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To: Jennifer Marsocci, MS
Project Manager – HSTP, Executive Office of Health & Human Services
Via E-Mail: jennifer.marsocci@ohhs.ri.gov

From: Garry Bliss, Program Director
PHSRI-AE

CC: Libby Bünzli, Director of Health System Transformation
Charlie Estabrook, Accountable Entity Program Manager
Christopher Dooley, Vice President, Coordinated Regional Care, Prospect Medical

Re: AE Program Year Five Roadmap and Sustainability Plan

The following comments are provided in response to the ***AE Program Year Five Roadmap and Sustainability Plan*** ([LINK](#)) circulated and posted for public comment **September 3, 2021**.

We commend EOHHS for continuing to refine and adjust the sustainability plan first developed as part of the PY4 Roadmap. The comments offered below reflect our belief what is necessary to accomplish the goals of the AE program overall and to sustain that in the years to come.

Fundamental Delivery and Payment Transformation is Necessary





As stated in our comments on the *PY4 Roadmap and Sustainability Plan*, we believe the key to achieving the ambitious goals of the AE program **and** for achieving sustainability is fundamental delivery and payment reform, fully moving away from the current fragmented fee-for-service payment system to a **population-based payment system**.

The COVID crisis has revealed many weaknesses in the current health care and social service system. In addition to highlighting health inequities and barriers to care experienced by the most vulnerable in society, this crisis has also demonstrated the ways that fee-for-service payment is fundamentally incompatible with the goals of population health. Providers were severely restricted in their ability to meet the needs of their patients in the middle of a pandemic because they were, largely, operating within a billing and coding system not suited to the moment.

This should not be surprising. Fee-for-service was not effective in a pre-pandemic environment. COVID has only served to heighten the shortcomings of the current financial and incentive structure.

Given this, it is disappointing the degree to which the proposed sustainability strategy continues to be built on a fee-for-service foundation. It is necessary to move to an **accountable, population-based payment system** (capitation) at the AE/system of care level, with a robust risk-adjustment model to account for differences in population from AE to AE. This is, we believe, the best route to accomplish long-term sustainability of reformed healthcare delivery.

The roadmap references the APM Framework (2017) issued by the Health Care Payment Learning Action Network (HCLAN). We have used this document to analyze and inform our comments regarding the need for fundamental payment reform as part of the state's sustainability plan.

			
CATEGORY 1 FEE FOR SERVICE - NO LINK TO QUALITY & VALUE	CATEGORY 2 FEE FOR SERVICE - LINK TO QUALITY & VALUE	CATEGORY 3 APMS BUILT ON FEE-FOR-SERVICE ARCHITECTURE	CATEGORY 4 POPULATION - BASED PAYMENT
	A Foundational Payments for Infrastructure & Operations (e.g., care coordination fees and payments for HIT investments)	A APMs with Shared Savings (e.g., shared savings with upside risk only)	A Condition-Specific Population-Based Payment (e.g., per member per month payments, payments for specialty services, such as oncology or mental health)
	B Pay for Reporting (e.g., bonuses for reporting data or penalties for not reporting data)	B APMs with Shared Savings and Downside Risk (e.g., episode-based payments for procedures and comprehensive payments with upside and downside risk)	B Comprehensive Population-Based Payment (e.g., global budgets or full/percent of premium payments)
	C Pay-for-Performance (e.g., bonuses for quality performance)		C Integrated Finance & Delivery System (e.g., global budgets or full/percent of premium payments in integrated systems)
		3N Risk Based Payments NOT Linked to Quality	4N Capitated Payments NOT Linked to Quality

The Comprehensive AE sustainability plan in the Roadmap aligns with the definition of a Category 3B model. The five sustainability strategies, essentially, seek to compensate for not moving to a Category 4 model. However, anything short of comprehensive payment reform – with capitated, population-based payment – will fall short in terms of sufficient funding and fall short in terms of investment flexibility.

Work arounds will not succeed when fundamental reform is needed.

