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| General Comments | 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.<br>**Closing Statement**:<br>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. | EOHHS appreciates the feedback regarding the different roles for MCOs, AEs, and EOHHS, and appreciates the feedback shared in response to the PY5 Roadmap. EOHHS intends to continue to set forth expectations for participation in the AE program, at least for the duration of the HSTP Incentive Program, in partnership with MCOs and AEs. |
| Attribution | IHP recommends EOHHS consider expanding this definition to include OB/Gyns as serving adults in a primary care capacity for attribution purposes. | EOHHS has carefully considered whether to include OB/GYNs in the AE attribution model. The challenge with attributing members based on primary care assignment to an OB/GYN comes when MCOs conduct attribution reconciliation on a quarterly basis. Reconciliation is based on where a member has received the plurality of their primary care visits. Some visits to an OB/GYN are coded with the same codes that PCPs |

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| | | use. EOHHS wants to ensure that members are not re-attributed to a new PCP and AE based on a specialty visit to an OB/GYN rather than a true primary care visit. While some Medicaid members have OB/GYNs as their assigned primary care provider, our understanding from discussions with the MCOs over time is that this is a small share of the membership. EOHHS does not believe that the definition of primary care provider for attribution purposes is having a negative impact of the accuracy/validity of AE attribution. |
| Attribution | Claims Provision: MCOs provide claims data on the basis of prior month's paid date. The omission of claims data for members' experience outside attribution disrupts the historical review of rising risk members while disabling the AEs' ability to create dynamic analytics in close approximation to MCO calculations. In order to maximize AEs' capacity for care, BVCHC continues to advocate that all claims for attributed members be supplied with historical look-back as attribution shifts. | EOHHS understands that historical data on newly attributed members is an important tool for care management. From discussions with MCOs, EOHHS understands that both MCOs participating in the AE program have mechanisms to deliver this information. To the extent that any AE is not able to access or use this information, EOHHS is available to facilitate discussion with the MCOs. |
| Attribution | We continue to believe that AEs should only bear the cost of attributed members for the time following attribution. The financial exposure for AEs, under the proposed model, is particularly acute in the fourth quarter of the year, a point at which an AE has no opportunity to manage newly attributed patients and meaningfully impact utilization or cost.<br><br>There is a related impact that results from retrospective attribution. AE assignment changes every month. This can result in an AE effectively "losing" the benefit of any investment they have made in a patient – quality measures, improved utilization, savings – and taking on the "cost" for the experience of the patient for the period prior to their assignment to that AE. This is particularly relevant as the AEs, MCOs, and EOHHS work to better | EOHHS understands that the nature of the attribution model can lead to some patients' costs being attributed to an AE that did not care for them when the costs were incurred and to some benefits of an investment in a patient accruing to an AE that did not make the investment. However, EOHHS has not seen evidence that suggests systematic advantage or disadvantage for any AE as a result. Just as an AE might "gain" a member who had higher costs before being attributed to that AE, so too might that AE "lose" a more expensive member and thus not have those costs count toward the AE's TCOC. Just as an AE might "lose" a member in |

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| | define our goals for "patient engagement." The monthly churn in AE enrollment is a major disincentive to sustained member engagement initiatives. Patient turnover also hinders the ability of AEs to develop action plans based on reliable data. We encourage EOHHS to engage AEs and MCOs in ways to address these issues. | whom the AE had invested, so too might an AE "gain" a member in whom a different AE had invested. EOHHS modeled the results of different attribution models (including a monthly attribution method) before implementing the current method and did not find significant or systematic differences in outcomes. Also, note that the quarterly TCOC reports are based on attribution in the final month of each quarter, so it is not the case that all the changes in attribution throughout the year are "saved up" for the final quarter. At this point in the program, there is also substantial value to stability in methodologies. Therefore, EOHHS intends to continue the current approach. |
| Attribution | ATTRIBUTION FOR SETTING INCENTIVE FUND POOLS.<br>First, we believe there is a typo in the following language on page 5 and the year should be 2022 instead of 2021: "For example, depending on the timing of data availability, EOHHS may use attribution data from April, May, June, or July 2021."<br>Second, we recommend EOHHS establish a defined date that will be used for the number of MCO members attributed to the AE for the performance year to which the Incentive Fund Pool will apply. While we appreciate the uncertainty of data availability, the four-month window that EOHHS may use to estimate member months for the performance year beginning July 1, 2022 creates confusion. We strongly recommend the date be as close to the new performance period as possible.<br>Third, as previously noted, missing from this guidance is a clear explanation of EOHHS's requirements about when and how an AE should make updates to their roster of TINs, and when those changes will take effect. We have found a confusing lack of clarity and consistency around the timelines for when roster changes | EOHHS appreciated the identification of the date typo and has fixed this.<br><br>EOHHS generally expects to use the April attribution data to set incentive fund pools, as noted in the Quality and Outcome Implementation Manual posted in September 2021. EOHHS agrees that it is better to be most clear about this and has revised Attachment M to reflect the expected use of April data. The reason to use April rather than a later month is to avoid delays in setting the incentive fund pools that lead to delays in executing MCO-AE contracts.<br><br>Updates to the AE TIN roster should always be conveyed to the MCO(s) with which the AE contracts as soon as the AE is aware of the change. As described in Attachment M, these updated lists are used for monthly attribution |

