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Roadmap	Vision/Goals/Approach	The EOHHS support of AEs is evident, however we observe that there is limited recognition of the ongoing value of the MCO. There is a need to broaden the scope of the sustainability plan to include MCO involvement going forward. The MCO dedicates significant staffing, time, and expense to support the AEs. As PY 5 requirements are being considered, we strongly encourage EOHHS to begin to pivot to expectations of programmatic outcomes and focus less on defining specific requirements for the AE. At this point of program maturation, as we move towards diminished HSTP funding, EOHHS needs to provide flexibility to the AEs and MCOs to achieve program objectives.	EOHHS appreciates the value that MCOs have brought to the work with AEs and appreciates this feedback. EOHHS appreciates the feedback regarding the future of the program in terms of the different roles of EOHHS, MCOs, and AEs. Over time and in line with directives from CMS, EOHHS has shifted the AE program toward paying for outcomes rather than process. As the incentive funding winds down, EOHHS will explore the best balance between flexibility and maintaining minimum expectations in line with good program stewardship.
Roadmap	Vision/Goals/Approach	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	EOHHS understands that there may be significant challenges involved in managing care across different provider systems (e.g., when a patient received primary care from one AE but sees a specialist affiliated with a different AE for other services). AEs share responsibility with MCOs, and EOHHS understands that there will be activities that are more appropriately conducted by an MCO rather than an AE, and that to some extent such activities may vary across AEs. EOHHS believes that the basic definition of an AE described in this Roadmap and the AE Certification Standards, posted separately for public comment, appropriately reflect the AE role. EOHHS looks forward to receiving public comment on the proposed revisions to the AE Certification Standards.

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		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.	
Roadmap	Vision/Goals/Approach	...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. 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. ...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. Reference to 2017 APM Model cited in Roadmap for following comment: 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	EOHHS appreciates the feedback that global/capitated payments at the AE/system level would be more effective for sustainability than the current approach of two-sided risk contracts built on the fee-for-service chassis. EOHHS is committed to forging a path toward advanced value-based payment and is partnering with the Rhode Island Health Care Cost Trends Project Value-Based Payment Subcommittee convened by the Office of the Health Insurance Commissioner to develop value-based payment principles and strategies to promote adoption of advanced value-based payment methodologies, including but not limited to HPC-LAN Category 4 models. EOHHS intends to work to align EOHHS payment methodologies with statewide goals. As EOHHS develops plans for advanced value-based payment, it is necessary to remain careful stewards and administrators of the AE program, which means that adequate planning and analysis must precede such a substantial change and that any policy must account for the wide

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		payment – will fall short in terms of sufficient funding and fall short in terms of investment flexibility. ...Population-based payments do provide sufficient funding to allow for sustainability of the very activities which define the AE program....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. 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.	differences in readiness and the possibility that for some providers, prospective payment for total cost of care will not be an appropriate payment method.
Roadmap	AE Program Structure	Neighborhood would like for EOHHS to share any plans for the AE program after HSTP funding for the AEs and MCOs is exhausted in FY 2025, the last year of incentive funding.	EOHHS looks forward to working with stakeholders to consider different approaches to structuring the AE program following the end of the incentive program. EOHHS would like to clarify that the incentive program is

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			scheduled to end following state fiscal year 2024.
Roadmap	Certification Requirements	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 advance standards.	EOHHS appreciates the feedback regarding shared AE and MCO responsibility for the AE-MCO collaboration. MCO responsibility to support AEs is documented in the contracts between EOHHS and MCOs. EOHHS believes it is appropriate to articulate a mutual expectation of both AEs and MCOs to partner thoughtfully in this endeavor.
Roadmap	AE APM	Regarding the APM requirements, we would like to reserve an opinion that may be influenced by the pending complete draft of the PY5 TCOC requirements. Neighborhood supports full HSTP incentive funding for any FQHCs that do not opt for down-side risk.	EOHHS appreciates this recommendation and looks forward to receiving public comment on the PY5 TCOC Requirements.
Roadmap	AE APM	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	EOHHS appreciates the recommendation to issue boilerplate contract language and will consider this option in discussion with MCOs.