The Framework notes, “traditional FFS payments are ill suited for initiating investments and sustaining population health management innovations.” [Page 8, *APM Framework, Health Care Payment Learning & Action Network*, 2017, p. 8]

The APM Framework includes the following, more inclusive statement:

Transitioning the U.S. health care system away from fee for service (FFS) and toward shared risk and population-based payment is necessary, though not sufficient, to achieve a value-based health care system. Financial incentives to increase the volume of services provided are inherent in FFS payments, and certain types of services are systematically undervalued. This is not conducive to the delivery of person-centered care because it does not reward high-quality, individualized, and efficient care... Shared-risk payments, population-based payments, and other payment mechanisms are better suited than FFS payments to support the care delivery that patients value and incentivize the outcomes that matter to them. Therefore, the health care system should transition toward shared-risk and population-based models.

[*APM Framework, Health Care Payment Learning & Action Network*, 2017, pp 1-2]

Population-based payments do provide sufficient funding to allow for sustainability of the very activities which define the AE program:

This is because population-based payments give providers more flexibility to coordinate and optimally manage care for individuals and populations. In combination with substantially reduced incentives to increase volume, and stronger incentives to provide services that are currently undervalued in traditional FFS, there is a consensus that this flexibility will expedite fruitful innovations in care delivery, particularly for individuals with chronic, complex, or costly illnesses.

[*APM Framework, Health Care Payment Learning & Action Network, 2017, p.8*]

It is time for EOHHHS to move beyond the constraints of prior models and to allow AEs that are ready to do so to adopt population-based payments. We urge EOHHHS to strongly consider the encouragement HCPLAN gives to adopting population-based payments:

LAN firmly believes that a shift to person-centered, population-based payments will, in concert with significant delivery system reforms, result in an acceleration of high-value care in the United States. As discussed in the next section, the APM Framework will provide a valuable tool in accelerating this process.

[*APM Framework, Health Care Payment Learning & Action Network, 2017, p. 9*]

The Framework explicitly addresses the intersection of payment reform and **sustainability**.

Principle 1: Changing payment to providers is only one way to stimulate and sustain innovative approaches to the delivery of person-centered care.

[*APM Framework, Health Care Payment Learning & Action Network, 2017, p. 12*]

HCPLAN acknowledges that payment reform is also necessary as we expand our definition of patient needs – i.e., to include social drivers of health (SDOH) – and expand the definition of patient care team to include community-based organizations, such as those brought in to help patients via the state’s Community Referral Platform, Unite Us.

FFS is not conducive to the pursuit of care delivery innovations that are capable of better addressing complex issues, such as social determinants of health and care management for patients with multiple chronic conditions. This is because solutions to these types of issues require considerable coordination beyond the walls of the clinic or hospital, which cannot realistically be itemized on a fee schedule.

[*APM Framework, Health Care Payment Learning & Action Network, 2017, p. 17*]

The language in the APM Framework discussing the advantages of Category 4 models strongly echoes EOHHHS’s sustainability goals:

Payments within Category 4 can be used to cover a wide range of preventive health, care coordination, and wellness services, in addition to standard medical procedures typically paid through claims, and this flexibility makes it easier for providers to invest in foundational and innovative delivery system components. Additionally, replacing the volume-based incentives of FFS with prospective, population-based payments creates stronger incentives for providers to maximize quality within a budget.

[*APM Framework, Health Care Payment Learning & Action Network, 2017, pp. 27-28*]

The APM Framework makes an important point about the need for payment arrangements to be sufficient in scale to support the flexibility and scope of services that will produce better outcomes. PCP capitation should not be confused with true population-based payment and will not in any way fundamentally transform the accountability and cost structure for the AE systems of care in Rhode Island.

While we strongly advocate for fundamental reform, we recognize organizations are – and will likely remain – at different places in terms of readiness to embrace such reform.

This reality, in fact, is acknowledged with the APM Framework,these mutually reinforcing characteristics of Category 4 payments – both the freedom to practice medicine without having to rearrange care delivery to meet strict reimbursement requirements, and the incentives to maximize the quality and efficiency of care delivery – hold special promise for providers and patients who are able and willing to participate in them.