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| | are accepted, and when both “adds” and “drops” of TINs will be effective.<br>Fourth, AEs need to be able to effectively manage networks that may be participating in multiple accountable care/risk programs, with different programmatic timelines, and to ensure that our agreements and arrangements with our participating providers are structured to ensure compliance with all of our programs. It is also important to have clear guidance in place to ensure that reporting received during a performance year is accurate with respect to the practices and patients for which the AE is actually accountable.<br>ATTRIBUTION FOR TOTAL COST OF CARE ANALYSIS.<br>As we have noted before, we have concerns about the decision to assign all costs for a member during the performance year to the AE to which the member is attributed in the final quarterly update (Attribution for Total Cost of Care Analysis, page 6). We do not have complete confidence that attribution is being properly updated to account for actual primary care utilization, and this approach has the potential to allocate costs to the wrong AE. Even if attribution works as designed, it will inevitably result in AEs being held accountable for costs that were incurred while a member was attributed to a different AE. We recommend that EOHHS develop an approach where costs are assigned to an AE based on the member’s monthly attribution (that is, the AE would be accountable for costs for services provided during member-months when the member was attributed to the AE).<br>Additionally, we would expect claims data sent to us by the MCOs to align to the attribution methodology (that is, we expect to receive claims data covering the entire population, and only the population, for which we are accountable). Retroactively changing attribution at the end of the year will add considerable complexity to the claims data feed.<br>ATTACHMENT C. | purposes and therefore are relevant for the uses of those monthly lists. The April list is used for setting the incentive fund pool and the December list is used for attributing patients for quality and outcome measures. The only attribution activity that does not use the monthly attribution lists and which should NOT be affected by TIN changes is total cost of care, for which the MCOs must use the same TIN list used to set the total cost of care targets for the year.<br>EOHHS understands that the nature of the attribution model can lead to some patients' costs being attributed to an AE that did not care for them when the costs were incurred. However, EOHHS has not seen evidence that suggests systematic advantage or disadvantage for any AE as a result. Just as an AE might "gain" a member who had higher costs before being attributed to that AE, so too might that AE "lose" a more expensive member and thus not have those costs count toward the AE's TCOC. EOHHS modeled the results of different attribution models (including a monthly attribution method) before implementing the current method and did not find significant or systematic differences in outcomes. Note that attribution reconciliation occurs on a quarterly basis, so some members will have utilization in the last quarter that impacts their attribution, many of the utilization-driven changes will have already taken place well before the end of the year. At this point in the program, there is also substantial value to stability in methodologies. EOHHS and the MCOs have spent significant time working to confirm |

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| | We are unable to locate Attachment C, referenced on page 6 as follows: “Please see Attachment C, “Illustrative Attribution and Rate Cell Examples” for more details on the TCOC attribution methodology.” We ask that EOHHS provide Attachment C for stakeholder review. | that members are being "re-attributed" correctly based on their primary care utilization and at this point EOHHS is confident that the MCOs are conducting this activity properly. Therefore, EOHHS intends to continue the current approach.<br><br>EOHHS apologizes for the outdated reference to Attachment C, which refers to a document provided to AEs and MCOs in late 2019 and which has not been updated since that time. EOHHS will remove this reference. If any stakeholder wishes to receive another copy of this, file EOHHS will provide it. |
| Certification | We appreciate that EOHHS is working to clarify the minimum standards for AE-led program activities. Coastal Medical agrees with the system of care framework displayed and the foundation of a patient-centered holistic approach.<br>We also understand the need for a better delineation of roles between AEs and MCOs. However, we are still in the early phases of improving collaboration between AE and MCO care management teams, such as holding care management meetings centered around the high-risk population. Shifting responsibilities from MCO’s to Accountable Entities for many of the functions outlined is inappropriate. AE staff lack the knowledge and experience required to administer many of the insurance assessments or current complex care management programs conducted by the MCO’s. Transferring this responsibility to the Accountable Entities will task them with administrative burdens that will not improve patient care and may result in the MCO’s failing to meet Medicaid requirements.<br>Enforcing requirements that relate to staffing, licensure, and transferring coordination of MCO activities will limit the extent of our ability to continue our current processes, which have demonstrated efficacy. Coastal Medical has developed an | EOHHS appreciates the support for the system of care framework.<br>The intention of the changes to the AE Certification Standards was to create a clearer framework that would facilitate appropriate delegation of certain functions from MCOs to AEs, and to begin strongly encouraging such delegation. EOHHS has determined, based on the public comment received and the circumstances described, that Program Year 5 is not the right time to require AEs to take on new responsibilities<br>Therefore, EOHHS has revised the AE Certification Standards so that all activities that were newly added in the earlier proposed Certification Standards are entirely optional for AEs in PY5. EOHHS has retained the new framework because it is easier to understand and implement. However, the required elements in the final version have all been present in prior years' AE Certification Standards. |

