

November 10, 2020

Executive Office of Health & Human Services/Medicaid  
3 West Road, Virks Building  
Cranston, RI 02920  
Attn: Attn: Jennifer Marsocci, MS, Project Manager - HSTP

### **IHP Response to PY4 Recertification Requirements for a Comprehensive AE**

- I. ATTACHMENT H - Accountable Entities Certification Standards – Comprehensive AE (Program Year 4)
  1. 4.4.3. Provision of actionable information to providers within the system
    - a. 4.4.3.1. Analysis of gaps, needs, risks based on evidence-based practice. Gaps in care reports based on deviations from evidence-based practice.
    - b. 4.4.3.2. To help enhance, help direct care coordination/care management. E.g. medication management.

**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.**

2. 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.
  - a. 4.4.4.1. Employ a Care Management Dashboard (real time dashboard of patient-admissions and discharges to EDs and hospitals)
  - b. 4.4.4.2. Employ Care Management Alerts (ADT notification via direct messaging of ED and hospital admissions and discharges)

**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.**

3. 5.2 Health Equity & Social Determinants of Health
  - a. 5.2.1. Recognizes and seeks methods to approach key social determinants of health. These can include social factors such as housing, food security, safety, transportation, and domestic violence.
  - b. 5.2.2. Population Health and SDOH Assessment Evaluate the social needs of their members and take actions to maximize the degree that Attributed Members receive appropriate care and follow-up based on their identified social needs.

**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.**

**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.**

#### 4. 6. Integrated Care Management

**IHP continues to request that sunseting 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.**

#### 5. 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 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.**

## ATTACHMENT M - ACCOUNTABLE ENTITY- ATTRIBUTION GUIDANCE

6. Beginning in Program Year 4, EOHHS expects MCOs to allow PCPs to participate in more than one AE through different TINs. This means that when MCOs submit Historical Base Data to support Program Year 4 TCOC target calculations, MCOs shall apply this methodology. MCOs shall then continue to apply this methodology for attribution during Program Year 4.

**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 is provided or lack there of outside of our AE. IHP strongly requests that the attribution stays the same which is that a PCP can only participate in one AE.**

### **7. Attribution to Inform AEs Which Patients They Are Accountable For and to Evaluate AE Performance on Outcome Metrics Measured for the Incentive Fund Pool**

This **monthly report** will be updated to reflect changes that have taken place since the previous monthly list, including new Medicaid members, persons who have lost Medicaid eligibility, persons who have requested a PCP not included in the AE, persons who have requested a PCP included in the AE, and the results of quarterly reconciliation.

- a. Request MCOs produce these reports monthly. Currently they are produced quarterly making the data old. For Example, on July 31, IHP receives DOS up to 3/31. This data is now 4 months old data and difficult to measure intervention impact.
- b. IHP requests MCOs list new or removed members with an explanation rather than a total count on the monthly attribution report sent to AE
- c. IHP requests that the report includes the last AE PCP Visit Date in monthly attribution report.

**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.**

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.**

## **8. 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?**

## **II. Incent Attachment\_K\_Incentive\_Program\_Requirements\_PY4\_**

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.

**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 reinsurance HSTP incentive funding will be renewed after PY4.**