Executive Summary

After soliciting stakeholder input on the HSTP Social Determinants of Health Investment Strategy, which was posted for public comment on August 17, 2020, EOHHS received 17 formal responses, representing accountable entities, managed care organizations, community-based organizations, consumer advocates, state agencies, and private citizens. Several themes emerged from stakeholder comments, and EOHHS has made edits to the Investment Strategy document to amend or clarify our approach, as summarized here:

- Stakeholders resoundingly agreed in principle that addressing social determinants of health is necessary to impacting health outcomes of AE populations. Some stakeholders requested EOHHS broaden the plan to include:
    - More emphasis on inequity and structural racism
    - More attention on children and families
    - More inclusion of BH/DD

  EOHHS agrees with each of these suggestions and amended the Investment Strategy document to more clearly identify how the investments will address each of them. Further, EOHHS and RIDOH will take steps to embed these priorities as we approach procurement and implementation.
- Some stakeholders pointed out that a $3.5M investment that is oriented toward reforms within the healthcare system is not sufficient to yield the system-level changes needed to reverse inequities and structural disadvantages that are borne by our members. EOHHS agrees; this plan is not the state's only approach to social determinants of health. Rather, this is an attempt to direct a finite investment to support a trajectory of change within the healthcare system – to foster better coordination with CBOs and engagement in community-level approaches to improve underlying conditions. EOHHS is also committed to engaging in more global policy making above and beyond this time-limited investment. The Investment Strategy document has been updated to add clarity on this point.
- Some commenters expressed concern about the implementation burden that these initiatives place on AEs. EOHHS is sensitive to this concern, and added clarifying language to link these investments back to the existing AE program requirements relating to social determinants of health, to demonstrate that the intent of these initiatives is to direct centralized investment in resources that will enable AEs to meet requirements and impact their members' health outcomes and cost.
- Many comments expressed uncertainty about the notion of AE-HEZ coordination, since HEZs are place-based by design, and the majority of AEs are geographically spread out and overlap with each other. EOHHS recognizes that this difference in geographic design means that one-to-one partnerships where each AE partners with a single HEZ and each HEZ partners with a single AE are unlikely to work well, and acknowledges that we do not yet know the most effective way for a HEZ and an AE to work together. The Investment Strategy document has been amended to clarify the rationale for AE-HEZ partnership and focus on the Rhode to Equity as a specific project that

provides some structure and technical assistance to support a fruitful and data-driven engagement and grants flexibility to participants to assemble a geographically focused team in the configuration they find best.

- Some commenters also expressed uncertainty regarding the intent of the Rhode to Equity project, citing ambiguity in the purpose of collaboration and in the desired outcome. The Investment Strategy document has been updated to clarify that while the Rhode to Equity will enable participants to select one concrete outcome to focus on, the core intent of the Rhode to Equity learning collaborative is for participants to develop the organizational capacity, skills, and relationships needed to address systemic barriers to health.
- While stakeholders are in consensus around the value of community health workers and community health teams, many commenters emphasized the need for a sustainable funding mechanism that adopts principles of value-based payment. EOHHS agrees and added detail in the Investment Strategy document to better articulate the planned approach to payment methodology and sustainability.
- EOHHS received conflicting feedback regarding the proposed investment in a Community Resource Platform. Many stakeholders supported the project as foundational to enabling standardized communication and referrals, centralized measurement of SDOH needs and referral outcomes, and shared understanding of CBO capacity. Stakeholders also articulated desired aspects of a CRP platform. Other stakeholders expressed concern about EOHHS' ability to effectively implement this platform and skepticism about prioritizing such a project over establishing financing mechanisms and capacity development for social services. EOHHS has retained this investment in the strategy and amended the Investment Strategy document to acknowledge that the financing for services rendered by CBOs has not yet been addressed. EOHHS also amended the Investment Strategy document to further explain that this piece of HIT infrastructure will support AEs' and CBOs' ability to understand how services are rendered and navigated and use these findings to support plans and proposals for appropriate financial support for this work.
- Most comments on the Participatory Budgeting project were directionally supportive, but stakeholders broadly requested more detail on the initiative. EOHHS acknowledges that the Investment Strategy document does not provide a deep level of specificity and did not edit the document to include more detail, quite simply, because EOHHS does not know yet how this initiative will be implemented. EOHHS retained this project in the Investment Strategy document to memorialize our commitment to directing funds and decision-making power to communities and will spend time in the coming months to devise an implementation plan, in consultation with AE program stakeholders.

Stakeholder Comments and EOHHS Responses

Topic	Comment	Response
Vision	We agree whole heartedly that tackling social determinants is key to moving the needle on better health outcomes. Numerous case studies and the examples of other countries prove the effectiveness of this strategy. However, although your plan recognizes this connection, it offers little in terms of significant tangible investments ($3.5M + participatory budgeting investment of unknown $) to address underlying social determinants.	EOHHS appreciates the support for the goal of addressing social determinants. EOHHS recognizes that the investment dollars available are limited in the face of the substantial needs experienced in Rhode Island communities. HSTP funding is available for restricted purposes, centered on "the establishment of Accountable Entities." Within this mandate, EOHHS seeks to invest in AEs' capacity to work in their communities to address social determinants, as well as to invest in data collection that will enhance AE and community advocacy related to social determinants.
Vision	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 two 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. A broader multi-payer and multi-sector programmatic and funding strategy will allow for greater long-term equity and sustainability.	EOHHS agrees that children and families deserve attention. AEs care for large numbers of children and their families, and EOHHS has included a number of quality metrics specific to children and adolescents in the program. The SDOH Investment Strategy encourages collaboration among AEs and CBOs, including CBOs that serve children and families. In particular, EOHHS expects that in the context of the Rhode to Equity, the HEZ team member can help identify appropriate community health needs on which to focus, which may include children and families. EOHHS agrees that AEs may focus on members whose immediate health costs can be mitigated through the AEs' efforts and that these members are more likely to be adults with chronic diseases. The Investment Strategy is intended to encourage AEs to collaborate and engage in their communities in a way that is broader and more long-term than the AEs' other work to impact annual total cost of care.
Vision	Unsure of how the AEs can best partner with the HEZs. Many AEs are statewide. Challenge with a HEZ model that is geographically limited. We believe it will take further	The Rhode to Equity project is intended to allow AEs to collaborate in a geographic area with a single HEZ, rather than

Topic	Comment	Response
	consideration to determine the best way to achieve alignment so as not to overburden the AEs, the HEZs, or the partner agencies. Also concerned about the duplication of efforts. Recognize that the AEs are still under development. Reallocation of significant funding to AEs instead of directly to Thundermist for frontline activities to address social determinants of health feels premature. Should funding go directly to the AEs, we would hope for a guarantee of level or increased funding through this funding mechanism to protect our service delivery and access for patients.	expecting the HEZ to work with multiple AEs on separate projects. EOHHS intends to ensure that resources are made available commensurate with the work different entities are asked to undertake, recognizing that due to federal requirements, HSTP funds must support "the establishment of Accountable Entities." This does not mean that all funds must be given to AEs but does create constraints.
Vision	We commend EOHHS for solid vision, strategies and seed infrastructure to advance SDoH solutions, believe that such efforts should be closely aligned with future-state enhancements to the AE program. A key enhancement to the program is to support greater alignment and partnerships between AEs and MCOs of choice to enable SDoH investment. Such partnerships may achieve the necessary scale with member assignment support from EOHHS to allow attributed patients to remain with their PCP and avoid continuity of care disruption. Higher scale of attributed patients to a single AE/MCO relationship provides a platform for SDoH investments that can be sustained beyond the HSTP seed infrastructure.	EOHHS appreciates this feedback.
Vision	Applaud 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 approach. To break systemic racism in health care EOHHS will need a determined and focused effort that could	EOHHS agrees that it is vital to recognize and eliminate racial biases and inequality in health care and has added language to the SDOH Investment Strategy to describe how this is built into the proposed investments. EOHHS also looks forward to engaging with stakeholders to ensure that this lens is applied to all program development under this Investment Strategy.

Topic	Comment	Response
	benefit from the HSTP resources earmarked under this initiative.	
Vision	We request that the HSTP SDOH Investment Strategy proposal explicitly identify the relationship between SDOH and the behavioral healthcare and developmental disabilities systems. We believe that it helps to underscore the inextricable links between SDOH, behavioral healthcare conditions, and services for people with intellectual/developmental disabilities, as too often these care systems are treated separately and as though they are defined and impacted by a different set of factors with origins in different societal challenges. We request that EOHHS and its partners in the HSTP SDOH Investment Strategy prioritize how the proposed investments and future interventions will consider the complex care and treatment needs of individuals with intellectual/ developmental disabilities or behavioral health challenges or conditions. Our individuals often have concomitant health needs that must be considered together to ensure that they receive effective care. Maintaining flexibility in the interventions funded through the investment areas-and avoiding prescribed healthcare approaches-will ensure that these interventions are person-centered and adaptable to individuals with intellectual/developmental disabilities and behavioral health challenges.	EOHHS agrees that it is vital to ensure that individuals with behavioral health needs and/or developmental disabilities are fully able to access services intended to address SDOH/ health-related social needs, and that approaches to addressing SDOH/ health-related social needs consider the specific needs of these populations. EOHHS has revised language in the Strategy to better communicate this important point. The SDOH Investment Strategy is intended to support these connections. First, the Strategy proposed continued support for Community Health Teams - which each include a behavioral healthcare provider. Second, EOHHS anticipates that behavioral healthcare providers and developmental disability service providers will be able to access the Community Resource Platform to refer patients to CBOs, and that DDOs will be able to receive CRP referrals for non-treatment community services. Finally, EOHHS expects that the Rhode to Equity will encourage development of deeper connections with behavioral healthcare and developmental disability service providers.
Vision	Placing the HEZ work prominent in the strategy is important. I highly recommend you obtain feedback from RIHCA to gain the FQHC perspective. I do not believe you	EOHHS appreciates the importance of obtaining feedback from all stakeholders. EOHHS appreciates the support for the upstream, midstream, and downstream framework.