[*APM Framework, Health Care Payment Learning & Action Network, 2017, pp. 27-28*]

The point made in the final sentence above is critical, and it repeats a point we have made in previous submissions: Not all systems of care will be ready, able, or willing to accept the highest levels of payment and care delivery reform.

Systems of care should be allowed to operate at the highest level of innovation of which they are capable. Restraining reform to achieve a general uniformity does not serve the long-term goals of EOHHS and prevents EOHHS from realizing the full benefit of engaging a diverse array of providers.

Category 4 payments are not necessarily appropriate for all providers and markets. To be successful, providers will necessarily travel at different paces and along different trajectories in the collective journey of health payment and delivery reform. But over time, Category 4 APMs will offer an appealing destination for more and more providers and other stakeholders in the health care system.

[*APM Framework, Health Care Payment Learning & Action Network, 2017, pp. 29*]

Without a fundamental change in the payment system, there will never be sufficient resources for Accountable Entities and systems of care to do what they can directly, or in partnership with others, to serve their **population** under management and improve outcomes for their members.

We urge EOHHS to develop and implement an **accountable, population-based payment system**, one that that will provide the resources to begin to achieve all the goals of the AE initiative. Without delivery and financing reform, achieving equitable access for all to healthcare, behavioral, and SDOH services will remain a laudable destination without a definable pathway to get there.

The following comments relate to specific sections of the document.

Approach

Page 6 of the document includes the following statement:

The Accountable Entity program is being developed in the context of Rhode Island’s existing managed care model. The AE program is expected to enhance MCO capacity to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum. [Page 6]

This statement should be revised to recognize the role of AEs, of systems of care, in the AE initiative.

The state has made significant changes in the role of AEs within the initiative since its launch. These changes are based on the recognition that is the front-line staff of the AEs – primary care providers, nurse care managers, community health workers, social workers, recovery coaches, health educators, and more – who provide the innovative care programs that will improve patient health and rebalance healthcare spending.

This statement should affirmatively reference the the fact the program, thanks to state investment, has increased **AE** “capacity to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum.”

Specialized AE Program

We continue to support the potential specialized AE and welcome the opportunity for additional collaboration between the AE and LTSS providers.

And, as we have in the past, we support including the dual eligible population in the AE program. This population includes those patients with the highest levels of need who stand to realize the greatest benefit of improved care, improved health, and smarter spending through comprehensive accountable care.

Comprehensive Accountable Entities

In the section on TCOC, the roadmap states the following:

Qualified TCOC-based contractual arrangements must also demonstrate a progression of risk to include meaningful downside shared risk or full risk. As AE incentive funding is phased out, AEs will be sustained based in part on their successful performance and associated financial rewards in accordance with their contract with MCOs. [Page 13]

As discussed in the first section of this memo, and discussed in greater detail below in our review of the five sustainability strategies, TCOC funds will be insufficient to compensate for the forthcoming decrease and elimination of Infrastructure Incentive Payments.

As the AE program evolves and as the role of different AEs changes in line with the capacity each AE, funding will need to flow to the AEs to support the roles and responsibilities they take on. For example, an AE that takes on delegated Utilization Management and Care Management, the funding currently provided to MCOs should flow to the AE. Funding must follow function.

Oversight Meetings with MCOs

In the interest of transparency and in order to further encourage the development of a multi-party partnership, which is the vision behind the AE initiative, we encourage EOHHS to share pertinent and relevant information from the MCO oversight meetings.

It would be helpful to the AEs, in fact to all parties involved, if any issues identified and discussed was more broadly available.

Rhode Island Health System Transformation Project Accountable Entity Sustainability Plan

We wholeheartedly support the following statement:

It is important that the changes made and programs developed utilizing the DSHP funds are continued even after the incentive funding ceases, in order to sustain the progress that has been made in transforming the healthcare delivery system. [Page 22]

We agree that the AE program has improved the quality, effectiveness, outcomes, and spending efficiency for its members. This has taken steadfast leadership from the state along with steady, significant investment in building AE capacity. It is not in anyone’s interest to lose any ground gained in recent years.

Understanding AE Activities and Costs

The analysis on pages 28-30 is interesting and instructive, however, drawing definitive conclusions from the information gathered to date about the real costs of operating an Accountable Entity is probably risky.

