Topic	Focus Area	Comment	Response
Roadmap	Vision/ Goals/ Approach	Page 6 of the document includes the following statement: The Accountable Entity program is being developed within, and in partnership with, Rhode Island's existing managed care model, enhancing the capacity of MCOs to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum. Page 6 This statement should be revised to recognize the role of AEs, of systems of care, in the AE initiative.	EOHHS appreciates the feedback on better integrating the AE role and function in the efforts to enhance delivery reform efforts.
Roadmap	Vision/ Goals/ Approach	The PY4 Road Map appears to be taking a direction counter to the recommendation from EOHHS's Strategic Planning work carried out by Day Health. The recommendation: Establish clear roles and lines of accountability (EOHHS, MCOs, AEs, community providers) … the State needs to strike the right balance between prescription/standardization, flexibility/innovation and micromanagement/oversight. Instead, as written The Roadmap and Sustainability Plan leans greatly towards "prescription and standardization". Neighborhood encourages EOHHS to put more emphasis on flexibility and innovation and to clearly recognize the role of the MCOs to carry-out a program that is tailored to the needs and attributes of each AE. Neighborhood offers this input to ensure ongoing full AE participation and to guide the program to sustainability. Neighborhood is an experienced and highly successful partner in EOHHS managed care program and beginning in PY4 should be allowed, along with the AEs, more (rather than less) autonomy to manage the AE program. Neighborhood also cautions EOHHS carefully set new priorities. Initiatives such as SDOH and ongoing changes to quality measures, require significant undertaking by the AEs and MOCs and distract from the projects needed to realize the quality, access and savings goals of the program.	EOHHS continues to do its best to strike a balance between flexibility and standardization. EOHHS also plays a direct role in the certification of the AEs and in the sustainability of the program from a regulatory and managed care contract perspective. EOHHS has always indicated and believed from the onset of the AE program that BH and SDOH integration were critical to the AE program. EOHHS does not see SDOH integration and investment in such efforts as a distraction but as a need/gap that EOHHS through managed care via the AE program must begin to address. Regarding quality, EOHHS has invested in the provision of ongoing facilitation, consultation, and TA from Bailit Health to support an ongoing process to review and modify quality

Topic	Focus Area	Comment	Response
			measures, as appropriate and needed based on measure changes, events such as COVID 19 etc..
Roadmap	Vision/ Goals/ Approach	We commend EOHHS' continued commitment to leverage value-based arrangements to shift the focus of care delivery from volume to value. In our feedback on last year's Accountable Entity (AE) Roadmap, we highlighted opportunities that EOHHS could use to improve member experience and further advance the system's ability to take on risk for the total cost of care (TCOC). While EOHHS has made additional strides towards these achievements, we believe there is still room for improvement. We recognize the need to be flexible with providers and their ability to take on risk due to the current public health emergency and expect the COVID-19 experience to influence alternative payment model (APM) advancement long-term. If crafted thoughtfully, EOHHS has the opportunity to use APMs to address and prevent future financial strain, like that caused by COVID-19, especially for providers who rely heavily on fee-for-service (FFS) or FFS-like payment arrangements.	EOHHS appreciates the comment and notes the recent communication from the OHIC regarding the payment and care delivery advisory committee. This advisory committee will be one forum for EOHHS/Medicaid and other payers, providers and community to discuss fuller and increased transition to VBP.
Roadmap	Vision/ Goals/ Approach	We recommend including a central role incorporating the person with lived experience to better address underlying conditions and needs in the expectations, plan and metrics. · People live in the community and the community can provide place-based solutions. We recommend including an emphasis on taking a place-based approach as a key principle. This input would be useful for the development of "in lieu of" and value-based service provisions. · We need to not treat everyone the same and recommend incorporating risk stratification. Using the RIQI Care Management Dashboard is a helpful tool for identifying people in need of assistance and would recommend considering adding Social Vulnerability Index to better identify people in need based on potential disparity based on poverty, race and ethnicity. The Pathway to Population health framework includes 4 interconnected portfolios of work: the clinical side works on improving health and	EOHHS appreciate your feedback and is committed to continual improvement especially as it relates to ensuring that all Medicaid and Medicaid managed care programming includes the community voice. Currently EOHHS has several outlets where we attempt to engage Medicaid members and obtain community input into our programming including the Medicaid Community Advisory Committee, AE program certification requirements where

Topic	Focus Area	Comment	Response
		wellbeing of people and clinical—community linkages improve the health and wellbeing of places.	each AE is required to have Medicaid member representation in their Governance and a Community Advisory Committee, and the Medicaid MCOs are also required to have a member advisory committee. Of note, the Medicaid MCO member advisory committee would be the main forum for member input on Medicaid managed care requirements and benefits such as "in lieu of services". Ultimately enhancement or add on to in lieu of services can be proposed but are approved by CMS. EOHHS is working on implementing SDOH risk factor to our Medicaid managed care rate setting process. This is similar to the MassHealth SDOH adjustment factor. As we move forward the goal is to determine how best to integrate outputs of SDOH screening into the predictive modeling and risk stratification being done at both the MCO and AE level.
Roadmap	AE Program Structure	The roadmap provided to AEs continues to emphasize incentives tied to project fulfillment under various Accountable Entity Incentive Pool (AEIP) guises, particularly Health System Transformation Projects (HSTP). Not	The incentive program will continue until June 30, 2024. The Sustainability Plan outlines the process that EOHHS plans to follow

Topic	Focus Area	Comment	Response
		evident in the memo is where the funds can be procured following the expiration of the current waiver in December 2020.	to identify sustaining financial resources.
Roadmap	AE Program Structure	PCP centric model – we believe that the AE model needs to place increased focus on the PCP to patient relationship, by increasing alignment and affinity to systems accountable for care delivery. As an example, many new Medicaid enrollees affirmatively select an MCO but do not select a PCP and are auto-assigned without affinity, and without incurring a single annual visit, to an AE or system of care. We believe this is a significant issue that warrants attention for long term program sustainability. Several infrastructure changes are needed to improve AE/ PCP affinity, starting with eligibility and enrollment through the Health Source RI gateway to improve the selection of a PCP/ AEs. Additionally, a centralized repository ('source of truth') for member/ AE attribution, managed by EOHHS, is critical for reliable and standardized TCOC calculation. We believe that accountable care, inclusive of upside and downside financial risk, can only be accomplished through AE/ MCO relationships of scale, with a minimum baseline of 5,000 attributed members. Long-term financial sustainability requires actuarially-stable populations that justify scalable and sustainable commitments by AEs and MCOs, beyond the duration of the HSTP program. While the AE program has captured a significant portion of the RI care delivery system, not all large care delivery systems are currently participating. Sustainable transformation with market-wide impact can only occur through market-wide adoption.	EOHHS understands and agrees that increasing member affinity with their assigned PCP and attributed AE is an important goal, and is considering possible approaches to achieve it, including assigning members to an AE instead of to an MCO upon enrollment in Medicaid. EOHHS expects to discuss these possibilities and their tradeoffs with stakeholders in the coming months. EOHHS appreciates the feedback that the minimum number of attributed lives in a given AE-MCO contract should be 5,000 rather than 2,000. EOHHS will continue to review this type of information with its actuarial vendor. EOHHS agrees that increasing participation in the AE program is an important goal, and regularly communicates with providers considering participation to provide assistance in preparing for certification as an AE."

