

To: Libby Bunzli, Director of Policy and Delivery System Reform, Rhode Island Executive Office of Health and Human Services

From: John Tobin, Program Manager, Accountable Entities-

Cc: Nancy Hermiz, V.P. Medicaid, Beth Marootian, Director of Business Development and Strategy

Date: November 8, 2021

Neighborhood Health Plan of Rhode Island appreciates the opportunity to respond to the Executive Office of Health and Human Services' (EOHHS) proposed Rhode Island Accountable Entity Program Year 5 Requirements - We are committed to continuing our close partnership with the EOHHS and the AEs to position this important policy initiative for future success. Neighborhood looks and look forward to discussing our input with EOHHS to answer any questions and clarify our comments and and/or recommendations.

General Observations:

Neighborhood applauds EOHHS for listening to and acting upon feedback the MCOs and AEs.

As EOHHS contemplates the PY 5 Requirement Public Comments, we strongly encourage EOHHS to consider using a wider lens that focuses on expectations of programmatic outcomes with less focus on defining specific requirements for the AE. At this point of program maturation, and as we move towards diminished HSTP funding, EOHHS needs to provide greater flexibility allowing the AEs and MCOs to achieve broad program objectives collaboratively. This is most notable in PY5 regarding the overly prescriptive AE Certification requirements for Care Management.

The PY5 Requirements feedback from Neighborhood is identified by PY5 Attachment and follows the sequence of Attachment Sections by page number.

Attachment J

P.3 TCOC Methodology - Neighborhood recommends aligning that the trend setting process used in target setting for the TCOC Shared Savings model to exactly with the rate setting process for Medicaid premiums. Since shared savings payments are paid by the plan, the trend methodology used to determine the plan's revenue and the methodology used to determine AE performance should be the same.

P4. Minimum Savings Rate - Neighborhood recommends that EOHHS apply a 2% MSR to all AEs with qualifying membership of 2,000 to encourage full engagement in the model by even providers with relatively small attributed membership. Neighborhood is concerned with assumptions from the Medicare ACO experience used by EOHHS to set the MSR given the significant differences in the overall program rules and population acuity between Medicaid and Medicare hat elements used by. Most savings in Medicare populations are generated by reductions in hospitalization and post-acute care expenses therefore Neighborhood contends that the MSR is currently set at a rate that is prohibitively difficult for small AEs to achieve.

Neighborhood further asserts that if the rationale for including a MSR in the upside-only model is to limit the impact of statistical variation in utilization and spending in small populations, it would follow that there be a comparable MSR and a minimal loss rate when an AE progresses to the risk model.

P. 7 TCOC Reporting Requirements - Neighborhood recommends EOHHS include risk adjustment accounting to the quarterly performance period update reports to mitigate potentially significant “actual to target” fluctuations during the performance period. Neighborhood reiterates the importance of the inclusion of risk adjustment estimates accounting for changes in risk profile from the benchmark years to the performance period in the EOHHS/Milliman quarterly reports. There is currently no attempt made to estimate this change and that can be misleading by unintentionally misrepresenting results.

P.10 Quality Score Determination (and implementation Manual p. 13)- Neighborhood recommends gauging improvement by closing the gap between historical performance and the achievement target by the same relative percentage. Neighborhood agrees with EOHHS’s decision to reward quality improvement as well as attainment of the target for each quality metric. However we call into question that: “the improvement target will be a fixed number of percentage points, with three percentage points as the default value”. This approach favors lower performers over those who performance is close to but not reaching the attainment target. For example, it is much more difficult to go from 65% to 68% completion than 35% to 38%.

P. 28 Glossary of Terms and P. 11 TCOC – Risk Exposure Cap - Neighborhood requests clear and detailed definitions in the Technical Guidance around how AE Revenue should be determined for purposes of calculating the Risk Exposure Cap.

Total Cost of Care Technical Guidance Program Year 5

P.8 Timing of Calculating the Final TCOC Targets - The final TCOC targets are not calculated until ten months after the end of the performance period. EOHHS may adjust targets due to “extraordinary and unforeseen circumstances”. This creates substantial additional risk to an AE that has progressed to shared risk.

Neighborhood recommends an alternative approach that would use the two most recently completed years of historical experience by the time the performance period starts.

Attachment K

P.3 and 4 - Incentive Pool PMPM – Neighborhood appreciates that EOHHS increased the budgeted PMPM in the incentive program after updating the EOHHS budget following fiscal close. We recognize this reflects the increased responsibility and activities of the MCOs and AEs.

Attachment H

P.26-32 Care Program Design and Management – Neighborhood strongly recommends EOHHS remove the level of specificity found in the Care Management Section (6) and focus on an incremental path toward increased AE readiness for MCO care management delegation. Neighborhood recommends initiating the incremental approach with Transitions of Care. Allowing the AE and MCO to develop a care management partnership plan that takes into account the varied AE readiness. . The partnership plan could incrementally expand based on an AE’s readiness to assume responsibility for additional components such as Care coordination and Care management of the rising risk and Care management of high risk Neighborhood has heard clearly from the AEs any increased care management requirements need to be supported by adequate, commensurate funding.

Neighborhood requests that EOHHS to take time for listening and feedback before defining the care management approach. The care management requirements are substantial and are being introduced at a time when program should be emphasizing sustainability and significant new and are being introduced at a time the program should be focused on creating sustainability instead of introducing extensive change.

Neighborhood cautions EOHHS the current approach will result in potential duplication of care management infrastructure and responsibilities between the MCO and AEs.. The MCOs have a primary contractual responsibility with EOHHS for care management and have further responsibility to meet NCQA accreditation standards. A similar responsibility assigned by EOHHS to AEs does not eliminate the MCOs requirements. The new requirements create overlapping responsibilities with the potential for confusion and duplication of limited resources. AEs have expressed concerns about being burdened with having responsibilities of MCOs forced upon their Primary Care constructs and expressed apprehension about incurring the significant expense associated with the new specifications while incentive funding tapers away.

Closing

As we approach Program Year 5, EOHHS needs to develop a process of gradual disengagement from the program while focusing the State's efforts on supporting sustainability. Neighborhood listed several important sustainability considerations for EOHHS in our PY5 Roadmap Responses. Neighborhood recommends that EOHHS reimburse for E- Consults to achieve more efficient access to specialty care. Neighborhood also identified the critical need for IHH providers to have aligned incentives with the AE providers (especially the FQHCs), and recommend that IHH providers and BHDDH participate in AE planning discussions. Neighborhood also identified the need for AEs to have equal access to all medical and BH facilities, to allow for effective for Transitions of Care. The barriers to hospital access are directly impacting the AE's ability to manage post discharge care.

Consistent with our PY5 Roadmap Public Comments, Neighborhood contends the MCOs and AEs can work together to leverage the individual and prevailing aspects of each MCO AE relationship to achieve long-term sustainability as well as success with EOHHS' vision for care management. We hope EOHHS considers the points raised above and makes PY5 Requirement adjustments that are in the best interest of the program.

Thank you for your consideration,

John