Topic	Comment	Response
	can just rely on the AE organizations for feedback as it pertains to RI's FQHCs. While PCHC and BVCHC are stand-alone AEs, IHP represents 6 independent FQHCs and 3 independent CMHCs. Only obtaining AE feedback on such important work and not directly obtaining feedback from the individual FQHCs will diminish the impact of the sustainability strategy as well as the full implementation of the approach. The framework for upstream, midstream, and downstream make the system transformation you articulated very understandable. Explaining these concepts to a broad audience using this model will make the approach more viable and consistent with other healthcare transformation approaches. I encourage you to also see Rishi Manchanda's work that might make it easy to bring others onboard with these concepts- (https://healthbegins.org/ [healthbegins.org]; http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/Rishi-WhatIsAnUpstreamist.aspx [ihi.org]).	
Strategy	We strongly urge EOHHS to focus their strategy around large-scale, statewide, coordinated investments, and to try to avoid the temptation to simply delegate these investments to private entities (whether they are health systems or community organizations). Only EOHHS has the reach, funding, and mandate to make changes far enough "upstream" to have a transformative impact on SDOH. Also strongly recommend that EOHHS work with other players in the health care system, including managed care organizations and the Office of the Health Insurance Commissioner, to ensure that statewide investment in	EOHHS agrees that action at the statewide level will have the most significant impact on upstream SDOH. EOHHS also believes that investments to increase the capacity of non-state actors to engage in upstream issues and advocacy is worthwhile. EOHHS agrees that multi-payer approaches can be particularly effective and expects to work with the Office of the Health Insurance Commissioner and managed care organizations in the coming months and years to maximize the impact of EOHHS' SDOH work. EOHHS looks forward to learning from the initial progress of the SDOH Investment Strategy in order to ensure that the state can make appropriate adjustments.

Topic	Comment	Response
	addressing SDOH is not limited to Medicaid. Only a truly comprehensive approach, that allows systems of care to think about how to address SDOH across payers, will be able to be successful. While we believe that the strategy needs to "think big," we also recommend EOHHS not overlook the value of "starting small."	
Strategy	The proposed HSTP proposal invests heavily in "coordination of care" through Community Health Teams (CHT) and implementation of an IT Information & Referral Platform. We encourage you to think and act more boldly.	EOHHS agrees that the Investment Strategy includes a strong focus on coordination of care through CHTs and implementation of an IT solution to improve referrals between AEs and CBOs (as well as among CBOs). The Strategy also invests in Rhode to Equity, a major project to enhance relationships and collaboration among AEs, HEZs, CHTs, and individual community members, and participatory budgeting. EOHHS recognizes that there have been few details about participatory budgeting and looks forward to working with stakeholders to develop this part of the strategy.
Strategy	The Investment Strategy should encourage collaboration between AEs. While there is incentive for an AE to coordinate with HEZs whose areas cover the patients of the AE, there is currently less incentive for AEs to work together on projects. Many large-scale projects (such as housing) to have a meaningful impact, the investment of a single AE will likely not be enough. consumers will be best served by a model that does not result in losing access to SDOH support simply due to a change in PCP (or, in some cases, their PCP moving from one AE to another). SDOH investments should be able to serve consumers regardless of their AE or source of coverage.	EOHHS agrees that AE collaboration, particularly in geographic areas served by multiple AEs, is appropriate. The Rhode to Equity project is intended to allow AEs to collaborate in a geographic area, in recognition of this issue. EOHHS agrees that members should not lose support for social needs due to a change in their AE attribution. By enhancing the capacity of all AEs to work with CBOs to provide these services for patients, EOHHS expects to minimize the impact of changes in AE attribution. EOHHS also looks forward to working with other state agencies to develop multi-payer approaches to addressing SDOH.
Strategy	Concerned about additional funding being distributed thru the HEZs into the community. Agree that community input	EOHHS appreciates this information, which is very helpful, and looks forward to working with HEZs and other stakeholders to

Topic	Comment	Response
	is imperative to health equity, concerned about the unintended conflicts of interest that are created when the backbone agency is also an agency seeking funding from the HEZ. We are also concerned about the conflicts that may be created between other partner agencies. We believe this warrants further consideration and discussion.	ensure that any funding mechanisms, including for participatory budgeting, are implemented appropriately in light of potential conflicts.
Strategy	Shared standards and best practices for the collection of SDoH data. In order to leverage SDoH data across the care delivery system, standards should be established for the collection of SDoH data. Additionally, effective collection requires a high degree of cultural/ linguistic competence and empathy as patients are often reluctant to share such sensitive information, particularly due to a sense of fear or humiliation when seeking social services. Such fears are particularly pronounced within immigrant communities who have been most impacted by the recently-enacted Federal administration's "public charge" rule.	EOHHS agrees that collecting SDOH data requires cultural/linguistic competence and empathy and believes that resources provided through HSTP and/or through MCOs can be leveraged to gain appropriate staff training. EOHHS looks forward to continued stakeholder engagement regarding the need for and best approach to standardization of data collection.
Strategy	Encourages EOHHS to extend the SDOH investments and responsibilities with providers beyond the AEs. Neighborhood is extremely concerned with the additional time and burden placed on the AEs and their providers given the AEs focus and commitments for Year 3 is in place through the HSTP Project Plans. The addition of this significant undertaking will likely distract and diminish the time needed by the AEs and MCOs to focus on opportunities to identify and work on cost savings opportunities. Distracting our ability to realize the quality and savings goals of the program.	EOHHS appreciates that AEs and MCOs are working hard and devoting considerable time to HSTP endeavors, and notes that the SDOH Investment Strategy does not require that AEs change or add to these activities. Rather, it is an effort to support existing AE work, including engagement with CBOs and local communities through the HEZ.
Strategy	Encourage EOHHS to build out its investment strategy further and develop a framework that outlines the various	EOHHS appreciates feedback regarding the need to coordinate with other state agencies, and in particular suggestions

Topic	Comment	Response
	state agencies they intend to coordinate with (i.e., public housing agencies) and expectations of these relationships. As different agencies have different priorities and goals, outlining expectations will be critical to getting stakeholder buy-in for coordinated care. For example, data sharing between key systems and Managed Care Organizations (MCOs) such as public housing agencies and Continuums of Care can help identify shared membership and improve organizational capacity and the ability to address SDOH. Also, EOHHS should consider convening a working group that includes AEs, MCOs, and any other agencies or organizations EOHHS intends to leverage and integrate feedback fully. We request EOHHS provide additional guidance on how HSTP funds will be spread across the proposed initiatives, including how they will be split amongst Accountable Entities (AEs) and community-based organizations (CBOs), and how EOHHS intends to fund services long-term once HSTP funds are expended. We are concerned that the limited funding could be spread too thin to have any significant impact. We recommend EOHHS reexamine the proposal and focus on the most meaningful and impactful spread of funding, including limiting the number of funded initiatives.	regarding potential coordination among such agencies and MCOs. EOHHS expects to connect with other state agencies and MCOs in this way as opportunities arise. EOHHS expects to share more information about the distribution of funds across projects in the coming weeks and is sensitive to the need to ensure that each project is funded adequately to achieve its goals.
Strategy	This is a strong approach that can be enhanced. The press of time, the short timeline of HSTP funding, and the massive undertaking to transform a system of care to address the SDOH challenges that have been around for decades can move planners and policy makers to take a simpler and more manageable approach. I encourage you to think boldly and to take time to build a broader	This document is part of a broader and longer-term statewide commitment to addressing SDOH and ensuring strong inter-agency collaboration - including between EOHHS and BHDDH. EOHHS expects that giving AEs tools to enhance their engagement with their communities will be an investment in the future work made possible through this engagement.

Topic	Comment	Response
	coordinated planning structure to really lay out a sustainable course of action so this does not fulfill the skeptics' voices that the waiver and HSTP initiative is merely a federal money-grab. I believe it can and should be more.	
Metrics & Timeline	A set of performance metrics should be established to monitor SDoH processes and outcomes across AE program participants. Such metrics may include, but limited to: o Subpopulation analysis across major SDoH markers (e.g., % of members screening for food insecurity) and corresponding TCOC to measure overall impact cost through SDoH interventions o Referral analysis to determine subpopulation with a referral in place o Case status to determine referral effectiveness o Health disparity dashboards by AE to determine quality metrics by race/ ethnicity, in order to inform culturally-oriented population health interventions.	EOHHS agrees that it is vital to examine SDOH markers across a population, analyze referrals, and measure health disparities and the effort to reduce them. EOHHS has not established system-wide metrics at this time, but seeks to facilitate AE and MCO work in these areas, for example through the development of a Community Resource Platform (e-Referral platform) that can assist AEs and others in understanding health-related social needs as well as the outcomes of referrals to address those needs. Measuring health disparities by AE is currently a challenge due to data gaps. However, EOHHS is aware that this is already a priority for AEs and MCOs and is actively working on approaches to improve and incentivize collection of race and ethnicity data.
Metrics & Timeline	The proposal would greatly benefit from clearly articulated metrics. Metrics will inform and help to define the true purpose of each proposed investment. EOHHS should rely on quantifiable and measurable metrics instead of process measures, which tend to be more subjective. Neighborhood recommends adding an overall project timeline to understand when EOHHS intends on starting and ending each investment.	EOHHS intends to provide more detailed project timelines and appreciates this feedback. In addition, EOHHS agrees that each project must be properly evaluated.
Metrics & Timeline	EOHHS should work with members, AEs, CBOs, and MCOs to develop a standardized screening tool to capture priority SDOH elements such as housing, transportation, food insecurity, and interpersonal safety. Also, member	EOHHS appreciates the recommendation to standardize SDOH screening and mechanisms to capture key member data and preferences. Historically there have been significantly differing