Topic	Focus Area	Comment	Response
Roadmap	AE Program Structure	Special attention needs to be paid to children and families since health systems will naturally (and should) focus efforts on higher cost and rising risk patients. Leveraging existing assets and natural connections of the 2 place-based CHTs – Family Services of RI (FSRI) and South County Health (SCH) – both connected to family home visiting services, will facilitate this child/family focus. Engaging schools is also very important in serving high-risk children and families. Recognizing the interconnection between Medicaid and commercial coverage for the "working poor", as well as Medicare and dually-eligible members, requires a more comprehensive approach than a simple focus on the Accountable Entity (AE) structure. A broader multi-payer and multi-sector programmatic and funding strategy will allow for greater long-term equity and sustainability.	EOHHS agrees that the HSTP/AE program has provided RI Medicaid program with the opportunity to leverage these funds in establishing the foundational start of a value based model of care. The intent is to use HSTP to build a strong basis and learning that can be built upon. The sustainability portion of this document starts to speak towards some of the planning and thoughts related to long term equity and sustainability of these efforts.
Roadmap	Certification Requirements	Add Health Equity as part of Certification Process: CTC-RI strongly supports the proposal included on page 10 to add an additional element to the certification process on health equity for the AEs. This addition would: ~Provide needed spotlight on the critical work that must be done to address existing inequities. ~Add weight and priority to initiatives outlined in the sustainability plan and the previously released SDOH strategy document, including the Health Equity Challenge and CHTs, that we believe are central to our state's efforts to eliminate systemic racism and inequities. ~ Ensure that resources – time, funding and attention – are dedicated to this work. .... we would suggest a reframe of the terminology on page 22, where you describe some outstanding examples of community—clinical partnerships that support sustainability. Instead of referring to these partnerships as "External Partnership", we suggest changing this to say "Community—Clinical Partnerships" to better reflect and be more aligned with the approach and intent behind the SDOH Strategies document."	EOHHS will clarify the language on page 22. Certification Standards for PY 4 have been posted for public comment and have been updated to include a more defined approach to Health Equity.

Topic	Focus Area	Comment	Response
Roadmap	APM	UnitedHealthcare appreciates the flexibility EOHHS continues to provide managed care organizations (MCOs) when working with AEs and we encourage EOHHS to continue to foster innovation by allowing MCOs and AEs to tailor value-based payment (VBP) models that can produce meaningful outcomes. This will make certain that members' needs are addressed, and providers are appropriately supported and incentivized. We recommend EOHHS review the TCOC model at least annually to make any necessary adjustments based upon new learnings and year over year financial changes, including TCOC improvements, outcomes, and uptake from MCOs and AEs to determine if meaningful progress is being made. We agree with EOHHS that AEs should be held responsible for the health of the population they serve and should therefore be held responsible for reducing TCOC with MCOs serving as the compliance foundation to assess the quality and financial performance of AEs. We are, however, concerned that the financial and regulatory burdens of these arrangements currently sit only with MCOs and that there is limited motivation for providers to participate. 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 resulted as a result of providers refusing to participate in VBP/APM arrangements1.	EOHHS appreciates the feedback and will consider comments of parity between AE and MCO as well the example from NY as the strategic planning and sustainability efforts are continued. However, nothing at this moment precludes an MCO from engaging in other APMs with providers and/or within such an arrangement including language regarding passing on incentive and/or penalties. EOHHS is required per CMS to review all program requirements including the TCOC model on an annual basis.
Roadmap	APM	Financial Viability – For the State of RI, financial viability means demonstrated reduction in the Medicaid TCOC growth trend, without compromising overall quality outcomes. While there is likely to be performance variation across AE stakeholders, all constituents need to be set up for the opportunity to succeed. For MCOs, this means program	EOHHS agrees that it is important to set capitation rates and TCOC targets in a fair way, so that payers and providers have a reasonable opportunity to succeed. With

Topic	Focus Area	Comment	Response
		capitation rates that cover the underlying cost of managing the population of members with necessary risk corridors to protect against unpredicted variation. For AEs, this means a TCOC methodology that accurately represents the risk profile of accurately-attributed patient populations.	respect to TCOC, EOHHS has worked closely with the state's actuarial vendor to enhance the risk adjustment methodology to better account for underlying population risk. As all commenters are aware, the state of Rhode Island, EOHHS, and Medicaid all operate under significant financial constraints, and efforts to ensure appropriate capitation rates occur in that context.
Roadmap	Medicaid Infrastructure Incentive Program (MIIP)	Incentive Program: Neighborhood requests a clarification of when AE and MCO incentive funding will be eliminated. Please add more specificity to the timeline on pages, 7 and 8 to understand the key steps and decisions associated with the various deadlines: 1115 waiver, DSHP and HSTP. Project Merits Incentive Funding: Please clarify, the requirement where an AE can reclaim the payment for a missed performance metric at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric. Neighborhood recommends removing the requirement that there is a combination of achieving the metric with a subsequent related metric since that subsequent metric may also have an extended deadline.	EOHHS will revisit the timeline on page 7-8 and appreciates the feedback. The reclaim of payment for a missed performance metric is based on the STCs and current incentive funding requirement for the HSTP project based metrics if an AE missed their milestone or target the AE has up to 1 year to achieve that target and "reclaim payment.
Roadmap	Monitoring/ Reporting/ Evaluation	Throughout the program, EOHHS has required various elements be reported, typically in narrative form, to afford the state insight into AE and MCO progress. More requirements laid out here (particularly for MCOs) that will likely prove to be a distraction to managing our businesses: see AE budget reports (p. 23) and MCO deliverables (pp. 16-17) in addition to ongoing deliverables, template fulfillments, etc. required of AEs. Despite these requirements, EOHHS has yet to routinely provide meaningful data	The MCO deliverable listed on pages 16-17 are existing reports that the MCOs submit as a contractual requirement. As with any new program or initiative there are a number of data integrity issues and processes to be resolved

Topic	Focus Area	Comment	Response
		on the program's impact or expenditures/budgeting as reported to CMS. AE-MCO dyads cannot continue program participation in PY5 and beyond without realistic insight into what impact the program has made, what it promises to make, and avenues EOHHS can explore through program-imposed returns on investments as opposed to waivers.	before final data reports are published. One challenge with many ACO programs, to which the Medicaid AE program is no exception, is member attribution. EOHHS has worked with the MCOs to ensure a robust and sound attribution process and ultimately data integrity process. EOHHS is in the process of vetting key indicators of utilization and cost with leadership and anticipates sharing this information more broadly. Also, as a reminder, HSTP is a key program focus of the 1115 Wavier Evaluation being done by NORC.
Roadmap	Monitoring/ Reporting/ Evaluation	The Roadmap document identifies that the state has contracted a qualified independent entity to conduct an evaluation of the entire delivery system reform demonstration. Please include the evaluation timeline and the name of the contracted vendor.	NORC is the State's evaluator for the 1115 Waiver which includes HSTP. The Evaluation Design Plan is posted to the state website here as Attachment Y to the Rhode Island 1115 Waiver Special Terms and Conditions. The timeline is as follows: **Draft Interim Evaluation Report to CMS:** 12/31/2022 **Final Interim Evaluation Report:** 4/30/2023 **Draft Summative Evaluation Report to CMS:** 12/31/2022