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		"base contract checklist" but feel that EOHHS can go further.)	
Roadmap	AE APM	....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.	EOHHS would like to note that the previously planned change in incentive funds has been amended in the Program Year 5 Requirements such that the reduction relative to Program Year 4 is smaller (i.e., the per member per month amount will be higher than previously stated). EOHHS agrees that as AEs take on responsibilities and are able to meet them to appropriate standards, resources should follow.
Roadmap	LTSS APM	Within the roadmap, RI EOHHS describes thoughtful planning for the Long-Term Services and Supports (LTSS) as well as the Behavioral Health (BH) populations of Rhode Island residents. There is, however, a distinct oversight and missing population in adults and children with Intellectual and Developmental Disabilities (I/DD). This population has significant, long term chronic conditions which are not effectively managed. The Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH) supports approximately 5,000 adults with I/DD and Rhode Island Kids Count estimates 4,457 children under the age of 19 that receive medical benefits for special health care needs. Adults and Children with I/DD in the State of Rhode Island are overlooked within the AE	Thank you for the thoughtful comments on the importance of supporting RI's I/DD population and leveraging lessons learned over the years through the I/DD medical homes. The I/DD population enrolled in managed care along with the medical/acute services covered under their managed care benefit are a part of the HSTP AE program. As such, AEs have accountability for those patients' care and health care costs. EOHHS will consider options for enhancing AEs' ability to effectively do so. Specific to the LTSS APM program and the MMP, I/DD individuals receiving home care services through the MMP would also be a part of the LTSS APM, per the federal

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		program. While the overall population may not be as significant in numbers as other populations, their utilization of health care dollars is. For example, in a study conducted by Zubritsky, Abbott, Hirschman, Bowles, Foust and Naylor (2013), health-related quality of life domains have failed to take the particular needs of the IDD population into account. We know that adults with cognitive disabilities have a dramatically higher rate of chronic conditions than adults without disabilities, including being five times more likely to have diabetes than the general population (Reichard & Stolzle, 2011). Rhode Island adults and children with special health care needs and/or I/DD face increased challenges in accessing appropriate healthcare to meet their complex needs. Rhode Island would benefit from a pilot program that includes this target population as a stand-alone AE to address the continuity of care challenges and obtain aggregate data to spotlight this area of need. The AE program has the opportunity to build on the current understanding of the social determinants of health as well as the knowledge gained from successful IDD medical homes and DSRIC projects nationally. Rhode Island's effort, if IDD is included, could reduce the cost of care for the IDD population while concurrently maintaining them within their communities of choice and reducing the need for expensive, long term care beds or long hospitalizations. The supported	parameters this program operates under. The BHDDH waiver services, however, are not covered services or part of the Medicaid managed care benefit package and thus they would not be included in the APM arrangements established under either AE or LTSS APM programs.

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		individuals in the State of Rhode Island with Intellectual and Developmental Disabilities and Special Healthcare Needs are in desperate need of evidence-based options to decrease hospital/emergency room visits and to increase the overall quality of care provided in the State of Rhode Island. Ultimately, their inclusion would reduce the need for expensive residential options while creating a more equitable quality of life.	
Roadmap	LTSS APM	...we support including the dual eligible population in the AE program. This population includes those patients with the highest levels of need who stand to realize the greatest benefit of improved care, improved health, and smarter spending through comprehensive accountable care.	EOHHS appreciates the support and response.
Roadmap	Monitoring/Reporting/Evaluation	Neighborhood would like to point out that quality measures (applicable to the TCOC multiplier) need to be meaningful but reasonable. Neighborhood recommends that EOHHS adopt a process whereby the benchmarks are arrived at via a more collaborative, consensus driven means, driven by the MCOs instead of EOHHS. Allowing EOHHS to introduce processes consistent with a post-HSTP program. Neighborhood would like to be an active participant in the EOHHS AE Evaluation Plan.	AEs and MCOs participate every year in an extensive stakeholder process through which quality measures are set and targets are established. While EOHHS does retain final decision-making authority, EOHHS believes that the process is quite collaborative. EOHHS looks forward to sharing our AE Evaluation Plan in the coming months and offering opportunities for AE program participants (payer and provider alike) as well as other stakeholders to engage in the evaluation process.