Topic	Comment	Response
	preferences, including self-identified race and gender, primary language, preferred communication method, and other key factors, should be captured. EOHHS can require AEs, MCOs, and CBOs to use this screening tool to enable a shared understanding of a member's most critical social needs and individual care preferences. Improving SDOH data accessibility will allow for appropriate program coordination and linkages across an individual's whole experience. Targeting state resources to bring consistency to SDOH data collection and storage methods across social service programs and enabling the collection of enough information will allow testing interventions and predictive analytics to target individuals' limited resources based upon combined needs.	views on this matter from different stakeholders. EOHHS looks forward to continuing this conversation with all stakeholders.
Scope & Priorities	Contractual and service level agreements should be established with community-based organizations rendering SDoH services and resources. MCOs play an important role, and bring the know-how to establish such agreements, leveraging similar structure in place provider networks. Agreements may include reimbursement terms, turnaround times for completing SDoH referrals, and data exchange, among other terms.	EOHHS encourages AEs and MCOs to work together to establish effective partnerships with CBOs.
Scope & Priorities	Recommend eliminating 2-3 of the proposed investments to reduce the participation and implementation burden on the AEs. The proposal fails to include the funding EOHHS is allocating to each investment, which would assist in understanding potential priorities. Neighborhood recommends launching, learning and evaluating: Rhode to Equity and Community Health Teams (CHTs). Further, we	EOHHS recognizes that the lack of specific funding details makes it more difficult to understand priorities and looks forward to providing more detail in the coming weeks. EOHHS understands the recommendation to focus more narrowly and intends to ensure that each effort is funded appropriately upon being launched. EOHHS notes that AEs are not required to participate in any program in the strategy. EOHHS intends to engage with

Topic	Comment	Response
	recommend the development of CHTs managed directly by providers and AEs.	stakeholders to develop the most effective approach to CHT sustainability and efficiency.
Scope & Priorities	We recommend considering behavioral health-related concerns, issues, and challenges. In particular, alcohol-, tobacco-, and vaping-related projects could provide a strong platform for community-driven, place-based strategies that improve long-term health outcomes and prevent tobacco addiction. Further, Rhode Island's Regional Prevention Coalitions may also prove to be valuable partners in addressing issues of alcohol and other substance use. Prevention Coalitions have statewide reach and strong community infrastructures that Health Equity Zones and community-based organizations can leverage for greater reach.	EOHHS appreciates the recommendation to leverage Rhode Island's Regional Prevention Coalitions as important partners in addressing alcohol and other substance use issues. EOHHS will ensure that AES in general and Rhode to Equity teams in particular are familiar with Prevention Coalitions and aware of the opportunities for partnership. EOHHS and RIDOH welcome the opportunity for the Rhode to Equity teams to address BH and SUD related concerns, and if they do so, would be expected to engage with appropriate behavioral health partners.
Rhode to Equity	• No clear objectives other than to promote undefined improved outcomes. • Unclear how collaboration will yield any positive impact beyond what AEs already accomplish in existing relationships to refine referral channels. • AEs have very little power or resources to foster system-wide supports...fearful that these efforts will simply add administrative burden to work already performed while expending resources that may admirably institute small-scale projects (i.e. one-time community screens) without addressing systemic difficulties wrought by poverty. • Language used to describe Rhode to Equity appears to perpetuate a vague call for “collaboration” that ultimately confines solutions to symptoms, not the	The intent of the Rhode to Equity learning collaborative is for participants to develop the capacity, skills and relationships needed to address systemic barriers to health. EOHHS has added clarifying language to the Investment Strategy on this point. EOHHS has not defined specific health outcomes expected to come from the Rhode to Equity because Rhode to Equity teams will choose which outcomes they will pursue. Those decisions will be made with the support of subject matter experts and the MCOs. Collaboration among Rhode to Equity team members is expected to go beyond “contracting to address individual social needs,” to encompass development of place-based solutions to SDOH issues. As EOHHS has stated in public meetings, AEs are not expected to solve these problems alone, but are expected to play a role in solving these problems alongside other stakeholders in the community.

Topic	Comment	Response
	problem itself. There is a danger of overwhelming CBO and HEZ capacity • Relatively tight geographic overlap of the AEs inevitably leads to several AEs contracting with the same CBOs and HEZ organizations. • EOHHS' acknowledges need to address "upstream" factors, yet there remains a large degree of political inertia to truly tackle systemic barriers such as limitations to SNAP benefits, lack of affordable housing, and lapsing public education constructs among Rhode Island's upcoming generation. Rather than move large-scale solutions into the hands of participants who can only address smaller scale symptoms, BVCHC first recommends EOHHS share with stakeholders current legislative and administrative plans to address "upstream" factors so that Rhode to Equity collaborations can launch from known efforts to make statewide change.	EOHHS understands the need to limit any administrative costs associated with this optional program. EOHHS recognizes that more than one AE may have a significant number of patients in the geographic area of a single HEZ, and therefore the Rhode to Equity program will permit flexibility on the number of AEs that participate with one HEZ on a Rhode to Equity team. EOHHS acknowledges that both policy and legislative efforts must be made to fully address upstream factors and is engaged in several different efforts outside of HSTP. EOHHS is leading an Equity Council that discusses and makes recommendations related to upstream factors in the context of COVID-19, and there are regular EOHHS-level discussions on equity beyond Medicaid and across the Secretariat. EOHHS has also participated in the Governor's efforts to invest resources in housing, through a dedicated funding stream, bonds, and revamped governance structures. EOHHS will continue to demonstrate quantitatively the opportunity for Medicaid cost savings to make the case for meaningful investments in housing. EOHHS can certainly look into having EOHHS present and discuss strategies as it pertains to this topic as part of a future AE Advisory Committee meeting.
Rhode to Equity	**Lack of Geographic Coverage**: What happens in the Rhode to Equity model when no single AE has a substantial population in a given geography—for example in rural areas, higher-income areas with pockets of poverty, or geographies with high proportions of uninsured residents? There a risk of exacerbating inequities in this case, and we encourage EOHHS to step in with strategies to mitigate this risk.	Rhode to Equity is intended to foster strong community-clinical linkages among AEs, HEZs, and CHTs. For this reason, Rhode to Equity teams will do their work where these team members are located. This will also allow participants to explore how multiple AEs can effectively collaborate with a single HEZ in a particular, shared geography. EOHHS understands that there will not be teams covering every part of the state. However, EOHHS appreciates the feedback that it will be important to pay

Topic	Comment	Response
	Consulting Resources: Recommend that EOHHS defer specifying that Wellbeing and Equity in the World will act as the consultant and facilitator for all initiatives under the Rhode to Equity strategy. Integra suggests that an open procurement process could result in a broader set of options to facilitate focused health equity engagements under this strategy. Potentially EOHHS could pre-approve multiple vendors and allow groups to choose consulting services that are best suited to their needs and scope. **Solutions Beyond Zip Code**: Many adverse social determinants of health are concentrated geographically—but the solutions to unequally distributed conditions may be more effectively addressed in ways that are not hyper-local. E.G.: people experiencing homelessness may congregate or reside in specific locations as a downstream consequence of policy and economic conditions—but sustainable solutions require (at least) statewide engagement to address those conditions at their roots in budgets, employment policy, behavioral healthcare access, service coordination, etc. Integra suggests allowing for the possibility of one or more "Rhode to Health" convenings that are defined by subject matter as opposed to geography. To extend the example, a working group on housing and homelessness could follow a similar, focused format, and allow for HEZ(s) to participate, without restricting the scope to a given ZIP code.	attention to which places do not have the focus of a Rhode to Equity team and will actively consider this during the project planning process. EOHHS plans to leverage current Department of Health vendor contracts to prevent delays in implementation and to purposefully build upon the current work, experience, and lessons learned to date through the Diabetes Health Equity Challenge. The vendors for this optional program will therefore continue to be the Care Transformation Collaborative and Wellbeing and Equity in the World. EOHHS understands the value of statewide work, especially around large policy issues that require state-level action. The Rhode to Equity is a place-based program intended to support AEs and HEZs in local collaborations.
Rhode to Equity	Coastal Medical remains supportive of the work of the Health Equity Zone (HEZ) organizations throughout the State as well as furthering the goals of achieving health	One significant aspect of future AE-HEZ collaboration will be the Rhode to Equity project. This project will provide a context through which AEs can work with a HEZ serving a region where a significant share of the AE's patients' lives and collaborate with

Topic	Comment	Response
	equity for all individuals through engagement with Community Based Organizations (CBOs) and HEZ groups. Coastal Medical would like to have a clearer view of how the collaboration between Accountable Entities (AEs) and HEZ organizations would be accomplished. Some of the concerns we have are around the often narrow focus that many of the HEZ groups have, as well as an effective way in which to identify and partner successfully with the HEZ groups. As Coastal Medical has patients within every HEZ geographical location, and as there are several AEs within Rhode Island, Coastal would like to learn more about how AEs and HEZ groups can pair up in the most efficient way, without overwhelming the organizations. Coastal is also concerned with adding excessive administrative burden during the process for both our own AE as well as for the community organizations.	that HEZ to identify health outcomes and social needs that can be jointly addressed. EOHHS appreciates the feedback that it would be helpful to provide more guidance to AEs and HEZs to facilitate pairings and will take this into consideration in planning the project in more detail.
Rhode to Equity	Recognize the importance of learning collaboratives and sharing best practices. Can you provide further detail as to time and resource commitments and clear goals and deliverables during and post participation? As mentioned, we have limited resources as well as would want to allocate and bring forth appropriate subject matter expertise in an efficient and effective manner.	Over the next six months, EOHHS and RIDOH will be planning the Rhode to Equity program and will bring comments regarding resource constraints into the design process. While the exact time commitments are not known, and EOHHS and RIDOH expect that teams may allocate resources differently from one another, it may be helpful to note that in the current Diabetes Health Equity Challenge, teams allocated approximately five hours per week to this effort. Medicaid will also provide financial support to the teams for their time in participating in this learning collaborative.
Rhode to Equity	While the proposed AE/HEZ projects will pilot and improve how AE/HEZ collaboration, they will do so on specific projects. They will not, necessarily, result in a structure crossing all domains (housing, food, transportation, utilities,	The primary goal of the Rhode to Equity is to build and enhance community-clinical linkages between AEs and the HEZs. The facilitation and coaching will help participants build the skills and knowledge needed for these relationships and collaborations.

