



To: Melody Lawrence, Dir. of Policy and Delivery System Reform, RI EOHHS
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From: Tom Douglass, Director of Finance, PCHC Accountable Entity

CC: Ray Parris, Executive Director, PCHC Accountable Entity; Dr. Jonathan Gates, Chief Medical Officer, PCHC Accountable Entity; Ben Shaffer, Deputy Secretary and Medicaid Director, EOHHS

Date: October 9, 2020

Re: Public Comments for Accountable Entity Roadmap and HSTP AE Sustainability Plan

Comments: Providence Community Health Centers (PCHC) is enthusiastic about innovating with RI EOHHS and MCOs to produce the highest quality of care at the lowest cost within the Accountable Entity Program (AE). PCHC has reviewed the EOHHS proposed policy statements and is grateful for the opportunity to provide feedback. We are supportive of the direction outlined by EOHHS and offer the following comments and recommendations.

Improved Risk Adjustment Methodology

PCHC supports the use of a consistent risk adjustment approach for all MCOs and AEs in the RI market, as noted on page 26. It is a critical component of a sustainable approach and equitable distribution of resources. The work of the actuarial support vendor to adjust risk adjustment factors for RI experience and cost should deliver a better distribution of funds based on patient need than an off-the-shelf model.

Risk adjustment models are constantly improving and evolving, and we encourage the continued use of an actuarial support vendor to study and introduce new risk adjustment categories and factors as merited. Specifically, we encourage further examination of including social determinants of health categories to explain a portion of increased costs, instead of attributing all spend to age- and diagnostic-based categories. This will be critical for the appropriate reimbursement of FQHCs and others in the delivery system who disproportionately service Rhode Islanders in these categories.

SAMHSA 42 CFR Part 2 Revised Rule

The application of Part 2 rules in Rhode Island has significant impacts on all providers' ability to manage and provide care for patients with behavioral health and substance abuse issues. This is especially true for AEs who are measured on quality metrics related to behavioral health care, such as timely follow up after a serious behavioral health event. Unfortunately, AEs often have no reliable and timely source for this information and no means to compel other organizations to provide it (even in the name of patient safety), in part due to varying interpretations of Part 2.

In July 2020, HHS revised 42 CFR Part 2, with important changes made to permitted disclosures for health care operations and disclosures of data to central registries. Despite this change, differences in legal interpretation of the Part 2 rule from organization to organization are likely to slow adoption of needed operational improvements that would benefit Rhode Islanders.

Additionally, EOHHS correctly observes on page 24 of the Sustainability Plan that investments in centralized infrastructure are critical to maintaining efficiencies and sustaining accountable care. RIQI's tools, including CurrentCare and Care Management Alerts and Dashboards, are appropriately highlighted as key components of that infrastructure. Those tools are currently less effective than they could be relative to Part 2 providers and Part 2 data. Enhancing this infrastructure to achieve mental health parity in care management should be a core goal of our collective effort.

PCHC believes that EOHHS and their State partners are in the best position to provide clarity to Part 2 providers and participants in the AE program regarding the permissibility of current best practices under Part 2. PCHC takes seriously our responsibility to deliver improved outcomes for patients with behavioral health diagnoses, as emphasized by EOHHS as a specified investment area for HSTP project plans. PCHC requests collaboration from EOHHS on enhancing state health information exchange infrastructure to be inclusive of Part 2 data and providers.

In the interim, MCOs are encouraged to renew their commitment to providing actionable and timely data to support the processes needed to mutually succeed on quality metrics related to timely follow up and engagement after a behavioral health related admission.

Telemedicine

PCHC recommends that policymakers continue to work towards a permanent approach to reimbursement for telemedicine services. To advance the aims of managing population health in the Medicaid population, even in a post-pandemic delivery system, the work of community advocates and nurse care managers should be considered reimbursable via telemedicine. Because of the variety of language, social, and cultural competencies needed to succeed with a diverse patient panel, telemedicine will be an important part of bringing personalized care to scale, and to match the right resource with the right patient.

Policy and Benefit Changes

PCHC recommends the consideration of policy changes in Medicaid that could bring consistent savings to the Medicaid program. Medicare is implementing the required use of a clinical decision support tool to pay claims for advanced diagnostic imaging. We recommend that this approach is considered for Medicaid as well. Other strategies, such as allowing higher copayments for advanced imaging at higher-cost facilities, could also work to lower total cost of care. Waste tied to disparities in reimbursement between providers for equivalent services will require creative solutions from all parties in the AE program.

MCO Engagement in Community Investment and Social Determinants of Health

PCHC is supportive of efforts to incent investment in the health of our communities and the social determinants that frequently drive healthcare costs. It should be noted that MCOs already have incentive to make these investments, as well chosen investments are likely to

be offset by reductions in the total cost of care, and therefore a financial return in shared savings.

PCHC opposes a broad allowance for MCOs to include investments with a link to a social determinant need in the numerator of the medical loss ratio. This distorts the existing financial incentive to choose investments that also reduce healthcare cost, and creates a new incentive to find any connection to a social determinant need to reclassify an investment from operating expense to the medical loss ratio. Additionally, it creates a system where even less of Rhode Islanders' premium dollar will be spent paying for their medical care.

The goal of incenting additional SDOH investment is worthy, and the mechanism should be carefully considered to guide the most appropriate investment in Rhode Islanders.

Accountable entities have closer connections to community based organizations that drive real value in social determinants of health for Rhode Islanders, and we recommend that appropriate funding for innovation at the AE level is the best way to incentivize investment in SDOH that will meaningfully impact total cost of care.