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Roadmap	Monitoring/Reporting/Evaluation	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.	EOHHS agrees that it would be better if the time between when performance occurs and when AEs receive reports on their performance were lower. For any performance related to claims, however, most of this lag is unavoidable. If there is not at least a three-month claims runout period, the data will be too unreliable to use. It is correct that further time is spent preparing reports. At this time, EOHHS does not believe that MCOs take unreasonable amounts of time to prepare reports. However, EOHHS would welcome MCO feedback on the possibility of preparing reports in less time. In addition, EOHHS notes that MCOs may have less formal reporting mechanisms in place that can give some information on performance with greater frequency.
Roadmap	Oversight Meetings	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.	EOHHS will discuss with MCOs the recommendation to share certain information from MCO oversight meetings. EOHHS appreciates this suggestion and feedback that more transparency and communication between state, payer, and provider would be helpful.
Sustainability Plan	Conceptual Framework		

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Sustainability Plan	Conceptual Framework	The “Efficient Care Threshold” concepts depict costs in the AE program that are not currently calculated in the Total Cost of Care. To fully reflect the cost of the AE Program, EOHHS needs to build in the expenses associated with the MCO and EOHHS support. The MCOs are a significant contributor to AE success and a driver of program efficiency. The data analysis and technical assistance from the MCO has a direct impact on each AEs ability to succeed. EOHHS needs to account for adequate funding for MCO expenses that flow downstream to the AEs. As the program moves into PY5 and PY6 Neighborhood would like to offer that EOHHS strongly consider less prescriptive, specific requirements. Instead, an expected outcome should be required. An outcome that can be achieved with the flexibility of allowing for individualized AE/MCO targeted approaches. As we approach the AE Program Year 5, it is time for EOHHS can begin to plan for a gradual disengagement from the program. Neighborhood contends that the MCOs and AEs in partnership can work together to leverage the individual aspects of each MCO AE relationship to achieve long-term sustainability and success.	EOHHS appreciates the value that MCOs have brought to the work with AEs and appreciates this feedback. EOHHS appreciates the feedback regarding the future of the program in terms of the different roles of EOHHS, MCOs, and AEs. Over time and in line with directives from CMS, EOHHS has shifted the AE program toward paying for outcomes rather than process. As the incentive funding winds down, EOHHS will explore the best balance between flexibility and maintaining minimum expectations in line with good program stewardship.
Sustainability Plan	Conceptual Framework	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	EOHHS appreciates the recommendation to assure a predictable administrative payment to AEs and will consider this opportunity in the coming year. EOHHS directionally agrees that ongoing

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		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. 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	resources are needed to support functions like care management that AEs must implement to succeed under total cost of care and is committed to continuing our exploration for an effective mechanism for funds to flow to AEs to support those functions in a predictable manner.

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		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.	
Sustainability Plan	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?	EOHHS appreciates the correction regarding Algorex and will correct the description in the Sustainability Plan. In general, EOHHS does appreciate that not all technology-related investments are one-time and will revise the text to better reflect this. EOHHS very much appreciates the AEs' support in completing budget template information. Clearly, having more and better information on AE activities and expenses will aid in planning activity. EOHHS continues to refine our plans to sustain AE work following the end of the incentive fund program. As has been shared in several stakeholder sessions, incentive funds will decline from Program Year 5 to Program Year 6, although EOHHS is open to receive feedback on this trajectory. While the state cannot commit to level funding from Program Year 4 - 6 due to budget constraints, EOHHS notes that we have revised the