Topic	Comment	Response
	IPV, job training, care giver support, etc.). They will also be unique to the community in which each HEZ works, when what is needed is a way for effective partnerships across all communities in Rhode Island.	The projects are a critical tool through which this development can occur, while making meaningful local improvements. EOHHS does not anticipate that these projects will, on their own, resolve upstream community conditions, and agrees that each project will, by design, be focused on a particular geography. However, in working together through these projects and with coaching from experienced facilitators, the participants will be better positioned for long-term collaborations that can continue to address such social determinants of health. EOHHS appreciates the feedback that it would be valuable to build statewide partnerships across all communities and will consider this in future program development. For the Rhode to Equity project, EOHHS believes that a place-based focus is appropriate.
Rhode to Equity	CTC-RI strongly supports the expansion and rebranding the Diabetes Health Equity Challenge (HEC) learning collaborative to become the Rhode to Equity. Even in just the few months since CTC-RI has worked with RIDOH to launch the HEC, this approach has already proven effective. The proposed HSTP investment in the Rhode to Equity 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 Rhode to Equity should recognize this and encourage coordination between the multiple AE practices along with the CHT/HEZ and Managed Care Organizations (MCOs). clearer guidance from EOHHS would be helpful to define what constitutes a CHT for this	Over the next several months, EOHHS will be working with RIDOH to determine the budget for team participation in the Rhode to Equity, including for CHTs. EOHHS recognizes that many geographies are served by multiple AEs and expects to permit multiple AE to participate on each place-based team for this reason.

Topic	Comment	Response
	investment opportunity. With funding for the 2 place-based CHTs (SCH and FSRI) secured only until 6/30/21, consideration should be given to the timing of Rhode to Equity challenge and a plan for multipayer/multi-sector engagement to ensure long-term sustainability. 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. We advocate for a strategy to address a mechanism whereby all Medicaid patients have access to CHT and strategy for ensuring that children, families are included in having access to CHT.	
Rhode to Equity	I'm pleased to see emphasis on moving upstream – and I appreciate the challenge in doing so given the fact AE's are situated in the clinical care setting. However, the Rhode to Equity, as described in the document, is midstream at best. From page 5: "It is intended that through this collaboration the team members [AE and HEZ team] will develop the skills and processes needed to better coordinate the healthcare services and social services to improve health outcomes for Medicaid members." On page 7: "Initial engagement will be facilitated through Rhode to Equity by having HEZ and AE's jointly identify strategies to address one or more social determinant of health and its relationship to a specific health outcome within the AE/MCO cost model. In general, the document appears to imply the CBO role is synonymous with classical service provision. I would encourage a broader interpretation to	Teams will have the opportunity to invite other CBOs to the table, such as housing developers, schools, workforce developers, etc. In addition, a key focus of Pathways to Population Health is to direct organizations' attention further upstream.

Topic	Comment	Response
	include community-based organizations that are housing developers, workforce developers, artists, environmental justice advocates, schools, etc.	
Rhode to Equity	Include in the expansion of the Health Equity Challenge, an asthma model for improving health & reducing health care cost for patients covered by Medicaid by providing training, education, outreach, and home rehabilitation interventions for the following priority areas: Housing remediation for health and safety (including indoor air quality, lead poisoning prevention and trip and fall safe practices). This strategy will connect Accountable Entities and other health system actors to the HEZ infrastructure as partners in addressing upstream determinants of health.	Data will drive decision making for what projects a Rhode to Equity team will chose to embark upon. It is very possible that a team collectively could chose to work on asthma, and team composition can be inclusive of stakeholders with expertise related to addressing this chronic condition.
Rhode to Equity	Neighborhood endorses the Rhode to Equity investment however, we highly recommend holding off AE and MCO participation until the Program Year 4. Commitments and projects for Program Year 3 have already been made and the AEs and MCOs are well underway carrying out the requirements in the HSTP Project Plans as well as our collective focus on the Outcome metrics and Quality Improvement.	EOHHS plans for Rhode to Equity to begin at the start of PY 4.
Community Health Teams	BVCHC's hope that EOHHS recognizes this solution as a steppingstone, it is, after all, a fee-for-service model. To avoid reliance on billing activity where AEs are incentivized to maximize service volume in years to come, BVCHC suggests that reimbursement continue to move towards value-based care where initial operating revenue stems from fair capitation. This is particularly vital to FQHCs, who	EOHHS agrees that the proposed actions detailed in the Investment Strategy reflect short term steps that EOHHS intends to take, and that long term sustainability planning will have to adopt principles of value-based payment to reduce the risk of unintended consequences like incentivizing volume or low quality services or creating administrative barriers to care.

Topic	Comment	Response
	continue to remain shackled to the Prospective Payment System (PPS) while balancing efforts geared toward value-based initiatives. Regardless of reimbursement, “costs” that are seemingly added as a result of community health activity should be accounted for in baseline shared savings models.	
Community Health Teams	Sustaining CHT's: The suggestion that individual AEs’ HSTP projects or Rhode to Equity engagements develop strategies for eliminating overlap is likely insufficient to address these systemic challenges comprehensively. Integra suggests that EOHHS and OHIC allocate funds for a system-wide study of coordination and sustainability problems and solutions and identify a funding source for any needed infrastructure to facilitate coordination. Broadly, we believe a model in which AEs and ACOs lead CHT services for populations for which they are accountable, and independent CHTs lead services for other payers and the uninsured—and in which there is an efficient and clear mechanism for assigning the appropriate team—would help ensure equity and coordination. Sustaining CHWS: Integra is supportive of steps to promote the long-term sustainability of community health workers, a critical workforce for achieving health equity. While we support the option for fee-for-service reimbursement under Medicaid (whether through existing or new mechanisms), we believe that effective CHW-client engagements are built on trust, and trust takes time. Creating sustainability mechanisms that depend on or incentivize volume could have unintended consequences, including over-medicalization and prioritization of clients	EOHHS appreciates the input on the sustainability of CHTs and recognizes that further targeted efforts are warranted to identify and eliminate duplication of services. EOHHS agrees that it is appropriate for AEs to have more ownership of CHTs, as well as the flexibility to develop a community health function within their broader approach to population health management. The steps EOHHS has outlined are intended to support this transition. Furthermore, EOHHS recognizes the importance of adopting principles of value-based payment into a long term sustainability plan for CHWs, and appreciate this articulation of the risks of fee-for-service payment for such services

Topic	Comment	Response
	who require less time. Such effects could exacerbate, rather than improve health equity gaps. The state should incorporate voices from the field, and lessons from other states, in designing a sustainability strategy that incorporates multiple options and remains true to the spirit of the CHW field built on trust, time, and accompaniment.	
Community Health Teams	A unified approach to offering the services a CHT provides across all these different populations makes the most sense from a provider perspective, and the current circumstance of external all-payer funding support allows for this. Should that funding support come to an end, for Coastal as a system of care (SOC) with sufficient scale, sustainably funding CHT's over the long term would become a "build it or buy it" question, and the solution might be some hybrid of both. Factors to consider in looking at that question would include cost; ease of communication with the CHT; the ability to coordinate the care of a CHT with other clinical programs serving a patient; the ability to measure and influence performance; and the ability to offer a streamlined, coherent and unified experience of care to the patient.	EOHHS appreciates this articulation of the important features for CHT implementation from the system of care perspective and will continue to coordinate with OHIC to support a multi-payer vision for sustainability.
Community Health Teams	We continue to have concern that our broader care management programming will no longer be funded and ask for consideration that this funding can also be applied to support, maintain, and expand care management programming that focuses on rising risk and high risk individuals and specific populations.	EOHHS recognizes the concern about sustainable funding for care management more broadly and intends to begin operationalizing a transition of care management - in terms of the clinical function and financing - to a provider-based model, as outlined in the 2019 policy statement on delegation.
Community Health Teams	We are concerned the sustainability plan is essentially grounded in the fee for service payment model. This contradicts the direction the state is working to drive the	EOHHS appreciates and agrees with the importance of developing a value-based payment model that includes the functions of community health teams. EOHHS agrees that long