But this information does reenforce our arguments, made throughout this memo, that shared savings will be inadequate to operate a sufficiently robust AE operation. For that reason, we argue for population-based payment and argue that funding should follow function when it comes to Utilization Management and Care Management.

Strategies for Sustainability

EOHHS identifies the following sustainability strategies:

- A. Centralize key investments to achieve efficiencies that will reduce AE costs and enhance shared savings opportunities.
- B. Support achievement of shared savings through the total cost of care arrangements that AEs have with MCOs to provide some support for AE costs.
- C. Obtain the authorities needed to provide reimbursement for high value services that require consistent support (e.g., Community Health Workers).
- D. Leverage contractual relationship with MCOs to increase the support of care management and social determinants of health (SDOH) activities.
- E. Leverage multi-payer statewide policies to support AEs. [Page 30]

Centralize key investments to achieve efficiencies that will reduce AE costs and enhance shared savings opportunities.

Quality Reporting System

Should EOHHS seek to expand the number of practices participating in the QRS, this will require funding.

The entire process of onboarding practices has proven to be more complicated, time consuming, and expensive than everyone originally anticipated. EOHHS is to be applauded for steadily increasing its hands-on management of this process and for obtaining the extension which will allow PHSRI-AE, and others, to meet the required threshold.

However, for this achievement to endure, EOHHS must continue to provide financial support. First, some EHRs are charging exorbitant annual fees. This is not an expense practices are prepared to bear. Additionally, long-term success of the QRS will require constant addition of practices and EHRs. It is in the interest of EOHHS to see more practices adopt the QRS. This will not happen without administrative, project management, and financial support.

Community Referral Platform

Given the fact the PHSRI-AE was the first AE to adopt a community referral platform and also selected Unite Us, is not surprising that we strongly support the initiative EOHHS has taken to expand and advance this invaluable resource.

Rhode 2 Equity

This is an excellent example of the ways EOHHS, and partners, can promote, support, and incubate innovation **and** collaboration. We encourage EOHHS to include initiatives like this in future plans and to identify a way to finance such projects in the years ahead.

That said, we also urge EOHHS to find ways to lessen the burden of participation on all involved. It might prove difficult to get systems of care, community-based organizations, payers, and community members to match the current time and personnel expectations.

Support achievement of shared savings through the total cost of care arrangements that AEs have with MCOs to provide some support for AE costs.

We will not repeat here the argument we have made throughout this memo that shared savings will not be sufficient to support a robust AE program on an on-going basis.

Fundamental payment reform is essential. A list of multiple strategies does not necessarily move us closer to the goal which could more easily and effectively achieved with a more aggressive adoption of population-based payment.

Obtain the authorities needed to provide reimbursement for high value services that require consistent support (e.g., Community Health Workers).

We share the conviction of EOHHS that Community Health Workers are essential to the success of the AEs. For this reason, we have made CHWs a part of our dedicated AE Care Team.

Should a reimbursement model be developed that allows CHWs to conduct the broad range of activities currently executed by our CHW, we would take advantage of this opportunity. It is critical that this reimbursement not be driven by coding which would lead to this innovative enhancement devolving into a FFS service.

We concur that the “value-add” and “in-lieu of” options are under-utilized in Rhode Island and would gladly participate in any efforts EOHHS undertakes to explore the opportunities for leveraging funds through these mechanisms.

We will not repeat here the point we have elsewhere that primary care capitation will be insufficient to support this and that primary care capitation, alone, does not achieve fundamental payment reform as we have encouraged.

Leverage contractual relationship with MCOs to increase the support of care management and social determinants of health (SDOH) activities.

Through this planned procurement, EOHHS is exploring opportunities for future subcontractor delegation of functions and the associated financing structures from MCOs to AEs. In particular, EOHHS is exploring opportunities to delegate the function of delivering certain care programs (e.g., care coordination, care management, etc.) from MCOs to AEs, and to require that AEs be reimbursed for delegated functions.

[Page 37]

As discussed previously in this memo, we applaud the recognition that funding needs to follow function when AEs take on duties currently carried out by the MCOs.