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			budget recently to substantially slow the decline in PMPM over the last two years of the program. This is reflected in the Program Year 5 requirements that have been posted. As significant incentive funds will still be available in Program Year 6 and given the continued availability of shared savings and new support for CHW services for example, EOHHS expects that AEs will not face substantial reductions in resources at that time. EOHHS expects, therefore, that receiving information about AE budgets in the first quarter of CY 2022 will allow enough time for EOHHS to use the information in a revised sustainability plan.
Sustainability Plan	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.	EOHHS believes it is worth attempting to understand AE costs more accurately but agrees that it is important to be clear on the limitations of the data we have been able to obtain and analyze to date. EOHHS agrees that at this point, it is not clear that AEs will be able to cover all their costs through shared savings, although EOHHS expects some improvement as AEs reap some performance benefits of their experience. That is why EOHHS includes a range of strategies in the sustainability

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			plan, including discussion of the possibility of delegating care management activities and their associated resources. EOHHS understands the rationale for population-based payment to address these concerns and is committed to forging a path toward advanced value-based payment. EOHHS is pursuing this in alignment with the Office of the Health Insurance Commissioner and the recommendations and actions of the Cost Trends Project Value-Based Payment Subcommittee. As EOHHS develops plans for advanced value-based payment, it is necessary to remain careful stewards and administrators of the AE program, which means that adequate planning and analysis must precede such a substantial change and that any policy must account for the wide differences in readiness and the possibility that for some providers, prospective payment for total cost of care will not be an appropriate payment method.
Sustainability Plan	Centralizing Infrastructure	**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	EOHHS appreciates the feedback regarding Quality Reporting System sustainability and will evaluate opportunities to enhance support for AEs to expand and maintain the system.

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		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	EOHHS appreciates the support for and engagement in the Community Resource Platform and Rhode to Equity.
Sustainability Plan	Centralizing Infrastructure	Neighborhood recommends EOHHS should include ongoing vendor costs, IT infrastructure costs, licenses and other permanent costs along	EOHHS agrees that ongoing costs other than staffing should be recognized as such and has revised the text of the Sustainability Plan to make clear the

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		with the staffing costs, which EOHHS has recognized.	EOHHS view that staffing only one large example of a permanent cost involved in AE operations.
Sustainability Plan	Centralizing Infrastructure	**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	EOHHS understands that not all AEs will experience the CRP as a sustainability strategy, for the reasons described here. For the program as a whole, though, this centralized investment is useful in reducing costs that AEs might otherwise need to fund independently. With respect to the social determinants of health screening issue, the revised Quality and Outcomes Implementation Manual includes revised language intended to address the issue of needing to have the screening in a provider's EHR, as the platform's capabilities align with the spirit of the requirements to ensure providers have easy access to information without having to log into multiple systems. EOHHS is pleased that many AEs are participating in the Rhode to Equity project and includes it as a sustainability strategy because it invests in AE capacity to engage with community partners and provides resources to support AEs in developing strong community partner relationships. Those skills and relationships are expected to remain a

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		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	valuable resource to AEs going forward. EOHHS looks forward to sharing more about the behavioral health investment plan in the coming months. EOHHS appreciates the recommendations for further centralizing and reducing AE costs and will examine opportunities to implement these ideas.
Sustainability Plan	Strategies for Sustainability	Neighborhood Recommends greater model flexibility to help the historically lower cost AEs. The difference between the historically lower cost providers and the higher spend providers has not been adequately addressed in the Market Adjustment. Secondly, any assumptions based on Medicare (or any non-Medicaid product) should be tempered as the populations and program requirements are different.	EOHHS plans to continue the Market Adjustment trajectory set forth in earlier TCOC Technical Guidance documents. In order to remain budget neutral, greater market adjustments in favor of more efficient providers must be offset by market adjustments that make it harder for less efficient providers to achieve shared savings. EOHHS has sought to strike a balance between supporting