Topic	Comment	Response
	healthcare system. As we have stated before, we believe capitation holds the most promise for advancing innovative services like the CHT.	term sustainability planning will have to adopt principles of value-based payment to reduce the risk of unintended consequences like incentivizing volume or low quality services or creating administrative barriers to care.
Community Health Teams	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. Without a reliable, multi-year funding stream, it will continue to be challenging to make the longer-term investments needed for this program to reach its full potential.	EOHHS agrees that that it is necessary to identify a sustainable funding stream to support the critical work that CHTs do under their current organizational structures and allow for innovation in the composition and scope of services.
Community Health Teams	I applaud you in seeking ways to permit reimbursement for community health workers. How might that be applicable for community health workers who are not employed by AE's or part of a CHT? There are now 11 CHW's in our CP-HEZ – nine of the 11 are employed by non-clinical employers (Providence Housing Authority, ONE|NB, Smith Hill CDC, Project Weber Renew, Federal Hill House.). CHW reimbursement in this plan both excite and worry me. The note of 'eliminating redundancy in the CHW/CHT sphere' appears to value AE-based CHWs over community based CHWs and I hope more consideration is put into the need for both. CHWs that are based in community are essential as there are many people who, regardless of whether or not they have been attributed to an AE, don't engage in the health care system. CHWs based at CBOs and other non-clinical settings may be the only way of engaging	Should EOHHS seek federal authority to reimburse for CHW services, it would become a covered benefit for any EOHHS member regardless of whether they are attributed to an AE. EOHHS anticipates that CHWs will become Medicaid reimbursable providers from many segments of the evolving delivery system. Currently, there is not enough evidence to determine whether clinically-deployed CHWs or community-deployed CHWs yield different or better patient outcomes. EOHHS' intention is to enable a financing mechanism for the service and foster better community-clinical linkage between AEs, HEZ, and other CBOs to allow for innovation and flexibility in this space, rather than endorsing and implementing a single model.

Topic	Comment	Response
	these individuals and, ideally, should be reimbursable through Medicaid as well.	
Community Health Teams	Recognizing that HSTP funds are finite, EOHHS should pursue long term sustainability by activating reimbursement of spot repair/removal (Rule 1115 Waiver), a service already covered by Medicaid for families with children with lead but that has not been utilized. EOHHS should identify any barriers to billing and ensure comprehensive understanding of what is covered to increase use. Please see enclosed Medicaid Summary on Rule on 1115 Waiver. In addition, in the pursuit of waivers and state plan amendments to have community health workers and other service providers as eligible for Medicaid reimbursement, RI should ensure that the compensation is high enough to create a market for this work. Indiana encountered this issue, which resulted in reduced uptake of the community health worker reimbursement by healthcare providers in the first year. GHHI's case study on the Indiana Community Health Worker Reimbursement State Plan Amendment goes into more detail about this issue.	EOHHS will look into the recommendation on lead removal. EOHHS agrees that there is an imperative to support a sustainable and equitable workforce of CHWs, and fair compensation will be a factor in our development of a rate, while working within the bounds of challenging budget realities in the wake of the COVID-19 pandemic.
Community Health Teams	An MCOs case management team may be conducting similar or identical services as the CHTs. To limit any possible duplication of services and costs and enhance the effort, MCOs should be included in HSTP planning discussions and related initiatives from the onset. It is important for both entities to understand their respective membership and whether there is overlap. By fully understanding potential areas of overlap, MCOs and CHTs can identify which organization is best suited to perform	EOHHS appreciates the concern about potential duplication between CHT services and MCO case management. As EOHHS continues to plan for CHT sustainability and better coordination of care management, MCOs will be included in the ongoing dialogue. To clarify the statement about partial HSTP funding for CHTs, the current CTC-led CHT program receives funding from several sources to implement CHTs in a multi-payer manner. HSTP funds are used to pay for services that are provided to Medicaid members.

Topic	Comment	Response
	overlap services and reduce duplication. We recommend that both MCOs and CHTs continue to have flexibility in their use of CHWs and should be encouraged to work together to share care management best practices to strengthen CHW capabilities and improve care coordination. Should EOHHS opt to streamline the CHW process, they must consider any changes in current CHW billing that are reflected in the MCO rate setting to ensure overall program sustainability. EOHHS states that CHTs will only be funded partially through HSTP funds. We request clarification on how EOHHS intends to fully fund CHTs. Should multiple funding sources be brought in, EOHHS must develop a clear mechanism to hold programs accountable and track funding. Given potential areas for overlap and duplication, EOHHS should require CHTs to work with MCOs to help identify these areas across organizations to lessen the administrative burden on EOHHS, while improving care coordination and lowering overall costs.	
Community Health Teams	We are pleased to see that Community Health Teams (CRTs) will receive continued investment through HSTP funds and closer alignment with the AE program, given the strong emphasis CHTs place on behavioral health. As this is still a young program, we will continue to work with EOHHS to understand how to evaluate the success of CHTs and if and how to tweak them to ensure that they provide a long-term benefit to holistic healthcare in Rhode Island.	EOHHS appreciates the strong collaboration with BHDDH to support CHTs and looks forward to continued joint efforts to develop and sustain this resource.
Community Health Teams	"To build sustainable funding in a systemic approach, the course taken needs to have multisector engagement. (b) EOHHS consists of RIDOH, DCYF, BHDDH and DHS. Families interfacing with one branch of EOHHS are very	EOHHS appreciates the suggestion to align more closely across secretariat agencies. The CHT program in particular has been implemented and overseen closely between EOHHS and BHDDH, with increasing RIDOH participation. EOHHS will continue to

Topic	Comment	Response
	likely to be involved with other branches of EOHHS. The vision statement that frames SDOH as an EOHHS and RIDOH vision is not as comprehensive and encompassing as is needed. (c) BHDDH and other EOHHS departments need to be shoulder to shoulder with you in this work, and their voices need to be evident in the document (plan). (d) To create a sustainable future state, the broad coalition building you engage in today will help strengthen the feasibility of a future that moves beyond short-term HSTP funding.	develop the role of CHTs and AEs more broadly in supporting whole family health and appreciates the suggestion to collaborate with DHS and DCYF to truly support families' holistic needs.
Community Resource Platform	BVCHC wholly supports EOHHS' commitment to a state-sponsored platform that automates referrals and data collection. BVCHC looks forward to participating in this process in the months to come. To facilitate more comprehensive and accountable care, BVCHC suggests local HEZ organizations support CBOs in their efforts to internally track progress as they relate to AE success. The intent is to neither impose a medical model on social agencies nor supplant existing reporting, but rather to tie formal deliverables where AE success is CBO success.	EOHHS appreciates the feedback regarding the importance of connecting AE and CBO success through formal deliverables and supports AE and CBO efforts to design such deliverables for their joint work. However, EOHHS does not require that formal deliverables be part of AE-CBO relationships. EOHHS expects that the CRP will support referral tracking for those participants who seek to track referral outcomes as part of such a relationship.
Community Resource Platform	Community Information and Referral Platform (CIRP), has the potential to reproduce inequities in unanticipated ways. We suggest that there are a number of complex considerations in evaluating a potential platform, which include: • What is the opportunity cost of adopting a platform? Are referrals and linkages the most urgent investment need, as opposed to investments in capacity to provide social services?	EOHHS appreciates the significant complexities involved in establishing an effective community resource platform and will take these issues into consideration in both the RFP review process and a continual review process in the CRP implementation phase.

Topic	Comment	Response
	• Has a large range of CBOs provided input into the structure and function of such a platform? Will such a platform drive resources towards organizations that are already well-resourced, and away from those with less—further replicating disparities among communities and the organizations serving them? • What does the platform's structure imply about what information is valuable? • What working relationships among organizations does a platform prefigure—for example, what is the nature of a "referral," and what relations does that imply and promote? Do resources follow referrals? • Are healthcare organizations able to engage in multiple ways to reflect different relationships with community partners, or is there a single mode of engagement? • Does the platform provide added value to trusting relationships between professionals and clients, or attempt to automate process best performed by people? • Does a platform displace or disrupt existing informational systems in the place, and is this a net good? • We suggest that the best fit for a platform may be one that preserves a lighter touch, and maximum flexibility. Good intentions around implementing a coordinated information system may accidentally worsen health inequities by being overly prescriptive, or failing to incorporate flexibility, community voice, and a robust analysis of organizational issues at play."	

Topic	Comment	Response
Community Resource Platform	Coastal fully supports having one system available across the State which is available and accessible for all health care providers and CBOs to more efficiently coordinate care and document and communicate outcomes across sectors. Due to the complex nature of the services and information inherent in such a platform, Coastal Medical supports the goal of adopting a solution with a proven record of providing the required data and communication tools in a successful way, such as the Unite Us platform. In addition, since some AEs have already purchased and begun using platforms for this purpose, we believe it would be beneficial and more expedient for EOHHS to adopt a platform that has already been implemented by the AEs.	EOHHS will follow all applicable state procurement requirements, which precludes the state from non-competitive selection of a system. Every effort will be made to ensure broad statewide adoption is not burdensome for participating providers and community organizations, and that systems work in concert, interoperable, rather than creating additional demands on staff.
Community Resource Platform	IHP would request instead of allocating all funding for the CIRP that some funding be allocated back to organizations like ours so we can coordinate care and triage across and within our IHP network. We have a robust continuum of care comprised of teams of multi-disciplinary experts. We would request access to some of these funds to enhance our reporting, analytics, and database to coordinate care within our AE.	The Investment Strategy does not allocate "all" funding to the CRP. Funding will also be available for Rhode to Equity and participatory budgeting, although EOHHS recognizes that the latter has not yet been described in detail. In addition, HSTP provides Incentive funds to AEs and requires that 10% of those funds be used to collaborate with CBOs and/or behavioral health organizations.
Community Resource Platform	As state above, we believe that a CIRP is essential for a robust, high-functioning SDOH program uniting healthcare providers and community-based organizations. Given how essential this platform/function will be, procuring and contracting for this might be best performed by an intermediary. Additionally, given the ambitious goals this plan has for a statewide, multi-sector referral platform, any platform/partner should be one with experience offering a statewide, multi-sector platform. The	EOHHS agrees that vendor experience is an important criterion for a CRP vendor, which will be taken into account in the RFP process. Although HIT infrastructure cannot create more capacity for community service delivery, it is a prerequisite to clearly identify and communicate gaps in care and health disparities as part of a data-driven strategic process. EOHHS intends CRP data and interoperable communications to better position community-based organizations within the value-based payment scheme of the AE program, in concert with investments

