

November 12, 2020

I am writing to offer public comments on behalf of Coastal Medical regarding the proposed and updated documents posted for the Medicaid Accountable Entity Program in Program Year Four (PY4) offered by EOHHS. We appreciate the opportunity to offer written comments on this document and remain committed to transforming the care delivery system and improving the quality of care for the Medicaid population.

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.

Total Cost of Care

In “Section 2. Adjust Historical Base Relative to Market Average” of the **Rhode Island Accountable Entity Program Total Cost of Care Technical Guidance Program Year 4**, Coastal agrees with the State that highly efficient AEs provide value to the MCOs by maintaining low expenditures relative to the market and agree that there should be an adjustment for this. We recommend that when comparing an AE to the market, that the AE should not be included in the market. This will provide a more accurate comparison of how the AE is doing relative to its peers.

Coastal appreciates the efficiency adjustment and requests further consideration be made to increase the market efficiency adjustment weighting. The TCOC model has Coastal’s baseline competing against ourselves. If an AE has been more efficient in TCOC management of their patient population than the rest of the network, then the AE should receive a substantial portion of this difference for their ability to maintain this cost efficiency. As the network becomes as efficient, the differential will be eliminated. By not allowing for full recognition of cost efficiency the model is making it less likely for cost efficient AE’s to achieve savings. By allowing for full adjustment, AE’s will not experience an eroding of their baseline due to prior year’s cost efficiency. Under the proposed guidance the baseline is updated each year and any cost efficiency generated by the AE in prior years will be eroded making it less likely to achieve shared savings (known as the race to the bottom). As an example, in the MSSP program for Track 1+ ACOs, an adjustment (similar to, but not exact) for prior years savings performance included an average of 100% of the savings from prior years. This allowed the ACO to retain some of their past savings in their future performance. If it were only 10% of their prior years savings, it would not have made a significant impact on the benchmark.

In “Section 1c. Mitigation of Impact of Outliers: Claims threshold for high cost claims” of the **Rhode Island Accountable Entity Program Total Cost of Care Technical Guidance Program Year 4**, Coastal appreciates that the threshold is a set amount each year and no longer includes the add-back of 10%. In Coastal’s experience with value-based care and total cost of care, when pharmacy costs are included at gross without rebates, a separate threshold has been set for the pharmacy costs. We feel that this is something the State should explore and implement an actuarially sound threshold for pharmacy costs separate from (and typically less than) medical costs.

Qualification of AE's Bearing Financial Risk - Financial Solvency

The pre-qualification process used in PY3 was a reasonable approach. AE's needed to submit an application by January 15, 2020 in order for OHIC to determine if the AE had sufficient assets to bear financial risk under a downside risk arrangement. AE's were notified by OHIC prior to the AE and MCO having a fully executed risk agreement. The proposed rule to have AE's submit qualifying financial information with an executed contract, only to be approved/denied for downside risk after executing a contract creates an unintended circumstance for the AE if denied. Seeing that the regulations as they relate to downside risk have already been evaluated and approved as part of the roadmap does not allow for variability amongst AE contracts. Therefore, knowing if the AE passes the financial solvency test prior to having a fully executed agreement with an MCO will reduce the administrative burden of having to re-evaluate the contract terms.

Additionally, AE's do not know their financial performance of PY3 agreements as the financial reports only reflect a rolling twelve months. Final financial performance reports for the conclusion of a performance year will come ten months after the performance year has ended there for leaving the AE at a disadvantage. Knowing final financial performance within a shorter timeframe after the conclusion of the performance period will allow for AE's to make impactful changes in utilization timelier.

Accountable Entity Incentive Pool (AEIP)

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 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.

Conclusion

We are grateful for the work of EOHHS and the RI Department of Health in the continued development of the Accountable Entity Program across the State, as well as the many thoughtful discussions around the continued sustainability of programs to improve the overall health outcomes for the Medicaid population. We appreciate the opportunity to participate in collaboration and to provide our written feedback.

Edward McGookin, MD, FAAP
Chief Medical Officer
Coastal Medical