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		*Neighborhood applauds EOHHS for adding Community Health Worker services as a Medicaid benefit. Neighborhood recommends that the state move the CHW benefit into the Managed Care benefit package in PY5, but no later than PY6. The administration of the benefit will be easier and access greater through the established provider-MCO billing mechanisms. *For Care Management, Neighborhood recommends a shared accountability approach using established criteria that would be implemented in phases. Shared accountability is based on the AE and MCO's capabilities and strengths, and ensures a clear delineation of where an MCO, AE, other provider or program is taking the lead in coordinating a member's care. Shared accountability reduces duplication of effort, inefficiency and incentive misalignment. *Neighborhood cautions EOHHS about assuming that AE incentives, policies and funding priorities will be aligned across payers (commercial, Medicare and Medicaid). FQHC AEs do not have the same payer population mix as the non-FQHC AE providers. EOHHS needs to recognize that not all AEs to have access to the same levels of funding and or staffing. The funding levels vary between payers and the demands and expenses of the various product's memberships differ greatly as well. FQHCs are the cornerstone of the	efficient providers while still making it possible for historically less efficient providers to improve and succeed. EOHHS agrees that no firm assumptions can be made about the trajectory of shared savings based on outcomes in other programs or states. However, the fact of positive results in Medicare is some evidence that it is reasonable to expect some AEs to succeed. EOHHS plans to carefully evaluate whether and when to move CHW services under the managed care benefit package. Generally, new services are first offered through the fee-for-service structure and included in the managed care package subsequently. EOHHS appreciates the feedback about a shared accountability approach for care management and agrees that it is important to reduce duplication of effort, inefficiency, and incentive misalignment. EOHHS agrees that FQHCs are different from other providers, and notes that AEs are fairly heterogeneous in general. Each AE has a different payer mix and different financial circumstances. EOHHS remains open to receiving information

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		Medicaid AE program based on both total membership and innovation. As such, EOHHS should differentially consider the impact to the FQHCs of any new programmatic or policy direction.	about possible adverse effects of any policy proposal on any provider.
Sustainability Plan	Shared Savings/TCOC	To ensure program sustainability, we encourage EOHHS and MCOs to continue working together to effectively evolve the total cost of care (TCOC) methodology over time. We recommend EOHHS consider gradually increasing the shared downside risk level and further aligning incentives and penalties across MCOs and AEs as part of that effort.	EOHHS appreciates the feedback regarding the value of downside risk as an incentive to improve TCOC performance. The progression to downside risk described in detail in past year's TCOC Requirements is aligned with this approach, and EOHHS proposes to implement the planned progression in the Program Year 5 TCOC Requirements, such that the downside risk level increases for PY5.
Sustainability Plan	Shared Savings/TCOC	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.	The comparison between AE costs and shared savings is described on page 35 of the Roadmap posted online. The analysis indicates that AE expenses for Program Year 4 (as reported to EOHHS as part of the Program Year 4 certification process) are indeed greater than shared savings payments received by AEs for each of Program Years 1 and 2. Program Year 2 shared savings payments would have "covered" a higher proportion of expenses than Program Year 1 payments. Results varied considerably across the AEs.

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			EOHHS agrees that at this point, it is not clear that AEs will be able to cover all their costs through shared savings, although EOHHS expects some improvement as AEs reap some performance benefits of their experience. That is why EOHHS includes a range of strategies in the sustainability plan and remains focused on ensuring that appropriate costs for managing patient care and reducing unnecessary utilization (e.g., utilization caused by preventable exacerbations of chronic disease, utilization caused by difficult accessing primary care, etc.) are accounted for in a predictable manner.
Sustainability Plan	Shared Savings/TCOC	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.	In partnership and alignment with the Cost Trends Project Value-Based Payment Subcommittee, EOHHS will pursue opportunities to advance along the LAN continuum. This will entail substantial policy development and analysis in partnership with MCOs, providers, and other stakeholders. EOHHS agrees that adoption of population-based payment can be an effective sustainability tool for some providers. This model may also introduce a level of risk and/or set of operational

