level. Adjust historical base relative to market average: Integra recommends that EOHHS accelerate the impact of the "below market weight" adjustment to the Historical Base. We recommend that the factor should be weighted at 25% in PY4 and 50% in PY5. This factor is a critical component in an AE's ability to achieve shared savings, which becomes increasingly important as other sources of revenue begin to ramp down. Impact of quality and outcomes: We recommend that AEs who achieve an exceptionally high quality score be able to reduce a shared losses pool, in recognition of the importance of achieving or maintaining high quality care, and in acknowledgement of the significant level of attention quality measurement has in the AE program. Specifically, we recommend that for AEs with a quality score $Q > 0.85$, any shared losses payment be multiplied by $1.0 - Q/2$.	EOHHS understands that members who have a birthday that causes the member to change rate cells during the performance year (e.g., a RIte Care member turning 45) could accrue costs above the high-cost claims threshold, because the member's costs would be counted separately in each rate cell. EOHHS does not expect that this policy will materially impact TCOC results. It is expected to reduce the administrative burden associated with reporting costs in the baseline and performance years, because MCOs will not need to track individuals across rate cells. EOHHS understands the importance of the market/efficiency adjustment and agrees that it is important to reward providers who are already efficient relative to the market. If the adjustment were higher than the 10% for PY4, EOHHS would need to introduce an adjustment for AEs whose TCOC has been above the market average as well in order to avoid a general cost increase (in a program intended to support lower cost growth). EOHHS does not believe it is appropriate to introduce the above-market adjustment until PY5, when AEs with higher TCOC have had more time to improve these outcomes. Therefore, EOHHS will maintain the 10% adjustment for PY4. EOHHS appreciates the recommendation to use quality performance to reduce a shared loss pool and will add an adjustment to the PY4 TCOC methodology under which quality performance will mitigate shared losses.

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TCOC Technical Guidance	In Section 5, Calculated Shared Savings/(Loss) Pool, subsection a, Minimum Savings Rate, we recommend EOHHS remove the minimum shared savings provision and allow AEs to share in first dollar savings. In section 5, Calculate Shared Savings/(Loss) Pool, subsection c, Risk Exposure Cap, we recommend EOHHS remove the requirement for the AE and MCO to obtain an independent actuarial analysis for pursuing a downside risk contract agreement. We recommend that EOHHS allow the AE and MCO to present their mutually developed and agreed-upon financial analysis of their proposed downside risk contract arrangement to substantiate the risk mitigation.	EOHHS agrees that it is valuable for AEs and MCOs to make progress in the LAN Continuum, away from fee-for-service and toward ever more advanced types of value-based payment. Currently, it is EOHHS' understanding that the underlying fee-for-service chassis remains necessary for many providers, both for administrative and financial reasons. However, to the extent than an AE and an MCO seek to develop a capitation contract, EOHHS is open to discussing how that would work and collaborating to make it happen if appropriate in the overall context of HSTP. EOHHS strongly agrees that investment to address underlying social determinants of health is vital, and also believes that the healthcare system has a role to play in supporting community health and wellbeing - a view EOHHS knows is shared by all AEs and MCOs, who work hard to address these issues.
TCOC Technical Guidance	TCOC Historical Base calculation: 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 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 en force has been signed puts	EOHHS agrees that it is valuable to include the explanation of attributed members in each relevant document and appreciates the feedback that this language was not included in the TCOC Technical Guidance. EOHHS has added this language. EOHHS understands the importance of the market/efficiency adjustment and agrees that it is important to reward providers who are already efficient relative to the market. If the adjustment were higher than the 10% for PY4, EOHHS would need to introduce an adjustment for AEs whose TCOC has been above the market average as well in order to avoid a general cost increase (in a program intended to support lower cost growth). EOHHS does not believe it is appropriate to introduce the above-market adjustment until PY5, when AEs with higher

