

Comments on Attachment L Accountable Entity Roadmap

As always, Integra is pleased to have the opportunity to provide comments on the Accountable Entity Roadmap Document.

We remain committed to participation in the Accountable Entity program, and are optimistic about our ability to achieve both our own and EOHHS's strategic goals through the program. We offer these comments in the spirit of collaboration to ensure that the program is as successful as possible.

We appreciate the effort to minimize structural changes to the program, after several years of significant change. We are committed to continuing to work with EOHHS and MCOs to move the system way from volume-based models towards value-based models.

Note: page numbers throughout refer to the Microsoft Word "Track Change" version of the roadmap, dated September 9.

Comments on Sections I through VIII

ROLE OF THE AE IN HEALTH SYSTEM TRANSFORMATION. We encourage EOHHS to think carefully about the role of the Accountable Entity, and in particular, what problems in the health care delivery system can be solved by an AE, and which cannot. For example, EOHHS defines an AE as "an interdisciplinary partnership of providers with a strong primary care base that ensures coordinated access to other services, including specialty care" (page 7). For many AEs, including Integra, the majority of our attributed members' specialty care is provided by providers outside of our AE. As a result, while we can provide services to attempt to coordinate that care, we can't ensure access to that care. Instead, it is our MCO partners, who build and maintain the comprehensive provider network, who are responsible for ensuring adequate access to specialty care.

Similarly, while AEs are the "foundation" (page 10) of EOHHS's efforts to improve population health, EOHHS should acknowledge that there are some areas that AEs are not well suited to address. For example, because AE attribution is based on primary care services, an AE may not be able to effectively improve maternal/child health outcomes, because many women are primarily seen by their OB/GYN during pregnancy, not their PCP. Since an OB/GYN may or may not be affiliated with the same AE as the patient's PCP, the AE may not even be aware of the pregnancy and will not have an opportunity to coordinate care and offer service.

RE-CERTIFICATION FOR PY5 AND PY6. EOHHS will require AEs to "identify concrete ways in which their MCO contracts and partnerships are being leveraged to assist the AE in achievement of the advanced standards in domains 4 – 8" (page 12). As we have suggested previously, this expectation may not accurately reflect the dynamic of the relationship between an MCO and its contracted AEs. It seems more appropriate for this to be a requirement of MCOs: to identify how they will assist their AEs in achieving these advanced standards.

MCO/AE CONTRACTING. As we have shared in the past, the different approaches of each MCO to risk contracting, population health, and management of the AE program makes contracting cumbersome. To the extent that there are specific terms that EOHHS requires to be included in an MCO/AE contract (pages 14 and 18, for example), EOHHS should issue boilerplate contract language that MCOs are required to use. This will dramatically simplify contract negotiation, and remove ambiguity about the appropriate interpretation of EOHHS requirements. (We appreciate the addition of the "base contract checklist" but feel that EOHHS can go further.)

REQUIRED REPORTS. Integra appreciates the thoughtful and comprehensive set of reports (pages 20-21) that are included in the program. However, often these reports come to AEs with such a delay that they are not actionable,

and we go for many months without feedback as to the efficacy of our population health efforts. We encourage EOHHS to work with contracted MCOs to reduce the lag of claims-based reporting.

ATTRIBUTION. We appreciate the specific mention of oversight of the member attribution process (page 22).

Comments on Section IX: Sustainability Plan

We appreciate EOHHS's description of the conceptual framework behind the expectations that AEs will help reduce the growth in health care costs. We agree that achieving that goal will have to include changing practice patterns and making investments to improve healthcare outcomes for higher-risk patients.

However, we do not believe that EOHHS has articulated a strategy that will ensure that AEs have access to sufficient revenue to be sustainable without HSTP funding. We describe some of our concerns below.

As we have noted in the past, while shared savings, and the incentive to reduce cost, are an important part of EOHHS's management of and funding for managed care organizations, MCOs are not expected to operate their programs solely based on shared savings revenue. On the contrary, MCOs receive a predictable and generous administrative payment, in acknowledgement of the expense needed to successfully manage this complex population.

As we have proposed in the past, EOHHS should commit a predictable administrative funding stream to AEs, to ensure that variations in cost performance do not force an AE to drop out of the program because it is not financially sustainable. We propose that EOHHS require each MCO to provide their contracted AEs with a monthly administrative payment equal to at least one percent (1%) of the month's aggregate medical capitation for that AE's attributed members.

AE ACTIVITIES AND COSTS. We are concerned that EOHHS may not have a complete understanding of AE activities and the costs associated with them. Many of the examples listed on pages 27-28 are not, in fact, one-time investments that will not require ongoing funding. Population health platforms, survey tools, and analytic vendors will all require ongoing costs for maintenance, services, and enhancements. For example, Integra's with Algorex, is not a technology investment: it is a contract for purchased services that would have to be renewed annually.