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			responsibilities that is not appropriate for some AEs, or that some AEs may not be ready to accept. Policy design must account for this provider heterogeneity.
Sustainability Plan	Medicaid Reimbursements	We encourage EOHHS to deepen their commitment to CHWs and provide forums for the MCOs and AEs to share best care management practices, including best practices around staff training and performance metrics. The COVID-19 pandemic intensified the negative impacts of SDOH faced by Medicaid beneficiaries nationwide, including food and housing insecurity. As EOHHS explores opportunities to add additional services and supports as Covered Medicaid benefits, we encourage evaluating these needs and the extent to which the state can work to address under current CMS authority, as well as with current federal aid. Improved health outcomes and individual goals cannot be attainted without fully addressing social needs. We welcome the opportunity to collaborate with EOHHS on exploring additional services.	EOHHS appreciates the support for CHW reimbursement and will consider opportunities to provide forums for MCOs, AEs, and others to share best practices related to CHWs. EOHHS intends to continue to evaluate opportunities to address beneficiaries' health-related social needs under existing CMS authority as well as through seeking new authority, and welcomes the collaboration of MCOs, AEs, and others in this work.
Sustainability Plan	Medicaid Reimbursements	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	EOHHS appreciates the support for community health workers and the value they bring to care teams in Medicaid. EOHHS would like to note that in the most recent State Plan Amendment for CHW services posted for public comment, EOHHS increased the rates relative to the first posting in response to

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		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.	concerns about rate adequacy. EOHHS hopes that this will at least partially address the concern about rates. EOHHS performed considerable analysis and stakeholder engagement in designing the CHW benefit and determined that a fee-for-service reimbursement structure is appropriate for this new Medicaid benefit, notably to ensure that not only medical providers, but community-based organizations would be able to earn compensation for services rendered to Medicaid members. EOHHS expects to work with stakeholders to identify alternatives that can be implemented in the coming years as the delivery system evolves. Please see page 9 of *Attachment K - Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities* for details on allowable and dis-allowable uses of HSTP funds.
Sustainability Plan	Medicaid Reimbursements	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	EOHHS appreciates the support for CHW reimbursement and agrees that minimizing coding complexity is an important goal. EOHHS looks forward to stakeholder

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		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.	engagement related to enhancing use of "value-added" and "in-lieu of" services.
Sustainability Plan	CM and MCO Support	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.	EOHHS agrees that it is important to align incentives and funding and reduce duplication of effort between AEs and MCOs and agrees that delegation may be a path to achieve this.
Sustainability Plan	CM and MCO Support	UHC recommends that all sites within an ACO become NCQA PCMH certified in order to delegate care management activities from the health plan to the AE. This includes any new sites that are to join the AE in the future. The health	EOHHS appreciates this engagement on how to implement potential future care management delegation. EOHHS looks forward to working with MCOs and AEs to identify opportunities in this area.

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		plan is held to NCQA standards, which is the gold standard in health care, and would also recommend the ACOs be held to the same standard. This will allow for our members and their patients to receive the best care and health outcomes possible. It will also allow for consistency and standardization across the health plan and AEs. Please note that if ACO sites are not PCMH certified by NCQA, this puts each health plan at a very high risk of losing NCQA Accreditation; therefore, not adhering to Medicaid contract requirements.	
Sustainability Plan	SDOH and MCO Support	To encourage MCOs to develop unique value-added benefits and innovative in-lieu of services in addition to the base Medicaid benefit package, we recommend EOHHS: • Continue to allow MCOs the flexibility to develop tailored benefits and programs. MCOs can leverage these tools to achieve program goals by providing individualized beneficiary supports and having the ability to emerging member needs, as with the pandemic. • Maintain the current methodology of including the cost of these services in the numerator of the Medical Loss Ratio. • Limit value-added and in-lieu of services to benefits that are currently not covered or cannot be covered by the Medicaid benefit package. This will ensure that benefit packages are designed to meet the needs of the covered populations and that MCOs are able to accurately measure	EOHHS appreciates the recommendations for how to maximize the use of value-added benefits and in-lieu of services. EOHHS will consider these recommendations in developing more detailed policy in this area.