The PHSRI-AE has long argued for delegation of Utilization Management and Care Management. We have made this argument because UM and CM delegation are essential under a population-based payment model. If a system of care is going to take downside risk, the SOC must have all the tools available to manage that risk and to control utilization, costs, and outcomes.

The roadmap also describes the goal of EOHHS to increase MCO investment in addressing health-related social needs:

EOHHS is also exploring ways to increase MCO investment in social determinants of health. Respondents to the Request for Information recommended that EOHHS require MCOs to take actions such as building partnerships with community-based organizations, Health Equity Zones, and other agencies; providing in-lieu of services and value-added services to target improved health; participating in and supporting the community resource platform to improve closed-loop referrals to community-based organizations; and expanding use of community health workers, peer specialists, and recovery coaches to delivery in-lieu of services. [Pages 37-38]

We support this goal, but EOHHS should not stop here.

EOHHS needs to proactively convene the diverse stakeholders required to develop and implement transformational initiatives such developing long-term affordable, supportive housing. Projects like this will require significant investment and collaboration. Making them happen will take leadership. They will not naturally occur, but if EOHHS takes the lead and brings together other parts of state and local government, community-based organizations, systems of care, higher education, social impact investors, and philanthropy, significant projects could be advanced.

Leverage multi-payer statewide policies to support AEs.

Much of what has been pioneered within the AE model would benefit patients across the spectrum in Rhode Island.

While health-related social needs may be more extreme in their impact with the AE population, no demographic is immune from social drivers of health. The steps EOHHS has taken to develop a community referral platform for the AE program will, in fact, benefit Rhode Islanders regardless of payer.

The advances in Integrated Behavioral Health supported with Infrastructure funds will, ultimately, benefit all Rhode Islanders. The same can be said of other innovations developed by the AEs to better address behavioral health and substance use disorder of our patients.

While the need may be most extreme with the AE population, these needs are not unique to these patients. However, as we have stated elsewhere, primary care capitation will not be sufficient to realize the goals of EOHHS.

Conclusion

We commend EOHHS for sharing this document for comment.

We agree with EOHHS that the innovations that have been funded with infrastructure incentive funding must be maintained, and expanded, in order to achieve the goals of the AE initiative.

The sustainability plan proposes numerous ways of ensuring funding continues when infrastructure incentive resources expire. All options should certainly be considered, but we strongly urge EOHHS to prioritize the following:

- 1. AEs should be at the center of policy and program decisions.**

The success of the AE program rests upon the ability of AEs to deliver the goals of the program. Given this, all policy and program decisions should be based on supporting the work of the AEs, the strategies of the AEs, and advancing the accountable performance of the AEs.

The AE program is a partnership that draws on the strengths of all stakeholders – the state, payers, and the AEs themselves. This is why we suggested re-drafting the description of the state’s “Approach” to the program to include a reference to the AEs. For this reason, we support the steps the state will take to clarify that care management responsibility rests with the AEs. Similarly, AEs should be a part of the conversation about how to deploy any new resources the state or MCOs identify and devote to the AE initiative.

Execution and delivering on the AE program will depend upon the front-line work of AEs. We urge the state to maintain and expand the opportunities for AEs to help shape policy and program decisions.

2. Adopting an accountable, population-based payment system is essential

The best route to long-term sustainability for the AE program is to enact fundamental payment and system reform by adopting an **accountable, population-based payment system** with a robust risk-adjustment model to account for differences in population from AE to AE. Without fundamental reform of the payment system the ambitious goals we all share will not be realized.

This is why transformation of the underlying accountability and payment system – aligned with the goals of the accountable entity initiative – is essential. This is the only way to achieve the significant reallocation of resources from medical services – too often high-cost, unnecessary and inefficient services – to interventions that will fundamentally improve population health—clinical, behavioral and socially determined – in an accountable way.

Therefore, we urge EOHHS to put provider accountability and payment system reform back at the top of the Medicaid transformation agenda and timeline, with the clear acknowledgement and understanding that real improvements in SDOH will need to be paid for within the current, increasingly constrained resource environment.