Topic	Comment	Response
	effectiveness of the CIRP will only be realized with the kind of fundamental payment reform we discuss at the opening of this memo. Without a change from the current model, this platform runs the risk of being a very high-functioning waiting list. Without new mechanisms for additional investment and resources, the CIRP will be reduced to identify need when what we want is to close needs.	in service-based innovations like Community Health Teams also identified in this strategy.
Community Resource Platform	In our experience, Information & Referral (I&R) Programs/Platforms generally do not address gaps in community services or facilitate the community problem-solving and resource leveraging needed to address them. I&R systems typically provide a mechanism to exchange and track information. They are not designed for warm handoffs and the kind of networking provided through Community Care Teams, a relationship-based alternative to a traditional I&R program for improving health outcomes of patients with complex needs. Community Care Teams are less clinical and more cross-sector, leveraging the assets and strengths of multiple agencies in addressing patients' multiple medical, behavioral, and social/economic issues. We urge you to consider this model instead of investing money in an IT system. Further investments in I&R systems are to us nothing more than building bridges to nowhere without substantial investments in community resources to address underlying	Although HIT infrastructure cannot create more capacity for community service delivery, it is a prerequisite in order to clearly identify and communicate gaps in care and health disparities as part of a data-driven strategic process. EOHHS intends CRP data and interoperable communications to better position community-based organizations within the value-based payment scheme of the AE program, in concert with investments in service-based innovations like Community Health Teams also identified in this strategy.
Community Resource Platform	RIPIN believes it is important not to over-prioritize the planned unified referral system, or to treat it as a goal in and of itself rather than simply as a tool. RIPIN is happy to participate in any referral platform, but we believe that its potential costs (both time and financial costs), its likelihood	The point is well taken that HIT initiatives need to serve health goals, and not vice-versa. The primary objective of the CRP is to build foundational IT infrastructure that plays a supporting role in strengthening AE/community relationships, and to that end, EOHHS understands the need to position the CRP as a tool

Topic	Comment	Response
	of achieving broad success, and its potential benefit to patient experience and health outcomes merit some moderation of expectations, and concomitantly some tempering of its overall priority in the proposed Investment Strategy.	serving those parties. Given the varied interests in and uses for the CRP, it will be critical to focus efforts on the CRP's core objective.
Community Resource Platform	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 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.	EOHHS intends to support necessary interoperability where appropriate, such as the state HIE. Specific functionality to be supported will be identified throughout the implementation process with consideration for the broader array of project objectives and the value of a given function in light of the resources (state, provider, and community organization) needed to implement it. Key concerns and best practices will be prioritized, such as sensitivity to patient consent and privacy needs, and identification of a primary contact for a patient's care coordination. EOHHS looks forward to soliciting continual feedback from stakeholders throughout development and implementation.
Community Resource Platform	Embracing a single IT system would be fantastic and I wholeheartedly agree that it would “allow collection of data about the type of services that CBOs are not able to	EOHHS greatly appreciates the support for the CRP.

Topic	Comment	Response
	provide… (e.g. inadequate supply of affordable housing). This will facilitate advocacy by healthcare organizations and CBOs to increase resources for CBOs and communities in which they live.	
Community Resource Platform	The inability to share data and information across sectors is a major barrier to achieving coordination of care between healthcare providers and community-based organizations. We applaud this effort to build a system to remedy these common problems. Aside from being able to report back to the healthcare provider whether or not services were delivered to a patient/client, it would be helpful for all parties, including patients, if healthcare providers also received information about what services were provided.	Specific functionality, such as which pieces of information are collected by the CBO and reported back to "close the loop," will be considered throughout implementation with the solicitation of end user feedback. Including specific functionality and data elements must be considered within the context of the staff effort, resources, and costs necessary on the part of the CBO or medical provider to collect the desired data in a uniform and timely fashion. Specific recommendations such as these are appreciated at this early point in the development process.
Community Resource Platform	An interoperable SDoH data and referral platform, or Community Information and Referral Platform (CIRP) as referred to by EOHHS, is a foundational infrastructure to maintain information about CBO services and capacity. Such platform should be integrated with population health management systems in place by AEs/ MCOs. We support EOHHS' efforts to procure a common CIRP platform, understanding that there may need to be flexibility in the early and exploratory stage of SDoH infrastructure development if the market has existing disparate solutions in place.	EOHHS intends to support interoperable efforts where necessary for optimal non-duplicative system functionality, including population health management platforms used by AEs and MCOs. EOHHS shares the anticipation of needed flexibility during initial discovery and roll-out in order to ultimately transition to a more streamlined and aligned statewide approach to SDOH infrastructure.
Community Resource Platform	Neighborhood does not support the use of HSTP funding to develop the CIRP. As discussed at the recent AE Advisory Committee meeting, the launch and oversight of an IT project by EOHHS is highly risky and well beyond the importance for EOHHS to focus on Medicaid policy development and not direct services. Neighborhood	During the HIT Strategic Roadmap Stakeholder Assessment, EOHHS received considerable feedback from AE stakeholders in support of EOHHS taking a more direct role in better integrating technology into AE program requirements. EOHHS also received specific feedback that a coordinated statewide approach for a social services referral system was a high priority for AEs. EOHHS

Topic	Comment	Response
	strongly encourages EOHHS the business case for the CIRP including the revenue sources for long-term sustainability of the CIRP platform.	acknowledges the magnitude of this undertaking and is committed to a robust and transparent oversight process for system selection and implementation. EOHHS looks forward to, and appreciates, continued input from stakeholders, including concerns.
Community Resource Platform	EOHHS must ensure that any implemented tools can to plug into existing infrastructure (e.g., CurrentCare) to reduce system redundancy for providers. Implementing a statewide platform, similar to North Carolina's NCCARE3601, would allow EOHHS to connect to existing systems and would provide the ability to share critical care coordination data (i.e., screenings, assessments, and care plans). Through this connectedness and sharing of information, AEs and CBOs can use information from the platform and standardized screening to make connections to local community partners, enhancing their ability to address and mitigate identified social barriers. We recommend the system be designed to support direct payments to CBOs to allow for immediate functionality should EOHHS pursue that structure in the future. Mechanisms to directly pay CBOs for their services will enhance sustainability, simplify data collection for audits, and improve Medicaid beneficiaries' experience and outcomes.	EOHHS intends to support interoperable efforts where necessary for optimal non-duplicative system functionality, including CurrentCare, with specifics to be identified during requirements-building and throughout iterative feedback solicitation from end-users. Enhancements such as functionality to support direct payments to CBOs will be explored and taken under consideration in the context of the overall project objectives. Specific feedback such as this recommendation is greatly appreciated.
Community Resource Platform	Benefitting from the lessons learned in prior HIT investments made by the State, this investment proposal rightly identifies HIT as a promising way to better coordinate an individual's healthcare after refe1rnls are made. We ask that behavioral health providers and, to the	Behavioral health and applicable I/DD providers will be encouraged to access and utilize the CRP. EOHHS appreciates and acknowledges the critical role those providers play in supporting Medicaid beneficiaries with social services and wraparound services for whole-person care.

Topic	Comment	Response
	extent relevant, I/DD providers are included as patties that can access and make use of the CIRP.	
Community Resource Platform	Invest in IT Systems to Support Coordination: Community Information and Referral Platform (CIRP) – Midstream (a) Referrals – engage those doing the work, not just the planners. (b) There are many bright and experienced referrals coordinators who can tell you the "boots on the ground" challenges and barriers to a more coordinated and valuable referral platform. (c) The "sales force" at an IT company will promise the world. When it comes to implementation, the staff doing the work to refer, and coordinate services will be extremely valuable as part of the design team."	EOHHS intends to conduct an iterative, participatory development and implementation process that makes use as much as possible of direct input from key end users, particularly referral coordinators. EOHHS agrees that close oversight of implementation will be required to ensure the CRP is meeting objectives for all users.
AE HEZ Engagement	Geographic Overlap: Is the vision that multiple AEs partner with a given HEZ and CHT under the auspices of a single, focused convening—or would there need to be a different grouping for each AE? We caution that managing relationships with multiple AEs would put an undue burden on HEZs in high need communities. How would concerns about competition among AEs (for resources and covered lives) be managed? Reaching Most Marginalized: Pitfall in community engagement is that those who have the ability to attend meetings, formulate their perspectives in ways that are legible to existing systems, can predominate over those with barriers to attending and being heard. HEZs are at different levels of maturity and activity in different parts of the state. Service providers have established a strong presence in the HEZs— is there evidence that those most	EOHHS understands that there are multiple AEs with significant patient populations in some regions served by a single HEZ. For the Rhode to Equity, which is a concrete, manageable first step toward AE-HEZ engagement, EOHHS and RIDOH plan to permit teams flexibility in developing their team structure, including having multiple AEs collaborate with a single HEZ on a single project, which should mitigate the burden on the HEZ. For the broader AE-HEZ collaborations, EOHHS and RIDOH expect to work closely with both AEs and HEZs to consider the most efficient and effective approaches to joint work, accounting for the important feedback shared here and by other stakeholders that it would be resource-intensive for a HEZ to manage separate relationships with multiple AEs. EOHHS and RIDOH strongly agree that it is necessary to ensure that voices of community members with lived experience are engaged in AE-HEZ work and that these perspectives are centered. EOHHS and