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		utilization and bill for services provided through encounter data. • Address the potential for “premium slide” in capitation rates that could result from effectively addressing SDOH. Having mechanisms in place to reward evidence-based investments in SDOH activities could encourage MCOs and CBOs to take meaningful steps in creating partnerships and addressing members’ social needs.	
Sustainability Plan	SDOH and MCO Support	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.	EOHHS appreciates the support for the plan to encourage MCOs to more flexibly use "in-lieu of services" and "value-added services," and agrees that it is reasonable to explore potential inclusion of quality improvement activities in the MLR numerator.
Sustainability Plan	SDOH and MCO Support	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-	EOHHS appreciates the recommendation to engage in upstream social determinants of health work and looks forward to further stakeholder discussion on these opportunities.

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		based organizations, systems of care, higher education, social impact investors, and philanthropy, significant projects could be advanced.	
Sustainability Plan	Multi-Payer Policies	We encourage EOHHS and the Office of the Health Insurance Commissioner (OHIC) to work with health plans and providers to review lessons learned from existing models in the market to identify areas where meaningful alignment could occur across Medicaid, Medicare and commercial coverage. Successful VBP programs meet providers where they are and incent improvements in cost, quality and member experience. Providers are on varying paths in their journey towards accountability for outcomes and must have models tailored to their specific needs and abilities to set them up for success. In addition, tailored arrangements consider the diversity of patient populations and varying infrastructure support needs across providers. This flexibility to meet providers wherever they are and invest in their capacities to become ever more effective partners in managing care to deliver better outcomes is essential for delivery system transformation, TCOC reduction, and quality improvement. In offering services across the coverage continuum, we have found that it important to ensure that multi-payer approaches truly align	EOHHS agrees that it will be important to learn from existing alternative payment methodology models to identify opportunities for alignment. EOHHS agrees that some flexibility may be important to allow payers and providers to ensure that APMs are appropriate to a providers' specific situation. EOHHS also agrees that aligned incentives across payers can support providers in engaging in APMs, and to this end EOHHS is an active participant in the Rhode Island Cost Trends Project Value-Based Payment Subcommittee. Through partnering with the Office of the Health Insurance Commissioner in this work, EOHHS seeks to align with the statewide strategy to promote advanced value-based payment methodologies.

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		incentives to create momentum for transformation, and do not unintentionally stall provider engagement or create adverse incentives that could increase costs or worsen disparities in health outcomes. We look forward to continue working with EOHHS, OHIC, AEs and other provider partners to deliver high-quality, cost-effective care to all Rhode Islanders.	
Sustainability Plan	Multi-Payer Policies	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.	EOHHS looks forward to engaging with stakeholders regarding multi-payer APM alignment, including through continuing the partnership with the Cost Trends Project Value-Based Sub-Committee.
Sustainability Plan	Multi-Payer Policies	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	EOHHS agrees that work to address health-related social needs and improve integration of behavioral health care can have substantial benefits across different patient populations, and that this implies that there is significant value available through multi-payer initiatives in these and other areas. Primary care capitation is one example of an opportunity to align APMs across payers. EOHHS anticipates pursuing other opportunities in alignment with the work of the Cost Trends Project Value-Based Payment Subcommittee, potentially