Topic	Focus Area	Comment	Response
			Final Summative Evaluation Report to CMS: 12/31/2022
Roadmap	Specialized AE's	Integra will follow with interest proposals to implement an APM model for LTSS focused specifically on preventative care and services. We look forward to opportunities to provide additional public comment on the details of a proposed Specialized APM model through the MMP program.	EOHHS plans to provide additional stakeholder engagement discussion on this topic as we move forward with the design and development.
Roadmap	Specialized AE's	We continue to support the potential specialized AE and welcome the opportunity for additional collaboration between the AE and LTSS providers. And, as we have in the past, we support including the dual eligible population in the AE program. This population includes those patients with the highest levels of need who stand to realize the greatest benefit of improved care, improved health, and smarter spending through comprehensive accountable care."	EOHHS appreciate the feedback. Please note that the Specialized APM program is not an extension of the Comprehensive AE program. It is not the intent of EOHHS to extend the AE program to include the dual eligible population at this point. The Specialized APM program is a pilot of a quality/pay for performance program focused on care transition w/target LTC/LTSS providers.
Roadmap	Specialized AE's	The Specialized AE Program has been evaluated previously and needs to again be vetted as to the likelihood of success. EOHHS has documented Neighborhood's concerns about the limitations and potential possibilities associated with the LTSS AE concepts. As EOHHS' MMP partner, Neighborhood looks forward to planning and developing these concepts together. Neighborhood supports the initial proposal to implement a quality pay for performance model and incentives for appropriate hospital transitions of care to home with support.	EOHHS plans to provide additional stakeholder engagement discussion on this topic as we move forward with the design and development.
Roadmap	Other	In our response to last year's Roadmap, we urged the state to bring new sectors to the table. And since that time, one of those sectors we recommended has been added to AE meetings. We commend EOHHS for inviting Jennifer Hawkins, Executive Director, ONE Neighborhood Builders, to join AE meetings. Jennifer has been an invaluable addition to our	EOHHS appreciates the feedback and agree that ensuring that a diverse constituency of stakeholder both state agency and other critical organizations representing the

Topic	Focus Area	Comment	Response
		discussions, and we urge EOHHS to build on this by inviting representatives of other key sectors to AE meetings. At the same time, we reiterate that other state agencies and departments should be invited to participate in AE discussions and planning: housing (e.g. Housing Resources Commission), education, corrections, DCYF, human services, veterans' affairs, labor & training (beyond the current engagement around healthcare sector employment), and municipalities (consider prioritizing the urban core). Additionally, as we suggested last year, we urge EOHHS to invite philanthropy to become more engaged with this important work.	community, philanthropy etc. are important. EOHHS will consider this recommendation as we continue to also balance the size and scope of the committee.
RoadMap	Other	Phase 1: Comprehensive AE Program: Minor Correction is needed: Six AEs contracted with MCOs and entered into TCOC and AE Incentive Program arrangements for Program Year 2. EOHHS lists 5.[KA(-C1]	EOHHS appreciates the identification of this error and will revise it.
Sustainability Plan	Background/ Context/ Approach	We find that the proposals, especially those related to the long-term financial sustainability of the program, do not seem to adequately grapple with the challenges that AEs face, and do not offer sufficient concrete options to allow AEs to continue after the lapse of HSTP funding. We strongly recommend that EOHHS offer a revised sustainability plan that includes at its center a solid commitment to a predictable administrative funding stream for Accountable Entities, in recognition of the central role that the AE program plays in EOHHS's vision for transformation of the Rhode Island health care delivery system. We would recommend, however, that EOHHS look carefully at whether the current contracting model introduces inefficiencies. We also strongly encourage EOHHS to make it possible, as specified in its March 2019 policy statement, for an Accountable Entity to contract with a single MCO and retain its full attributed membership. In our PY3 recertification application, AEs were required to "identify concrete ways in which their MCO contracts and partnerships are being leveraged to assist the AE in achievement of the advanced standards in domains 4-8." We encourage EOHHS to require MCOs to answer the same question: how are AE contracts being leveraged	EOHHS appreciates the feedback regarding the need for a predictable administrative funding stream for AEs and expects to consider this in the context of alternative payment methodologies developed with MCOs. EOHHS appreciates the recommendation to allow an AE to contract with a single MCO and retain its full attributed membership, which would likely be best achieved by assigning members to an AE rather than to an MCO. EOHHS expects to discuss this with MCOs in the coming year. EOHHS agrees that it would be useful to understand how MCOs

Topic	Focus Area	Comment	Response
		to support the achievement of the state's goals? We believe that visibility into how MCOs answer that question will help inform our collaboration in the years to come.	are leveraging their AE contracts to support the state's goals and will consider opportunities to request this information.
Sustainability Plan	Background/ Context/ Approach	...we believe is the best way to ensure AEs have the resources they need to build and maintain capacity, an accountable, population-based payment system (capitation). Such a payment system would provide the flexibility for the range of investments – staff, training, technical assistance, start-up IT and enduring IT expense (e.g. licensing), non-traditional services, and more – required for a robust, effective AE. We understand the motivation for the following proposal from EOHHS to support AE staff through FFS billing, but this should be an interim, or transitionary, option. It is not an effective, long-term option and it runs contrary to EOHHS's goal of adopting alternative payment methodologies. While there is always room for achieving efficiencies and leveraging best practices, these are not likely to yield significant resources. Fundamental payment reform remains critical.	EOHHS agrees with the goal to move further along the LAN payment methodology continuum. MCOs and AEs are currently able to negotiate such contracts. EOHHS agrees that new FFS billing for care management services is not ideal and intends to pursue alternatives such as primary care capitation.
Sustainability Plan	Centralizing Infrastructure	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	EOHHS agrees that it is vital to maximize the ability of providers to use CurrentCare and Care Management Dashboards to support patients experiencing mental illness and/or substance use disorder. As mentioned in comments, this is challenging due to legal protections under 42 CFR Part 2. EOHHS acknowledges the need to work closely with providers to adhere to data privacy

Topic	Focus Area	Comment	Response
		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.	requirements while making the best possible use of these HIT tools.
Sustainability Plan	Centralizing Infrastructure	The care management alerts, quality reporting system, and CurrentCare do not represent operating costs today. The proposed Community Referral Platform could potentially represent a reduced cost to Integra if we were able to terminate our existing referral platform contract in favor of the state's, but that cost is quite low compared to other operating costs, and would not materially impact program sustainability. We are puzzled by EOHHS's characterization of the Health Equity Challenge proposal as "centralized infrastructure," and do not understand how it represents an efficiency or addresses sustainability.	EOHHS acknowledges that the Care Management Dashboards, Quality Reporting System, and CurrentCare do not represent operating costs today. EOHHS believes that by making these tools available to AEs, the state has prevented the need for AEs to invest in similar, duplicative products independently. EOHHS is currently engaged in an RFP process to procure a Community Resource Platform. It is therefore not known which platform will be selected. EOHHS acknowledges that for AEs that already have a platform that they consider low cost, a switch to a different system, or a reduced cost for their current system, will not make a major budgetary difference. For AEs that do not yet have such a system, the availability of a state-supported platform is expected to offset some time and expense. The Health Equity