Topic	Comment	Response
	directly impacted by adverse SDOH have attained a similar voice? We urge EOHHS to consider how AE-HEZ collaborations (Strategies 1 & 4) can ensure that community engagements continually center the perspectives of people impacted by the social, economic and environmental roots of ill health.	RIDOH look forward to working with stakeholders to ensure that this point is built into planning for ongoing AE-HEZ engagement.
AE HEZ Engagement	Coastal would like to better understand how equitable and efficient partnerships can be pursued across the many AEs, as well as the best way in which we can engage with them. Coastal's AE includes 17 internal medicine, family medicine or pediatric practice with patients and practices residing in every HEZ geographical region in the State. A single HEZ partnership would not address the needs of all of Coastal's Medicaid patient population and assist patients with needs in other geographic locations.	EOHHS and RIDOH understand that several AEs serve patients across multiple geographies in the state, encompassing service areas of several HEZs. EOHHS and RIDOH expect to work closely with both AEs and HEZs to consider the most efficient and effective approaches to joint work, accounting for the important feedback shared here and by other stakeholders that it would be resource-intensive for an AE to manage separate relationships and projects with multiple HEZs. Note that at this time, EOHHS and RIDOH consider Rhode to Equity to be the first step toward AE-HEZ engagement.
AE HEZ Engagement	Geography: We recognize the valuable contributions HEZs have made to our community and the individuals we serve. IHP would request further clarification as to how to navigate and partner with HEZs outside of our participating organizations. As one can imagine it is challenging to not duplicate efforts and coordinate care when we have over 50,000 attributed lives across the state and our 9 organizations. We are concerned as we are a lien organization the administrative and clinical burdens that will ensue particularly amidst the pandemic and other competing priorities.	EOHHS recognizes that the AEs have attributed lives across Rhode Island and that the AEs continually strive to balance the needs of their individual clinical sites while streamlining operations for optimal efficiencies. EOHHS and RIDOH expect to work closely with both AEs and HEZs to consider the most efficient and effective approaches to joint work, accounting for the important feedback shared here and by other stakeholders that it would be resource-intensive for an AE to manage separate relationships and projects with multiple HEZs. EOHHS and RIDOH commit to supporting AEs in understanding the geographies where they have significant numbers of attributed members. Note that at this time, EOHHS and RIDOH consider Rhode to Equity to be the first step toward AE-HEZ engagement.

Topic	Comment	Response
AE HEZ Engagement	As stated above, we support this component of the plan and believe many worthwhile projects will develop from this. However, it is likely the AEs will seek to work with a small number of HEZ. It is likely that most, if not all AEs, have a concentration of members in the same geographic areas. There might be a role for the state to play coordinating AE/HEZ partnerships to ensure this project proceeds efficiently and effectively.	EOHHS understands that there are multiple AEs with significant patient populations in some regions served by a single HEZ. For the Rhode to Equity, which is a concrete, manageable first step toward AE-HEZ engagement, EOHHS and RIDOH plan to permit teams flexibility in developing their team structure, including having multiple AEs collaborate with a single HEZ on a single project, which should mitigate the burden on the HEZ. For the broader AE-HEZ collaborations, EOHHS and RIDOH expect to work closely with both AEs and HEZs to consider the most efficient and effective approaches to joint work, accounting for the important feedback shared here and by other stakeholders that it would be resource-intensive for a HEZ to manage separate relationships with multiple AEs.
AE HEZ Engagement	Much of the Investment Strategy anticipates using the pre-existing HEZ infrastructure to enhance AEs' ability to leverage CBOs working in areas of identified SDOH need. RIPIN supports the use of this infrastructure, as the HEZs have demonstrated tremendous potential in building connections to strengthen a healthy community. There exists some tension between inherently "place-based" HEZs, and AEs that frequently have attributed lives spread throughout the state. We believe that considerations must be made to ensure that this tension is adequately anticipated and controlled for. Core cities will see considerably greater representation in most AE panels than other areas of the state. This has the potential to direct an outsized share of investment to those core cities, leaving well-equipped but underrepresented HEZs without sufficient investment to address community needs. The focusing of resources in communities with more Medicaid	EOHHS and RIDOH agree that it will be complex to develop relationships among AEs - many of which are statewide - and HEZs - which are inherently place-based - in a manner that does not create administrative burdens for participants. EOHHS and RIDOH expect to engage with these stakeholders in the coming months to discuss these opportunities. EOHHS and RIDOH agree that it is important to ensure that resources are distributed in a fair and intentional manner, rather than going to certain areas as a default. EOHHS and RIDOH also note that the primary aim of HSTP investment in AE-HEZ relationships through the Rhode to Equity is to strengthen community-clinical linkages among these entities, which means that these efforts are likely to take place in the geographies where the AEs have significant numbers of patients. EOHHS and RIDOH agree that it will be highly valuable for AEs to work with CBOs who are not engaged with any HEZ and/or

Topic	Comment	Response
	AE members may be a tolerable (or even desirable) outcome, but the State should indicate clearly in advance how it hopes for this inevitable tension to be resolved. Another potential tension relates to CBOs who work in areas not covered by HEZs, or who run statewide service models. An overreliance on a place-based, HEZ-centered strategy could mean foregoing the leverage these CBOs could bring to a broader strategy.	whose work is statewide. In the context of the Rhode to Equity, EOHHS and RIDOH encourage AEs and HEZs to consider inviting other CBOs to participate in the collaborative.
AE HEZ Engagement	While we agree with AE engagement with HEZ, we also think that the CHTs are an important midstream delivery system that should also engage with HEZ. We see the clinical – community linkages being strengthened through collaborative models like the Pathways to Population Health.	EOHHS and RIDOH agree that CHTs and other community health worker teams are an important midstream delivery system and that it is valuable to enhance CHT/CHW-HEZ relationships. EOHHS and RIDOH agree that this will primarily be achieved through the Rhode to Equity, because both CHTs/CHWs and HEZs are expected to participate on these teams.
AE HEZ Engagement	There are multiple barriers to achieving robust coordination between healthcare providers and community-based organizations including data sharing and privacy, unlinked referral networks, lack of shared expertise, and the administrative burden of exploring new territory. While the CIRP system can help with the first barrier, the others remain. One way to overcome these barriers and accelerate coordination is Health Connection Hubs, collaborative resource platforms that facilitate relationships across sectors, allowing partners to focus on their core work without dedicating precious resources to become experts in another field. Potential services include partnership development, payment facilitation, capacity building, operations support, and outcomes evaluation. Contractual relationships exist between AEs and the MCOs that allow the AEs to share in potential savings to the MCOs based on	EOHHS and RIDOH agree that it is challenging to achieve robust coordination between healthcare providers and CBOs and appreciates the feedback that the CRP can assist with some of these issues. EOHHS and RIDOH appreciate the recommendation to explore the opportunity presented by Health Connection Hubs and looks forward to discussing it with stakeholders in coming months. EOHHS agrees that it could be valuable for AEs and CBOs/HEZs/ a possible Health Communication Hub to share savings generated from their partnerships. EOHHS is available to work with AEs and their partners who seek to develop such an arrangement.

Topic	Comment	Response
	the successful management of healthcare costs. To further engagement between AEs and HEZs, EOHHS should explore models where HEZs (or the Health Connection Hubs mentioned above) can also receive a share of savings that would come out of these partnerships with AEs."	
AE HEZ Engagement	We welcome the opportunity to partner with health equity zones (HEZs) to promote and support the work we have seen thus far as they have a strong foundation to improve health outcomes. Still each HEZ has different motivations based on the specific needs of the community they serve. We are concerned that requiring AEs to work with one or more HEZ, combined with multiple HEZ priorities, could be administratively burdensome for AEs and inhibit HSTP initiative success. We recommend focusing HEZs on a select number of priorities, aligned with the Health in Rhode Island outcome measures already in place and selected based on HEZ collaboration and consensus.	EOHHS and RIDOH appreciate the concern over administrative burden with regards to varying and myriad HEZ priorities. In the context of the Rhode to Equity, which will begin in AE Program Year 4, there is time to account for this concern in program planning and development. For example, EOHHS and RIDOH expect to consider developing a crosswalk between the Health in RI measures, RIDOH's Health Equity Indicators, and AE measures. EOHHS and RIDOH appreciate receiving this feedback at this opportune time. In general, EOHHS and RIDOH look forward to working with stakeholders to consider the most efficient and effective approaches to joint AE-HEZ work, accounting for the important feedback shared here and by other stakeholders that it would be resource-intensive for HEZs to manage separate relationships and projects with multiple AEs.
AE HEZ Engagement	We encourage any partnerships between HEZs and AEs to rigorously include behavioral health and I/DD care metrics as a component of their planning, and to partner with Regional Prevention Coalitions in developing interventions. AEs and HEZs should consider behavioral healthcare and care for individuals with intellectual/developmental disabilities as a major component to any population health interventions they plan.	EOHHS and RIDOH appreciates this feedback. As Rhode to Equity teams are formed and begin planning, BH/SUD and I/DD issues can certainly be addressed by the teams, and EOHHS and RIDOH will work with AE-HEZ partnerships to actively engage with behavioral health and I/DD partners as well.
AE HEZ Engagement	Accountable Entity Engagement with Health Equity Zones – Upstream	EOHHS and RIDOH will consider encouraging Rhode to Equity teams to include entities other than AEs, HEZs, and CHTs to encourage cross-sector collaboration.