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	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.	TCOC have had more time to improve these outcomes. Therefore, EOHHS will maintain the 10% adjustment for PY4. EOHHS and OHIC agree that the timing of this process is complex, given that the final terms under which the AEs will take on downside risk will not be set until the contracts are signed, while AEs and MCOs will want to have assurances that the RBPO certification will be approved before they execute contracts. EOHHS and OHIC have therefore returned to the pre-qualification process that was used in PY3. AEs will then submit a final certification application after contracts are executed, based on those contract terms.
	COVID-19 Impact It is important to recognize that the COVID-19 public health emergency (PHE) has likely created hesitancy for AEs to continue to take on risk due to the financial strain endured as a result of utilization disruptions. However, VBP arrangements should not be abandoned as COVID-19 has highlighted the limitations of fee-for-service systems to provide sustainable quality care. We welcome the opportunity to collaborate with EOHHS to identify arrangements that work towards continuing to move providers down the risk corridor, while ensuring accountability for the cost and quality of care during these unprecedented times. COVID-19 PHE has highlighted chronic health disparities, especially among communities of color, prevalent across the country that must be addressed. EOHHS should ensure that health equity is an overarching principle for MCOs and AEs working on population health efforts. A culturally and structurally competent value-based system can help improve health outcomes and quality of care and can contribute to the elimination of racial and ethnic health disparities.	EOHHS appreciates the opportunity to work with MCOs to develop value-based payment methodologies that are appropriate for these challenging times. EOHHS strongly agrees that it is vital to incorporate health equity as an overarching principle in population health work. EOHHS looks forward to working with MCOs and AEs to identify and pursue opportunities. EOHHS applauds efforts to support FQHC capacity, especially during the Public Health Emergency, and looks forward to continuing to promote these collaborations across all MCOs.

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	EOHHS should convene stakeholders and promote quality improvement initiatives aimed at reducing health disparities, particularly as it relates to race and ethnicity. EOHHS should consider how it can utilize VBP arrangements to ensure providers implement interventions targeted to address health disparities and advance health equity. FQHC Collaboration UnitedHealthcare supports EOHHS fostering collaboration between MCOs and FQHCs. The COVID-19 PHE has had a significant impact on FQHCs and has put the nation's health care safety net at risk. In response, UnitedHealthcare launched the FQHC Transformation Investment Program to address decreased cash flow at FQHCs and the need to invest in capacity building efforts as a result of the historic shift in utilization caused by the PHE. Through this program, UnitedHealthcare recently invested nearly $500,000 in Rhode Island FQHCs to expand access to care and improve the health outcomes of those who rely on FQHCs. In response, FQHCs demonstrated capacity building by implementing rapid COVID-19 testing and contact tracing capabilities, building out telemedicine competences to maintain member access and tracking social determinants of health (SDOH) referrals for completion. Serving 1 in 5 Medicaid beneficiaries nationally, FQHCs are critical to reaching EOHHS' goal of improved health outcomes and reducing health care costs. Recognizing this, we intend to continue to collaborate with FQHCs to ensure they can be successful. Improved health outcomes of the Medicaid population cannot be achieved if FQHCs are not able to continue providing access to care. We encourage EOHHS to continue to promote MCO/FQHC collaboration across all MCOs in Rhode Island.	

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	HEZ Collaboration Addressing adverse SDOH remains a primary objective on part of BVCHC. However, state infrastructure limitations constrain the AEs' ability to intervene. AEs continue to staff community health teams and use multidisciplinary care to impact adverse SDOH. Beyond screening and data slices exists a dire need for the Medicaid population to be offered affordable housing, farmers markets to fully leverage SNAP benefits, and equitable education. It is unclear if HEZ constituents can support a sudden influx of case management as AEs strive to meet program needs, but even if they can there is no driving force at the state level to ameliorate the conditions of poverty and cultural disparities other than policy promises. BVCHC recommends allowing AEs to take a less prescribed approach in their SDOH-based endeavors until opportunity opens to push forth social needs addressment through structural capacity.	EOHHS does not require that AEs work with a HEZ in AE efforts to address SDOH but does encourage AEs to do so. EOHHS understands that it will not be possible for AEs and HEZs, even in collaboration, to address all of members' social needs, but does expect AEs to engage in these efforts.