Topic	Focus Area	Comment	Response
			Challenge/Rhode to Equity is considered part of enabling infrastructure because through this program EOHHS expects to provide training and coaching that will support AEs in forming closer collaborations with local CBOs. EOHHS agrees that this is not infrastructure in the usual sense and will change the wording to reflect that this is a centralized *investment*.
Sustainability Plan	Centralizing Infrastructure	Any such investments should be aligned with the priorities, strategies, and goals of the AEs themselves.... effective community referral will require sufficient resources to meet the needs that are identified. Without a change from the current model, this platform runs the risk of being a high-functioning waiting list. Without new mechanisms for additional investment and resources, the CIRP will be reduced to identifying needs when what we want is to close needs.	EOHHS agrees that for referrals to community resources to be effective in meeting patients' health-related social needs, there must be adequate resources to address those needs. Currently, AEs are required to conduct screenings to identify these needs, and EOHHS understands that AEs are working to refer patients to appropriate resources. The Community Resource Platform is expected to make those referrals easier and to facilitate learning whether and how the patients' needs are met by the referral. To the extent that resources are not adequate to meet the needs, the platform can help identify and quantify the type

Topic	Focus Area	Comment	Response
			and extent of these gaps, which can support planning and advocacy work to increase resource availability.
Sustainability Plan	Centralizing Infrastructure	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. Quality Reporting System: The Quality Reporting System established by the State addresses only one data source needed to produce accurate quality measures, notably the Accountable Entity Core Quality Measures. Data from the MCOs' claims systems and care management systems, in addition to other supplemental data such as the KIDSNET immunization registry, will be needed for the foreseeable future. Neighborhood recommends the Roadmap identify the MCOs as central to the quality reporting process, as this is a core function of the MCOs, which have effective and accurate processes in place for quality measurement, reporting, and improvement. EOHHS should also recognize that provider organizations currently submit quality data to payers and oversight agencies for multiple purposes, so the impact on administrative efficiency at the provider level is likely to be less than EOHHS is contemplating. EOHHS should consider focusing on other areas for streamlining efforts, where they are likely to have greater impact.	The QRS was not intended to be a system that covers all of care management reporting. However, the QRS is intended, and in fact does currently allow for, the participating AEs/providers to upload their entire EHR which substantially reduces the need to report out to multiple payers. EOHHS understands that claims data and care management system data from MCOs as well as supplemental data such as the KIDSNET immunization registry will be needed to produce accurate quality metrics and will revise the Sustainability Plan language to acknowledge this point.
Sustainability Plan	Centralizing Infrastructure	We fully support the role of the community health worker in assisting patients who are at high risk with a payment model that is not based on fee-for-service. For CHTs, we recommend a definition that includes provision of home-based BH services based on our findings that patients	EOHHS appreciates the suggestion to define Community Health Worker services to include home-based behavioral health services

Topic	Focus Area	Comment	Response
		referred for community health team services have high incidence of depression, anxiety and substance use disorders. We agree that figuring out how to support staffing needs over the longer term is a priority and needs more examination. We suggest adding Peer Recovery Specialists (PRS), especially PRS roles that are cross-trained to serve as Community Health Workers (CHWs) to the plan's comprehensive list (p. 23). And, as is pointed out in the Sustainability Plan, it is important to explore sustainable avenues to pay for these high-value services. As you note in the discussion of high-value services, there are barriers to billing, especially BH services delivered outside the health care setting, such as care provided in the community by the CHTs. From our experience supporting the CHTs, services provided in these crucial roles are often not fully reimbursable (i.e. BH Clinicians) or are not billable at all (i.e. CHWs). We look forward to working with our state partners to investigate forward-looking and creative ways to pay for these high-value services long-term, including alternative payment methodologies that support comprehensive primary care. Incorporating CHTs as part a comprehensive payment for primary care will help mitigate the challenges associated with billing for BH services, as many of the services provided by the BH Clinician on the CHT are not reimbursable (i.e. case conferencing, travel, warm handoffs). We want to strongly suggest that the Community Referral Platform be included as a main component of a centralized IT plan along with the other components already included in the document. Maximize connectivity with other systems to the extent possible, including to the HIE. ~Promote the use of one e-referral platform statewide, to the extent possible. With multiple platforms currently being promoted, we recommend EOHHS take leadership on the use of a single statewide system to ensure widespread use. Our concern is that with multiple e-referral systems in use in RI, providers will not use them. Ensure that the e-referral system is also available to health plans. This is an important way to improve coordination and reduce duplication of services. ~ Address concerns around patient	and will consider that carefully in developing this policy. EOHHS notes that Peer Recovery Specialist services are already eligible for reimbursement under Medicaid. EOHHS is happy to specifically add Peer Recovery Specialists to the list of staff providing direct services but notes that this list was not intended to be comprehensive but rather to identify some examples of key services. EOHHS appreciates commenters' support for using alternative payment methodologies such as a comprehensive payment for primary care to pay for high-value services such as CHWs and CHTs. EOHHS agrees that the Community Resource Platform should feature strong connectivity with the HIE, and notes that the platform is already referenced in the HIT Roadmap. EOHHS does not intend to require AEs to use the statewide CRP but does intend to encourage use of the statewide CRP because EOHHS agrees that this will be more efficient and easier for CBOs. EOHHS intends to make the CRP available to health plans. The CRP

Topic	Focus Area	Comment	Response
		consent, stigma and privacy while maximizing care coordination and avoiding duplication of services. ~This system needs to be able to easily and effectively identify a "primary care manager/ quarterback. This is a complex undertaking; recommend including strategy of using a peer learning community approach that includes goals, deliverables, infrastructure and incentive payment, and peer learning community approach. We were gratified to see the value and importance placed on CHWs and CHTs is included in the Sustainability Plan and included as one of the 5 key investments in the previously released HSTP Social Determinants of Health Investment Strategy. We want to suggest that sustaining the CHTs be called out more specifically in the Sustainability Plan, similar to the manner with which the Community Referral platform and Health Equity Challenge are noted in the document....in order to fully achieve their potential, these CHTs, and the organizations that employ them, need a sustainable, multi-year stream of funding aligned closely with the AEs, HEZ and other efforts to address SDOH and provide care coordination for families with complex, high levels of need.	will have robust patient consent and privacy protections. The system is expected to be developed with substantial opportunity for user engagement and support.
Sustainability Plan	Shared Savings/TCOC	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.	EOHHS agrees that it is important to consider the role of social determinants of health when building risk adjustment models and expects to work with the state's actuarial support vendor on this in the coming year.
Sustainability Plan	Shared Savings/TCOC	Integra is supportive of the Milliman-designed TCOC methodology in use in PY3 of the program and is grateful to operate under a single consistent risk model. We note that although there is a single state-specified model, each	EOHHS appreciates the recommendation to develop standard contract language for AE-

Topic	Focus Area	Comment	Response
		MCO is asked to articulate that model independently in their AE contracts. This led to a great deal of confusion, inefficiency, and delay in the execution of our PY3 AE contracts. We strongly recommend that EOHHS develop standard contract language for TCOC and other key features of the program and require MCOs to use that standard language in their contracts with AEs.	MCO contracts and although EOHHS cannot require that an MCO utilize it, EOHHS will develop a standard contract template for MCOs.
Sustainability Plan	Shared Savings/TCOC	We believe the key to achieving the ambitious goals of the AE program and for achieving sustainability lies in fundamental delivery and payment reform. We must move away from the current fragmented fee-for-service payment system to a population-based payment system. ...this crisis has also demonstrated the ways that fee-for-service payment is fundamentally incompatible with the goals of population health. Providers have been severely restricted in their ability to meet the needs of their patients in the middle of a pandemic because they have been, largely, operating within a billing and coding system unsuited to the moment. The overall strategy proposed here 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 that are outlined in the plan and elsewhere. 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. ...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. Experience to date would indicate the savings of the TCOC model are not sufficient to sustain robust AE operations. A population-based payment system is preferred. We do, nonetheless, support the changes EOHHS has made to the TCOC	EOHHS appreciates the support for the TCOC model's risk adjustment methodology. EOHHS has always agreed that the HSTP should enable participants to progress along the LAN continuum, from fee-for-service payment to global budget arrangements that are on a fee-for-service chassis to more capitated arrangements. EOHHS permits AEs and MCOs to develop payment arrangements that are further along this continuum, so long as OHIC RBPO standards are met.