Topic	Comment	Response
	(a) Each of the HEZ initiatives in the state have their own cultures of operation and some are more community engaged than others. All have deep roots in their local communities that understand the challenges, frustrations, and strengths within their respective communities. Their role in this initiative is going to prove extremely valuable. (b) However, they are not the only entities within local communities with a commitment to improve the health and well-being of their community's residents.	
Participatory Budgeting	BVCHC prefers additional clarification regarding this proposal before offering formal comment.	EOHHs appreciate the feedback and thoughts on Participatory Budgeting as a potential approach to support clinical and CBO linkage and more importantly community driven decisionmaking and integration of the community voice into potential centralized HSTP investment opportunities. EOHHS is very much at the infancy stages of deliberation on PB as a potential HSTP investment allocation. As such, EOHHS expects further stakeholder discussions on this topic over the next year.
Participatory Budgeting	We urge EOHHS to consider how AE-HEZ collaborations (Strategies 1 & 4) can ensure that community engagements continually center the perspectives of people impacted by the social, economic and environmental roots of ill health. How will the participatory budgeting process (Strategy 5) ensure this approach as well? We applaud EOHHS's foray into participatory budgeting, and caution that meaningfully engaging people without a technical background in budgeting processes and centering the voice of those directly impacted by systemic racism, poverty, stigma and systems failure is very difficult. We encourage EOHHS to provide for facilitators with credibility and a proven track record among communities of color and provide sufficient	EOHHS is in the preliminary stages of considering if and how a PB process can be implemented. We will seek future stakeholder feedback on this topic once we have developed a proposed plan/recommendation. EOHHS will continue to engage stakeholders in this discussion moving forward and is very much in the initial stage of making a formal decision as it relates to Participatory Budgeting.

Topic	Comment	Response
	time and financial support to allow for a deep, authentic engagement—including funds to compensate participants for time engaged in this process."	
Participatory Budgeting	Coastal Medical would like to reserve comments on Participatory Budgeting at this time. We look forward to learning more about how this process will function across all the involved organizations and interested groups. Our only feedback on this process at this time is to ensure that patients are included as a voice within the process.	EOHHs appreciate the feedback and thoughts on Participatory Budgeting as a potential approach to support clinical and CBO linkage and more importantly community driven decisionmaking and integration of the community voice into potential centralized HSTP investment opportunities. EOHHS is very much at the infancy stages of deliberation on PB as a potential HSTP investment allocation. As such, EOHHS expects further stakeholder discussions on this topic over the next year.
Participatory Budgeting	We applaud EOHHS for taking this bold and inclusive step to engage communities in a participatory budgeting process. This demonstrates the commitment to equity and inclusion. This process will likely facilitate the identification of people with the lived experience, so important to this overall proposal. This may be a good forum to share community health needs assessments that hospitals are required to conduct.	EOHHS appreciates this feedback and will take into consideration the opportunity to leverage the PB process and forum to share hospital-conducted community health needs assessments.
Participatory Budgeting	GHHI applauds the raising up of community voices in the budgeting process. We recommend that a part of the process be analysis on which potential investments may have the greatest return in value to the community. In this way, the participatory budgeting process will have the knowledge to prioritize different efforts and programs. GHHI has conducted this kind of analysis for multiple state, including New York and Connecticut.	EOHHS appreciates the feedback and will take this recommendation under consideration in the development of a potential PB framework and process.
Participatory Budgeting	We applaud EOHHS's foray into participatory budgeting, and caution that meaningfully engaging people without a technical background in budgeting processes and centering	EOHHS agrees that it will be important to select an appropriate facilitator for PB work. EOHHS will continue to engage

Topic	Comment	Response
	the voice of those directly impacted by systemic racism, poverty, stigma and systems failure is very difficult. We encourage EOHHS to provide for facilitators with credibility and a proven track record among communities of color and provide sufficient time and financial support to allow for a deep, authentic engagement—including funds to compensate participants for time engaged in this process.	stakeholders in this discussion moving forward and is very much in the initial stage of making a formal decision as it relates to PB.
Participatory Budgeting	We request clarity from EOHHS on how the participatory budgeting process will operate, including how members will be selected and can participate. While we agree that including the voice of the Medicaid beneficiary is critical, the process will only be successful if it includes a broad array of members. To ensure a broad spectrum of members are included and ensure the process is as authentic as possible, we recommend EOHHS work with CBOs, MCOs, and AEs to develop an operating procedure to ensure consistent member participation and authority. To expand and amplify community involvement, we encourage EOHHS to consider how participatory budgeting projects could fit the broader HSTP initiatives.	See above.
Participatory Budgeting	We strongly encourage that people of color with lived experience in the behavioral healthcare and I/DD systems (and/or advocates on their behalf as appropriate) are visibly involved in any participatory budgeting programs. The intersectional challenges to people of color with behavioral health challenges have been too frequently overlooked in Rhode Island, and participation of people connected to the behavioral healthcare system is a small step to addressing these historic inequities.	Agreed. EOHHS is committed to ensuring a diverse constituency of community representation in a PB process if and when this is implemented, including individuals and/or caregivers of individuals receiving behavioral health and I/DD services.

Topic	Comment	Response
Participatory Budgeting	Participatory Budgeting – Upstream (a) RIDE has many of the same families engaged. How are they involved? (b) Primary consumer feedback is tricky. It is imperative that you move beyond token engagement to obtain genuine feedback and participation in the planning as well as the implementation of the system of care. (c) There are numerous perspectives and strategies to engage local residents and recipients of services. One model does not fit all. (d) A single advisory panel approach is only a token approach. (e) The needs of single adults living in Providence differ from families with a single parent with 3 children under the age of 7. Rural challenges in Pascoag and Hope Valley will differ from those living in the urban core, such as Central Falls or the eastern part of Cranston. And so on…	EOHHS appreciates the feedback and thoughts on Participatory Budgeting as a potential approach to support clinical and CBO linkage and more importantly community driven decisionmaking and integration of the community voice into potential centralized HSTP investment opportunities. EOHHS is very much at the infancy stages of deliberation on PB as a potential HSTP investment allocation. As such, EOHHS expects further stakeholder discussions on this topic over the next year.
Recommendations/Other	Facilitating access to additional community resources is what is truly needed. Pick an issue and make a significant difference. Use your influence to garner additional public and private investments. Another model worth noting is the Healthcare Anchor Network, a national movement to use the power of a community's "anchor" healthcare organizations to foster local hiring, local sourcing of materials/resources, and local place-based investing. This effective model is harnessing everyday business practices to drive community health and well-being in the healthcare organization's home communities.	EOHHS appreciates the feedback regarding the importance of access to community resources. EOHHS agrees that access to community resources is essential and that Medicaid as an agency and part of EOHHS has a responsibility to leverage its role from a policy perspective and in partnership with other State agencies. There are federal limitations on how EOHHS can use HSTP funds, however EOHHS expects to be able to support access to community resources to some extent through building AE capacity to work with community partners. EOHHS appreciates these observations about how the business practices of health care providers can be leveraged to improve community health. EOHHS anticipates that these ideas will fit

Topic	Comment	Response
		into the Rhode to Equity framework very effectively, because this framework considers the role of health care providers as businesses and employers, as well as providers of health care services.
Recommendations/Other	1. Construction and preservation of affordable housing 2. Rental subsidies for low and very low-income households. 3. Necessary supportive services for those placed in congregate care facilities and permanent housing 4. Coordinated effort to retrofit homes in order to mitigate trips and falls, Lead poisoning, and asthma triggers.	EOHHS agrees that housing policy, including subsidies, are highly important to community health. While Medicaid is not able to directly pay for housing, EOHHS is implementing a supportive housing model. In addition, EOHHS expects that work with Rhode to Equity can increase the health system's engagement in housing advocacy.
Recommendations/Other	SDOH investment should take care not to medicalize community-based work A potential outcome of incorporating social determinant of health-related, community work into the Medicaid AE model (such that that work can be compensated through Medicaid funding) is viewing that work through the same lens that we view other health work. RIPIN believes that this would be an unwelcome development, and could create the same "volume over value" incentives that the AE model (and our healthcare system more broadly) is trying to move away from. Insofar as service-based billing will be used, RIPIN encourages that alternative payment models be utilized to encourage value- and outcome-based incentives.	EOHHS appreciates the feedback regarding the need to avoid medicalizing community-based work and will continue to seek additional input throughout the implementation of this strategy. EOHHS agrees that the goal is to provide CBOs with the infrastructure, capacity-building, and TA needed to partner with health care organizations to address SDOH needs. EOHHS does not expect to design payment mechanisms for CBOs. However, EOHHS does expect that value-based payment models for AEs will create opportunities for these AEs to pay CBOs for work that enhances community health. EOHHS intends to support AEs and CBOs in their efforts to design payment mechanisms that support CBO work without introducing incentives that distort or medicalize CBO work.
Recommendations/Other	We believe that MCOs play a crucial role in supporting the AE program achieve SDoH scale and sustainability. MCOs have expertise and resources to establish standardized SDoH contracts with CBOs, on behalf of AE partners.	EOHHS appreciates the engagement of MCOs in SDOH work and encourages MCOs and AEs to collaborate on these efforts.

Topic	**Comment**	**Response**
	Additionally, MCOs can deploy robust population health analytics and reporting on SDoH intervention outcomes, leveraging data aggregation. Lastly, MCOs can provide comprehensive performance management support to CBOs, to complement the potential resource and infrastructure gaps.	