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Comments on Accountable Entities Program Year 4 Requirements

Integra appreciates the opportunity to provide comment on the program requirements for PY4 of the Medicaid AE program.

For each comment in this document, we have listed a "priority" which is our attempt to reflect how important we believe the issue is to the success of the Medicaid AE program.

- Comments marked as **Priority 1** are **critical**: Integra will re-evaluate our ability to continue in the AE program beyond PY3 if comments are not addressed.
- Comments marked as **Priority 2** are **important**: the indicated guidance raises significant concerns.
- Comments marked as **Priority 3** are **recommended**: Integra believes that our comments would improve the program.

Our most significant concern continues to be that we do not feel the program is mature or robust enough for us to commit to downside risk in PY4.

We also have serious concerns about the proposal to allow PCPs to participate in more than one AE.

Attachment H: Accountable Entities Certification Standards

We applaud EOHHS's explicit emphasis on health equity and racial equity, and believe these are important additions to the certification standards.

Page	Topic	Comment	Priority
3	Background and Context	Typo: "cllaboration"	3
4	Certification Period and Continued Compliance with Certification Standards	Error in second sentence: "AEs are required to comply ~~will~~ with all standards and requirements throughout the certification period."	3
7	1. 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).	2

7	1. 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).	2
9	1.2.1	Missing words in first sentence: "Certification that all AE participating providers have agreed to participate in the AE,"	3

Attachment J: Accountable Entity Total Cost of Care Requirements

Page	Topic	Comment	Priority
5	5. Required Progression to Risk-Based and Value-Based Arrangements	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. 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,	1

		the impact of the pandemic will be reduced.	

Total Cost of Care Technical Guidance

Page	Topic	Comment	Priority
4	1.C. 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*.	2
6	2.e 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.	2
9	5.b 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 $1.0 - \frac{Q}{2}$.	3

Attachment K: Infrastructure Incentive Program Requirements

Page	Topic	Comment	Priority
4	2. 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.	3
7	VI. 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 two different amendments to achieve the same requirement has been frustrating.	2
8	VI. AEIP Funding Requirements	As we've shared in the past, 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.	2

		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 conversations, neither of our MCO partners has been able to articulate how they will operationalize this requirement, which creates considerable uncertainty.	

Attachment M: Attribution Guidance

Page	Topic	Comment	Priority
3	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 can articulate a compelling reason to make this change; we strongly recommend that EOHHS maintain the current requirements.	1
4	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.	3
4	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	2

		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.	
5	Attribution for Total Cost of Care Analysis	As we have noted before, 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 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. Take these two hypothetical situations: • A member is attributed to AE "A" while seeing primary care physicians from both AE "A" and AE "B." During this time, the member has many unnecessary ED visits that AE "B" is unaware of, because the member's utilization data is not provided to it by the MCO. Then, halfway through the year, the member's attribution switches when the preponderance of PCP visits switch to AE "B." Now, AE "B" is suddenly accountable for health care costs incurred while the patient was attributed to another entity. • A member has no primary care visits at all, but uses the ED frequently while attributed to AE "A." Finally, towards the end of the performance year, the member is seen for an E&M visit at a PCP affiliated with AE "B." AE "B" is suddenly accountable for a full year of costs for a patient they have only seen for one month. Either of these situations is quite possible, and neither is remotely fair. We recommend that EOHHS develop an approach where costs are assigned to an AE based on the member's monthly attribution (that is, the AE would be accountable for costs for services provided during member-months when the member was attributed to the AE).	2

		Additionally, we would expect claims data sent to us by the MCOs to align to the attribution methodology (that is, we expect to receive claims data covering the entire population, and only the population, for which we are accountable). Retroactively changing attribution at the end of the year will add considerable complexity to the claims data feed.	
6	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."	2

Quality and Outcome Measures Implementation Manual

Page	Topic	Comment	Priority
12	Calculation of the Overall Quality Score	Integra enthusiastically supports the 0.10 adjustment to the quality multiplier.	2
13	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.	2
20	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:	2
39	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.	2

Outcome measure	OPY4 Weight
All-cause readmissions	25%
Emergency department utilization for individuals experiencing mental illness	5%
Potentially avoidable ED visits	5%

		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 child's record may present additional technical implementation complexities. It may be simpler to apply the quality measure only to adult patients for QPY4.	