BUDGET TEMPLATE. We agree that it will be challenging to collect comparable, consistent cost data from AEs, and look forward to reviewing the proposed budget template (page 31). As we mentioned in previous public comments, we encourage EOHHS to think about timing. If this information is being collected for PY5 certification, it will presumably take at least a year for EOHHS to analyze the budget information and propose a resourcing plan for AEs. Until that plan is in place, HSTP will remain the primary source of funding for AE operations; can EOHHS commit to level funding HSTP incentive dollars through PY6?

COMPARISON OF AE COSTS TO SHARED SAVINGS. The document refers to "details on [sic] comparison between AE costs and shared savings payments...presented below" that we cannot find in the document (page 32). We also note that EOHHS's analysis, which shows that AE interventions may have a return on investment when compared to the total savings achieved, not just the AE share of those savings, suggests that shared savings on their own will not be sufficient to fund AEs over the long term.

COMMUNITY RESOURCE PLATFORM. Integra has previously described our skepticism of the community resource platform as part of a sustainability strategy. We may be the one exception to the "nearly unanimous" view that the CRP would be "extremely valuable" (page 35). While it is true that switching to the CRP from our own contracted platform would reduce budgeted costs, the reduction would not be significant enough to have a material impact on our sustainability strategy. In fact, switching to Unite Us now would likely entail more implementation costs (technical updates to EMR systems, retraining staff, etc.) at a time when there is less HSTP funding available for this kind of investment.

We are also confused by the description of the functions of the CRP. The first bullet claims that the platform will "record member responses to a social determinants of health questionnaire and identify their social needs." How does EOHHS square this opportunity with the requirement in the quality program that SDOH screenings must be recorded in a primary care provider's EMR system?

RHODE TO EQUITY. Integra is committed working with partners in the community and the health care space to advance health equity and reduce disparities in health outcomes. We are participating in two Rhode to Equity teams in addition to our own internal efforts. While we support the Rhode to Equity initiative, EOHHS has never satisfactorily explained how this can be considered part of a sustainability strategy. We look forward to the promised “exploratory process” to make additional funding available (page 36).

OTHER SUGGESTIONS FOR EOHHS INVESTMENT. EOHHS should consider additional ways to centralize and reduce costs for AEs. A few suggestions include:

- An ongoing funding stream to cover the maintenance and licensing costs associated with EMR connectivity to IMAT
- Funding to support new infrastructure and training around collection of REL/D data
- Licenses for AEs to connect with the Homeless Management Information System (HMIS) to have real-time access to homelessness information for our attributed populations

TCOC MODEL. We appreciate and acknowledge the work that EOHHS has done to align the AE TCOC benchmarking process with the MCO capitation rate-setting process. We look forward to opportunities to suggest ways to align these processes further.

COMMUNITY HEALTH WORKER SERVICES. Integra was pleased to see the State Plan Amendment to add community health worker services to the Medicaid State Plan. We believe that CHWs are an extremely valuable and efficient way to positively impact the lives of our members. We are concerned that the proposed reimbursement rates may be inadequate and are currently still evaluating the impact that the covered benefit will have on our ability to offset costs.

We also note that making CHW services reimbursable on a fee-for-service basis is a very imperfect fit for an AE like Integra, which is not, itself, a Medicaid provider. In order to be able to bill for these services, we would have to restructure our care teams so that our CHWs are employed by a sister operating unit within our organization that does bill for services; we are still evaluating our options and the disruption this change may cause. Because most of Integra’s CHWs are centralized, rather than practice-based, fee-for-service funding, and even primary care capitation, is not a great fit for us.

While we work through these issues, we request that EOHHS clarify the extent to which they will allow HSTP funds to be used to offset CHW costs, even once the benefit is covered.

In general, for services like CHWs, we encourage EOHHS to think beyond covered medical benefits, and consider directly funding AEs on a PMPM basis.

MCO PROCUREMENT. We strongly support EOHHS’s plan to encourage MCOs to more flexibly use “in-lieu of services and value-added services” to allow MCO/AE partnership to innovate (page 42). In general, we look forward to EOHHS exercising more leverage through its contractual relationship with MCOs to promote innovative approaches to population health, including social determinants of health.

EOHHS may also be able to encourage MCO investment in this area by facilitating the inclusion of SDOH investments as quality improvement activities in the numerator of the medical-loss ratio.

MULTI-PAYER INITIATIVES. Integra looks forward to working with EOHHS to explore opportunities to align APMs across payers. Aligning incentive structures is an important goal for the state, which may or may not have an impact on AE sustainability. We believe this is an issue that requires careful thinking and discussion.

Finally, we appreciate that EOHHS recognizes that sustainability is an ongoing project. We remain concerned that the current sustainability plan does not seem comprehensive or cohesive enough to give us confidence in the fiscal outlook for the program after PY6. We agree that sustainability considerations should inform a range of policy decisions in the coming years, and we look forward to being an engaged stakeholder in that policy-making process.