Topic	Focus Area	Comment	Response
		model which now account for population risk adjustment. We caution EOHHS to avoid being overly restrictive in the parameters you will allow for AE and MCO risk arrangements. Flexibility needs to be retained. Once an AE has been approved as a risk-taking entity, latitude should be granted to the AE and MCO.	
Sustainability Plan	Shared Savings/TCOC	BVCHC commends EOHHS for supporting centralized systems to meet uniform AE needs (i.e. social determinant platform, care management alerts). However, AEs must graduate to semi-autonomous organizations through greater discretionary earnings in the form of shared savings; such revenue is critical to framing operating capital. AEs have progressed to the point where they should provide value-based care through self-designated interventions that suit their total cost of care (TCOC) drivers as opposed to AEIP-prescribed endeavors (i.e. project measures, "outcome" measures already accounted for in TCOC). EOHHS mentions the prospect of greater shared savings through the revised PY3 TCOC model, yet it is unclear how well AEs will perform. Experience shows diminishing returns due to efficiency-related caps and understated inflation. Thus, BVCHC encourages EOHHS to maximize shared savings to all possible extents. Achievable targets motivate Es to continue program participation rather than AEIP reliance.	EOHHS agrees that shared savings should be an important source of AE earnings, and that it is important to ensure that TCOC targets are appropriate. It is for this reason that EOHHS worked with the state's actuarial vendor to improve risk adjustment and plans to continue to increase the market adjustment factor. EOHHS believes that AEIP funding for outcomes that are consistent with improved TCOC provides AEs and MCOs with additional incentive to focus their interventions on utilization that is closely tied to cost. Performing well on these outcome measures will increase the chance that the AE will achieve shared savings as well. To the extent that an AE believes its own cost drivers are very different, EOHHS is open to discussing greater flexibility in future years.
Sustainability Plan	Shared Savings/TCOC	Shared Savings from TCOC: In order for EOHHS to reasonably anticipate that shared savings will provide support to the AEs in the future, there	EOHHS agrees that it is important to review and share data on AE

Topic	Focus Area	Comment	Response
		needs to be an evaluation and demonstration of data that supports this key assumption. Neighborhood recommends EOHHS conduct a more detailed analysis of AE TCOC performance. The analysis will provide transparency to program performance, to date little has been shared on state-wide overall program performance and will clearly determine the additional levels of alternative support needed for sustainability. TCOC Model Developments: Neighborhood supports the concept of measuring efficiency, as well as the need for considering efficiency when creating targets each year. However, negative adjustments to targets for past inefficiency could have unintended consequences year over year. As the only primary care safety net in the state, EOHHS should consider the development of unique TCOC adjustments for the FQHCs. In PY4, Neighborhood is seeking the flexibility to negotiate down-side risk arrangements with willing FQHC AE partners. Neighborhood recommends the authority to engage in these arrangements be left to the AE and MCO to ensure compliance with the appropriate federal (HRSA) and state (OHIC) regulations and requirements. It is well known, that FQHCs in other states have engaged in risk-based contracting.	TCOC performance. However, due to significant data lag (as a result of claims runout and time to determine settlement amounts), this data has not been available. EOHHS has recently obtained data from both MCOs that participated in Program Year 1 regarding final performance for that year and expects to share this. As final Program Year 2 data is submitted, EOHHS expects to share this as well. EOHHS understands the concern about "negative," or "above market" TCOC adjustments, and shares the desire to avoid imposing such an adjustment. For this reason, EOHHS plans to delay the implementation of larger market adjustments until Program Year 4. EOHHS notes that for Program Year 3, the "below market" TCOC target adjustment is 10% and not higher because in order to make the below market adjustment higher than this, there needs to be a concomitant "above market" adjustment to avoid simply increasing program costs, which EOHHS did not wish to impose until

Topic	Focus Area	Comment	Response
			all AEs have had more time to develop infrastructure and care delivery reforms that could prevent the application of this adjustment. EOHHS understands that some FQHCs wish to negotiate downside risk contracts with MCOs. EOHHS has confirmed with CMS that EOHHS may not require this and that EOHHS must ensure that FQHCs are able to keep 100% of the FQHC's PPS payments.
Sustainability Plan	Shared Savings/TCOC	At the recent AE Advisory Committee meeting, slide 13 of the presentation shared, under attribution, EOHHS stated that MCOs would be required to allow PCPs to participate in multiple AEs if they were associated with two different TINs. On the surface, it appears that it would give rise to member confusion and possible misallocation of claims in a TCOC arrangement. We also thought that this was not allowed by CMS for Medicare even if multiple TINs were involved.	EOHHS understands that it is possible to track members to PCP visits at specific practices/TINs, and that by doing this, it is possible to allow more members to be attributed to AEs, since their PCP can participate through multiple TINs. EOHHS does not expect this to lead to member confusion because members generally see a primary care provider as a patient of a specific practice. This is different from specialists, whom patients may see at multiple sites. EOHHS is not aware of any CMS restrictions on this issue that apply to state Medicaid programs.

Topic	Focus Area	Comment	Response
Sustainability Plan	Shared Savings/TCOC	We understand the role of shared savings in terms of building ongoing sustainability and the need to concentrate on high-risk populations. The plan mentions prevention and children; however, the financial support for working on areas that may not reap immediate shared savings is of concern.	EOHHS agrees that AEs may not expect to generate immediate shared savings from work with children. EOHHS has included several quality and outcome metrics that require an AE to serve children effectively. In addition, EOHHS expects that interventions that benefit parents may benefit whole families, especially where community health workers connect families with community-based services.
Sustainability Plan	Medicaid Reimbursements	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.	EOHHS appreciates the recommendation to ensure reimbursement for telemedicine and will consider this in the coming months.
Sustainability Plan	Medicaid Reimbursements	As discussed above, this proposal should only be a temporary, transitional, means to sustainability. The goal of the state should be to move beyond FFS models, even those that support innovative “high value services.” Those services should be, and could be, sustained by AEs within a population-based payment system. We welcome the introduction of capitation into this document, however primary care capitation is not sufficient. Capitation must expand beyond primary care and encompass	EOHHS understands the concern that reimbursement will focus on the fee-for-service model. It is EOHHS' intention, however, to build reimbursement for services such as community health work into alternative payment