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		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.	including different types of global/prospective payment.
Sustainability Plan	Ongoing Planning	...we strongly urge EOHHS to prioritize the following: 1. AEs should be at the center of policy and program decisions. 2. Adopting an accountable, population-based payment system is essential ...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.	EOHHS agrees that provider accountability and payment system reform are essential priorities and expects to pursue opportunities to leverage new APMs to improve health system performance, in alignment with the goals, principles, and strategies of the Cost Trends Project Value-Based Payment Subcommittee.
Sustainability Plan	Outcome Measures	UHC appreciates EOHHS being receptive to feedback from the health plan regarding all elements of the AE program. UHC recommends that EOHHS continue to be receptive and use most recent data available to set quality and outcome measure targets. For QPY5, the health plan recommends not having a combined target for the outcome measures. It is too difficult for the health plan to support the AE not knowing what their interim rates are. If the health plan has its own benchmarks, we would be able to better support the AE. UHC also recommends all outcome measures be weighed equally. All of the outcome measures (e.g., utilization measures) are	EOHHS will work with stakeholders to finalize the approach to Quality and Outcome Program Year 5 (CY22). In general, EOHHS notes that selecting data for use in setting targets has been complicated by the COVID-19 pandemic.

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		as equally as important to help improve health outcomes for our members	
Sustainability Plan	E-Consults/CMHOs and IHH/Transitions of Care/Prescription Drug Costs	E-Consults Neighborhood recommends that EOHHS reimburse for E-Consults and build this concept into the Roadmap going forward. E-Consults are an effective approach to improve efficient access to specialty care. They offer a quick, direct, and documented communication between primary care and specialist. They could potentially reduce the need for face-to-face visits between specialist and patient therefore affecting the cost efficiency. CMHOs/IHH To date, the purposeful integration by EOHHS of the IHH providers and their oversight Agency BHDDH has been inadequate. IHH partnerships with AE organizations are critical to the sustainability of the program. Currently the IHH providers have very little incentive to approach the care of the AE patients efficiently. We recommend alignment of the IHH program with the goals of the AEs. At a minimum, IHH providers and BHDDH need to be a part of every AE discussion and planning. Neighborhood has offered ideas in this area and we continue to be willing to assist on this critical topic. Transitions of Care To date, most AEs do not have fair and equitable access to the major medical and BH hospital facilities to conduct in-person Transitions of Care.	EOHHS appreciates the recommendation on reimbursement for E-Consults and will consider the issue in the coming months. EOHHS appreciates the offer to assist on IHH integration with AEs and looks forward to working with stakeholders on this important matter. EOHHS agrees that transitions of care are important and that coordination between AEs and medical and BH facilities is essential. EOHHS expects to work with stakeholders to consider how best to achieve this coordination. Rising prescription drug costs are generally accounted for in managed care capitation rate setting, and changes in the capitation rates are translated into changes in TCOC targets. As with any part of the healthcare system, there may be many aspects of prescription drug costs that are outside AE control, but there are also aspects within AE influence, such as the opportunity to choose less expensive drugs where appropriate for a patient or the opportunity to address patients experiencing polypharmacy. EOHHS does

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		The recent experience with barriers to hospital access of the RI Parent Information Networks' (RIPIN) Transitions of Care project echoes with the AEs. RIPIN experienced resistance from many of the hospitals and EOHHS engagement was necessary to facilitate access. In-person at the bedside, Transitions of Care is the most effective in establishing a lasting patient relationship. Sustainability of the AE Program is only possible if AEs are provide equal access to all medical and BH facilities for transitions of care. Neighborhood strongly recommends EOHHS use it's purchasing and payment leverage to require all hospitals to allow AEs to carry-out care coordination functions inside of their facilities. Prescription Drug Costs Neighborhood recommends EOHHS recognize the impact of pharmacy cost and policies on AE sustainability. Rising prescription drug costs will significantly impact the AE total cost of care performance. A recent example is the removal of the need for a prior authorization for hepatitis medications. A policy such as this, without consideration of downstream AE impacts can cut into an AE's savings without any ability for the AE to manage or influence those costs. As EOHHS and the State makes policy changes, the downstream impact on AEs should be considered. If the changes are likely to result in a negative impact on the AE, without their ability to manage	not believe pharmaceutical costs are structurally so different from other healthcare costs that they cannot properly be included in a TCOC model.

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		those costs, a mitigating solution for the AEs should accompany the changes in policy.	