Topic	Focus Area	Comment	Response
		other, higher-cost, services or the resources will not be sufficient to achieve meaningful results.	methodologies such as primary care capitation. It is important to treat these services as reimbursable so that their cost can be properly built into capitation amounts. EOHHS understands that some AEs wish to move toward a capitation payment methodology beyond primary care, and notes that current policy does not prevent this for AEs and MCOs that are ready to do so.
Sustainability Plan	Medicaid Reimbursements	EOHHS' suggestion of technical assistance to maximize Medicaid billing (p. 28) implies reliance on billing mechanisms. These in turn inevitably influence how providers administer care. Furthermore, it risks perpetuation of a volume-based approach. The roadmap proceeds to mention primary care capitation (p. 29), but it is unclear if this is in a general context or specifically to community health reimbursement discussed in the preceding paragraphs.	EOHHS believes it is important for providers to understand how to bill for their services. EOHHS does specifically hope to develop primary care capitation as a mechanism to reimburse providers for community health work.
Sustainability Plan	Medicaid Reimbursements	We encourage EOHHS to allow MCOs the flexibility to use in-lieu-of services to meet member needs. In-lieu-of services are medically appropriate and cost-effective substitutes for covered services that can facilitate innovative and focused services and solutions, based upon individual members' unique needs. To support sustainability and program goals, we recommend EOHHS make in-lieu-of services encounterable services that are included in the rate setting process and counted toward the MLR numerator calculation. To address social service needs more comprehensively to improve health outcomes, EOHHS should consider expanding the current Medicaid benefit base to include additional SDOH-related services (in the domains of	EOHHS agrees that it is valuable to expand use of "in-lieu-of" services. Under the definition at 42 CFR 438.3(e)(ii)(2)(iv), CMS states, "The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services." In accordance with this, EOHHS will continue to account for in-lieu-of

Topic	Focus Area	Comment	Response
		housing, transportation, food, and IPV) as encounterable, covered services through State Plan Amendments (SPAs) and/or waivers where available. Several states have begun to define these subsets of social services as covered benefits as they acknowledge that expanding benefits to include social services can help improve access to, and delivery of, community resources that are the gateway to overall well-being and improved health outcomes. Lastly, we agree with EOHHS that AEs should take full advantage of billing for Medicaid-covered services. EOHHS should ensure that any additional programs and benefits AEs intend to bill MCOs for are built into the core Medicaid benefit package and that fee schedules accurately reflect the benefit package. We caution EOHHS on requiring MCOs to meet minimum spending targets on primary care. Spending targets are frequently used in commercial insurance and are often set too high for insurers to meet. We encourage EOHHS and MCOs to work collaboratively to identify other opportunities to increase primary care utilization for Medicaid members.	services in rate-setting and consider these expenditures as part of the medical-loss-ratio numerator. EOHHS agrees that it makes sense to explore options to add covered benefits that help address social needs. It is for this reason that EOHHS pursued and obtained CMS approval for Home Stabilization. EOHHS will continue to pursue similar opportunities, as permitted through the state budget process, recognizing the limits at the federal level. EOHHS appreciates the recommendation to ensure that new benefits that providers will bill to MCOs are built into the benefit package and fee schedules. It is EOHHS' intention to ensure that this is the case. EOHHS appreciates the concern that minimum spending targets on primary care may not be appropriate for Medicaid and is open to discussion with MCOs on alternatives.
Sustainability Plan	Care Management and MCO Support	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	EOHHS understands the concern that including some SDOH investments in the MLR numerator

Topic	Focus Area	Comment	Response
		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.	might encourage MCOs to make such investments even if they do not reduce health care spending. EOHHS expects that in moving forward with any such change, the state and MCOs would work closely to define exactly what investments can count in the numerator; the intent is not to permit an MCO to classify spending as an SDOH investment after the fact in order to, for example, treat administrative costs as an SDOH investment. In addition, EOHHS expects that most SDOH investments would be geared towards reducing health care spending, by improving member health. EOHHS specifically expects that SDOH investments made by MCOs will be done in active partnership with AEs, based at least in part on the community connections that AEs have developed.
Sustainability Plan	Care Management and MCO Support	**Full delegation of care management contractual obligations to AEs.** We believe this is an important step in the right direction and have urged EOHHS to move in this direction in previous comments. This will reduce patient confusion, avoid the risk of contradictory care management, and increase overall efficiency, all while aligning with the goals of accountable care and the AE initiative. We applaud EOHHS for responding to requests	EOHHS appreciates commenters' support for delegation of care management to AEs and agrees with commenters that the resources to support this work need to come together with the

Topic	Focus Area	Comment	Response
		by PHSRI-AE and other AEs to address this source of program confusion. But, as we have stated before, this change needs to be paired with allocating to AEs the resources that currently support care management activities by the MCOs. Funding must be commensurate the duties AEs will be assuming. We also support EOHHS exploring utilization management (UM) and utilization review (UR) as another way to manage costs. PHSRI has extensive experience with both UM and UR under our delegation agreements with payers. We urge EOHHS to consider allowing those AEs with UM/UR experience to take on these duties. We firmly believe this would greatly enhance our ability to achieve the goals of the AE initiative – coordinated, efficient care and improved management of healthcare costs. At the same time, if EOHHS supports "delegation" to AEs, resources sufficient to perform UM and UR must be provided to the AEs. **In-lieu of" and "value-based services**: We recognize this proposal may be driven by a desire to find ways to fund services not traditionally accommodated within the FFS system. However, this contradicts the previously stated goal of focusing responsibility and accountability for care with the AEs. If new in-lieu of and/or value-based services are initiative by the MCOs, and not driven by the AEs, care coordination will continue to be fractured. The services selected by the MCOs may not align with the varying priorities and needs of the AEs. Rather than pursuing a path that runs counter to other policy decisions, we urge EOHHS to find ways for AEs to drive the selection, management, and financing of new services.	obligation to do the work. EOHHS appreciates the recommendation to consider delegation of utilization management and utilization review to AEs. This would need to be paired with an appropriate system to allow patients to appeal AE decisions, as well as other administrative changes. EOHHS will consider this in the coming months. EOHHS expects in-lieu-of and value-based services to be developed in close partnership with AEs and agrees that it would not be efficient for MCOs to develop these policies independently.
Sustainability Plan	Care Management and MCO Support	Care Management: Neighborhood endorses a path to Care Management shared responsibility. Full delegation for all AEs will be difficult in PY4 based on the readiness of each AE and the need for the MCOs to meet certain EOHHS contractual requirements and NCQA accreditation requirements. Neighborhood has already started working with each AE on	EOHHS understands that care management delegation may take longer for some AE-MCO dyads and looks forward to working with

Topic	Focus Area	Comment	Response
		aspects of a shared responsibility care management arrangement and looks forward to furthering this work in the future. Neighborhood strongly recommends we be given flexibility and autonomy to develop a strong and shared care management program with each AE.	MCOs to consider opportunities for shared programs.
Sustainability Plan	Care Management and MCO Support	The connection to local, community-based care, especially for individuals with complex health issues or social needs, is critical to improve overall health outcomes and control costs. In thoughtfully improving the connection and coordination to community level care, EOHHS has an opportunity to transform the Medicaid delivery system in Rhode Island into a person-centered ecosystem by redefining the roles of MCOs as facilitators and connectors to enable and support AEs in delivering person-centered care. We appreciate EOHHS promoting collaboration between MCOs and AEs to build care coordination and care management capabilities. Based upon our experience working with AEs, we believe care management should be a shared responsibility between MCOs and AEs (who have applied for and been approved for care management delegation). Both MCOs and AEs should independently identify members in need of care management and work together to identify which entity is best suited to provide care management. By sharing care management responsibilities, care management can be delegated to MCOs, AEs, or can be a shared MCO-AE arrangement depending on the unique needs of the individual. To maintain MCO oversight of care management delegated to AEs, EOHHS will need to ensure rate setting is adjusted. We recommend a flexible team approach to care and service coordination leveraging predictive modeling, assessments, and comprehensive data to appropriately meet needs of members, especially those requiring complex care management. Together, MCOs and AEs can help close gaps and empower members to identify and achieve health and wellness goals.	EOHHS looks forward to working with MCOs to consider shared care management programs as one option to shift care management responsibility and funding towards AEs.
Sustainability Plan	Care Management and MCO Support	Payment for adult care management needs to be incorporated to provide care management across the age spectrum. Additionally, care	EOHHS agrees that it will be necessary to clarify the role and

Topic	Focus Area	Comment	Response
		management needs to be provided within the context of the patient-centered medical home, and cost savings and reduction in duplication of services can be better achieved by clarifying the role and responsibilities of the MCOs. It is not clear in the plan how the transition of MCO care management functions will be transitioned to the AE's.	responsibilities of the MCOs and AEs with respect to care management, and that at this time the plan for this transition has not been finalized. EOHHS expects that many AEs will want to run their care management work through existing PCMH practices.
Sustainability Plan	SDOH and MCO Support	If we are going to achieve more than identify health-related social needs and risk referring patients to over-burdened service providers, increased investment in interventions that ameliorate SDOH needs are needed. ...the state needs to find ways to expand the options for addressing and resolving health-related social needs. This includes not just new services – e.g. community health workers, medically-tailored meals, enhanced transportation, housing modification, etc. – but also capital investment, particularly in affordable housing and supportive housing, including the development of new housing types that meet the needs of the medically vulnerable such as housing that would allow seniors to age in place and delay or avoid costly – and risky – nursing home care. This kind of investment must part of a comprehensive, coordinated SDOH strategy built around the priorities of the AE initiative and the activities of the AEs themselves. AEs should be part of the discussions on the use of these funds.	EOHHS agrees that for referrals to community resources to be effective in meeting patients' health-related social needs, there must be adequate resources to address those needs. Currently, AEs are required to conduct screenings to identify these needs, and EOHHS understands that AEs are working to refer patients to appropriate resources. The Community Resource Platform is expected to make those referrals easier and to facilitate learning whether and how the patients' needs are met by the referral. To the extent that resources are not adequate to meet the needs, the platform can help identify and quantify the type and extent of these gaps, which can support planning and advocacy

Topic	Focus Area	Comment	Response
			work to increase resource availability.
Sustainability Plan	SDOH and MCO Support	EOHHS continues to recognize the need for "upstream" interventions, but there has yet to be any indication of movement in reinvigorating the state's social infrastructure. Such conversations go beyond even that of the AE Program. ~BVCHC doubts the Health Equity Zones' (HEZ) capacity to support what will be an influx of partnership requests to accommodate the thousands of AE members in need of case support. This is particularly acute for service areas such as Pawtucket and Providence hosting multiple AEs who will rely on the same HEZ constituents. ~Reimbursement for community health services, although recognized by EOHHS, requires further discussion. ~Cuts to community health funding through Cate Transformation Collaborative (CTC) have jeopardized community health teams in the short-term.	EOHHS appreciates commenters' support for broader statewide effort to enhance the state's social infrastructure. While this is not within the HSTP framework, it is valuable to discuss in this context. EOHHS agrees that it will be important to ensure appropriate coordination among AEs that serve patients in the service area of a single Health Equity Zone. EOHHS is committed to supporting Community Health Teams through HSTP in state fiscal year 2021 and through a reimbursement mechanism beyond that point.
Sustainability Plan	SDOH and MCO Support	Neighborhood continues to recommend to EOHHS to be flexible and open to opportunities to identify SDOH in ways other than the labor-intensive screens. Neighborhood has an innovative data-driven approach to identifying and targeting micro-populations with high risk factors for SDOH and poor health outcomes. Neighborhood requests that EOHHS allow use of this information to target populations in need of a comprehensive risk assessment. Neighborhood would like to collaborate more closely with EOHHS to shape the strategy. Neighborhood has provided input regarding the EOHHS SDOH Strategic Plan and requests that MCOs are included as EOHHS' strategic partners in any future planning. Neighborhood applauds EOHHS and HEALTH for recognizing the role of SDOH in health care. However, the proposal would be stronger if the impact of racial biases and inequality in health care were more prominent in the state's vision and	EOHHS appreciates feedback on opportunities to enhance SDOH screening and looks forward to collaborating with MCOs in this area. There are currently no prohibitions to MCOs on sharing their information on micro-populations with high risk factors for SDOH and poor health outcomes and EOHHS encourages MCOs to proactively outreach to their providers and AEs to do so.

Topic	Focus Area	Comment	Response
		approach. To break systemic racism in health care EOHHS will need a determined and focused effort that could benefit from the HSTP resources earmarked under this initiative.	
Sustainability Plan	SDOH and MCO Support	We agree with EOHHS on their proposal to include community investments in the numerator of the MLR calculation. We recommend EOHHS allow MCOs maximum flexibility in determining community investments and ensure broad inclusion of these investments in the numerator of the MLR, inclusive of investments that influence socioeconomic factors that affect populations/communities and are intended to impact quality. We also encourage EOHHS to continue to provide MCOs flexibility to target community investments to activities that may not be measurable at the individual level, but rather may result in the creation of additional community capacity and/or access to public social services and support (e.g., affordable housing; subsidies). Such investments can positively impact a community and population's health, drive down medical spend, and should count toward the MLR numerator. We encourage EOHHS to develop an investment framework and implement clear investment criteria to make certain investments are aligned to state priorities and that meaningful long-term relationships are curated. MCOs should be encouraged to make voluntary community investments but should not be penalized should they be unable to do so. Instead, EOHHS should consider providing incentives for MCOs to use profits toward community investments. For example, North Carolina incentivizes MCOs to make community investments by tying investments to member assignment. MCOs who voluntary elect to invest in the community receive preference in auto assignment over those who did not. To validate investments are done meaningfully, investments should be required to meet EOHHS's Quality Strategy standards to be eligible for incentives. We encourage EOHHS to explore incentive opportunities to promote community investment activities and welcome the opportunity to discuss other incentive examples from other states. To establish a	EOHHS appreciates the support for the idea of including SDOH investments in the numerator of the MLR. EOHHS agrees with the need to develop guidance to ensure that this is implemented for appropriate activities, with the aim of providing flexibility while preserving oversight. EOHHS also expects that MCOs will work with AEs in developing their investment strategies. EOHHS appreciates the support for different options to incentivize MCO investment in SDOH. EOHHS also notes the existing (new in 2020) waiver authority that is similar to Hawaii's tenancy supports, known as Home Stabilization.

Topic	Focus Area	Comment	Response
		sustainable, scalable funding stream for SDOH initiatives, EOHHS should consider maximizing their use of federal waiver authority. Hawaii: Uses 1115 waiver to fund tenancy supports. • North Carolina: Uses 1115 waiver to pay for social services in key SDOH domains: housing, food, transportation, and interpersonal violence (IPV).3	
Sustainability Plan	SDOH and MCO Support	Social Determinants of Health – We agree with EOHHS' vision that in order to achieve accountability for quality and total cost of care, significant actions must be taken to address the social determinants of health. Please refer to our previously submitted comments as part of the Health System Transformation Project Social Determinants of Health Investment Strategy.	
Sustainability Plan	SDOH and MCO Support	For strengthening clinical—community linkages, we support the inclusion of the MCOs for data management and potential use of MCO shared savings investment. We recommend including a role for the Health Equity Zone (HEZ) as a backbone for strengthening investment in building community solutions. We recommend outlining the key roles Accountable Entities have in building both community linkages and community solutions so their work on Rhode to Equity is not seen as "extra work".	EOHHS appreciates the importance of involving MCOs in developing clinical-community linkages, and also expects the HEZ to have an important role in this work. EOHHS believes that the Rhode to Equity can help AEs pursue their work towards building clinical-community linkages, and also will seek to ensure that those AEs that participate in Rhode to Equity are supported in doing so.
Sustainability Plan	Multi-payer Policies	…is a positive development and we agree with the following statement from the document: Most AEs receive a significant share of patient volume through Medicaid, but also have commercial and Medicare patients. To the extent that incentives, policies, and funding priorities are aligned across payers, EOHHS expects that AEs will be better able to leverage resources to serve their full patient population. Page 30	EOHHS appreciates the support for multi-payer initiatives and looks forward to working with commenters to consider how AE goals can be applied to other populations.

Topic	Focus Area	Comment	Response
		To the degree innovation can be advanced across all payers and all patient populations, change is easier to implement. At the same time, systems of care must have the flexibility to respond to the varying needs of different populations under contract. We would be eager to work with EOHHS on coordinating the expansion of AE goals etc. to other patient populations. For this to be successful at the provider level and with systems of care, AEs and their sponsor organizations need to be a part of the conversation.	
Sustainability Plan	Multi-payer Policies	Regarding section E under sustainability, it is unclear whether EOHHS is suggesting that certain measures to increase funding of ACOs/AEs be adopted by all relevant payers or whether OHIC should have expanded authority to require adoption of the affordability standards for Medicaid. It would be helpful to have clarification on this point.	EOHHS seeks to work with OHIC to consider ways that AEs can be supported by non-Medicaid payers, not to expand OHIC authority to cover Medicaid payers.
Sustainability Plan	Multi-payer Policies	We recommend taking a multi-payer approach that is additionally aligned with OHIC for strengthening the "clinical side" and providing payment for comprehensive primary care (which includes nursing, pharmacy, behavioral health (BH) care management, and community health teams (CHTs)). Value-based payments that are only based on total cost of care performance is inadequate to transform primary care. It is important for Medicaid and the MCOs to lay the groundwork and move quickly to pre-payment for primary care services (comprehensive primary care capitation) in concert with efforts from OHIC. This will help practices reach a desired threshold of 62% of attributed patients under capitation and maximize the care delivery workflows to support success.	EOHHS appreciates the support for primary care capitation.
Sustainability Plan	Ongoing Planning	EOHHS proposes going beyond common standards, including expanding funding sources like PCMH as described below. The Affordability Standards require commercial plans to contribute to patient-centered medical homes, on a per-member-per-month basis. Currently, MCOs are not required to make these payments for adult (i.e., non-pediatric) practices that have graduated from the Care	EOHHS appreciates the recognition that further alignment with OHIC Affordability Standards may support AEs in sustaining programs. EOHHS understands that these changes would not, in themselves,

Topic	Focus Area	Comment	Response
		Transformation Collaborative PCMH program. However, if in the future they did contribute, AE practices would be able to use payments from commercial and Medicaid insurers to create and sustain programs that serve more of their patients in the same program. Similarly, EOHHS may explore the potential for alignment with OHIC standards for requiring that a certain share of spending be for primary care. This would also increase overall support for AEs… [Emphasis added] Page 30 Again, we applaud the desire of EOHHS to find ways to provide the resources require for robust care management programming, we are concerned that, once again, EOHHS is finding ways to modify the current system and avoiding the fundamental change of adopting a population-based payment system. Measures like that described above may provide temporary, or transitional, funding flexibility but they are not substitutes for fundamental reform.	transform the care delivery system to a population-based payment system. As noted elsewhere, EOHHS supports AEs and MCOs that are ready to adopt this type of payment arrangement.
Sustainability Plan	Health Equity Challenge	CTC-RI strongly supports expansion of the HEC as a component of the effort to provide more centralized infrastructure and more effectively address social determinants of health. The proposed HSTP investment in the expansion of the HEC needs to include funding to support team participation and team coaching support. It is additionally recommended that the work plan include a focus on obtaining "lessons learned" from the 2 existing teams and identify what is needed to successfully implement action plans during Phase 2 action labs. Most communities have practices from more than one AE. The HEC should recognize this and encourage coordination between the multiple AE practices along with the CHT/HEZ and MCOs. From our experience in PCMH transformation, we recommend establishing common standards, goals, metrics across all CHTs; having infrastructure payment and incentive payments for meeting goals, together with a learning community and data management system for reporting metrics.	EOHHS appreciates the support for and feedback on the expanded Health Equity Zone/ Rhode to Equity. EOHHS agrees that this initiative will require funding for team participation and coaching support. EOHHS agrees that it will be vital to consider lessons learned from the existing HEC teams. EOHHS agrees that the Rhode to Equity will need to encourage coordination among AEs that work in the same area as a single HEZ. EOHHS expects that the Rhode to Equity may support development

Topic	Focus Area	Comment	Response
		We advocate for a strategy to address a mechanism whereby all Medicaid patients have access to CHTs and strategy for ensuring that children, families are included in having access to CHTs.	of common standards, goals, and metrics across CHTs, but this has not been determined and may not be a core element of the project. EOHHS agrees that CHTs are a valuable resource; Rhode to Equity is not intended as a major development or funding source for CHTs, but rather an opportunity to bring CHTs together with other team members to enhance collaborations.
Sustainability Plan	Other	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.	EOHHS appreciates the recommendations to consider creative policies such as clinical decision support tools. Increasing cost-sharing is a complex issue due to the need to protect patients from costs. However, EOHHS supports AE efforts to educate providers about the different costs associated with different sites of care.
Sustainability Plan	Other	In thinking about collecting data on AE budgets for evaluating sustainability, we encourage EOHHS to think about timing. If this information is being collected for PY4 certification, it will presumably take at least a year for EOHHS to analyze the budget information and propose a resourcing plan for AEs. Until that plan is in place, HSTP will remain the primary source of funding for AE operations; can EOHHS commit to level funding HSTP incentive dollars through PY5?	EOHHS does not expect that it will take a year to analyze information on AE budgets provided in the spring of PY3. Budget information is valuable to EOHHS efforts to consider funding needs following the exhaustion of HSTP funds.

Topic	Focus Area	Comment	Response
			EOHHS currently expects HSTP funds to be available through June 30, 2024 (which would be Program Year 6) and, incentive funds will be incrementally decreased annually starting in PY4.
Sustainability Plan	Other	We request consideration of a technical adjustment to a sentence on page 35 where the following language discusses primary care capitation: "Therefore, EOHHS plans to explore how primary care capitation and other alternative payment methods could be used to reimburse for services without requiring fee-for-service billing." We believe that capitation (partial or full) arrangements can result in administrative simplification for primary care providers, though careful consideration should be given to implementing in a way that avoids losing access to data necessary to track utilization activity and for risk score calculation.	EOHHS agrees that it will be important to implement primary care capitation in a manner that does not adversely affect data on utilization that supports care management and risk adjustment.
Sustainability Plan	Other	Key Role for Practice Facilitation We agree with the emphasis on best practice sharing and strongly support the comments noting the cost effectiveness of practice facilitation support for providers as a way to share best practices and support change efforts at the practice level. Having led the way in this practice over 10 years, we want to add that this approach is not only cost-effective but also highly effective.	EOHHS appreciates the support for practice facilitation as a mechanism to share best practices.