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| | infrastructure to support the care management of our patient population through participation in alternative payment models that reduce the total cost of care and generate shared savings. Historically, care management models focusing on longitudinal follow-up or process measures have limited our ability to deliver a population-health-driven strategy for engaging our patients. The core focus of our care management model is to provide care to the right patient at the right time. We have been successful in these programs by creating centrally managed clinical programs, providing timely intervention to activated patients, and focusing on alternative mechanisms for engagement, including remote patient monitoring. The stipulation of processes or the addition of administrative responsibilities will reduce the effectiveness of our population health management initiatives. | EOHHS understands that the new framework and the earlier proposed changes to the Certification Standards may have drawn more attention to these longstanding requirements. Historically, AEs that did not fully meet the Certification Standards in Domains 4-8 were asked to undertake HSTP Project Plans that would help the AE to meet the requirements. Going forward, EOHHS expects to use the Re-Certification process to monitor AE progress on these Domains. |
| Certification | I) IHP has serious concerns about the lack of clarity regarding the transfer of CCM services from MCOs to AEs. Please clarify the following:<br>• What would be the funding for AEs to assume CCM and are AEs guaranteed that funding post PY5? IHP would not agree with a FFS billing model and would need a pmpm or annual rate for a certain amount of Nurse Care Managers.<br>• 2. How will AEs take on this role when across RI there are critical workforce issues both for staff retention and recruitment to support a CCM program?<br>• 3. What are the reporting requirements as there would be significant EMR enhancements that would be time consuming in expensive?<br>• 4. What responsibilities would the MCO retain in terms of CCM?<br><br>II) Care Continuum: EOHHS lays out a comprehensive care continuum, with general members at one end and members with multiple or complex conditions at the other. The document also | The intention of the changes to the AE Certification Standards was to create a clearer framework that would facilitate appropriate delegation of certain functions from MCOs to AEs, and to begin strongly encouraging such delegation. EOHHS has determined, based on the public comment received and, on the circumstances, described, that Program Year 5 is not the right time to require AEs to take on new responsibilities.<br>Therefore, EOHHS has revised the AE Certification Standards so that all activities that were newly added in the earlier proposed Certification Standards are entirely optional for AEs in PY5. EOHHS has retained the new framework because it is easier to understand and implement. However, the required elements in the final version have all been present in prior years' AE Certification Standards. |

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| | lays out what is expected of AE for each category of members. See Comments (pgs. 2-3) - IHP extracted a section of the document for which the below comments reference.<br>The above represents a huge new lift for IHP. Not only are these new requirements, but they are poorly defined, and it is unclear the role of the MCO vs the AE. Additionally, IHP has multiple member organizations, unlike other AEs, creating an additional coordination burden.<br>IHP recommends EOHHS implement these requirements gradually. In PY5, AEs could be responsible for identifying members for each category and implement health promotion and care coordination activities. In PY6, AEs could add care planning and referring members to the MCOs for complex care management.<br><br>III) 1.1.2.2. Population-specific primary care and behavioral health capacity to serve adults, including adequate internists, family practice clinicians, primary care geriatricians, and/or APRNs/PAs and adult behavioral health providers.<br>IHP recommends EOHHS consider expanding definition to include OB/Gyns as serving adults in a primary care capacity for attribution purposes. | EOHHS understands that the new framework and the earlier proposed changes to the Certification Standards may have drawn more attention to these longstanding requirements. Historically, AEs that did not fully meet the Certification Standards in Domains 4-8 were asked to undertake HSTP Project Plans that would help the AE to meet the requirements. Going forward, EOHHS expects to use the Re-Certification process to monitor AE progress on these Domains.<br><br>EOHHS has carefully considered whether to include OB/GYNs in the AE attribution model. The challenge with attributing members based on primary care assignment to an OB/GYN comes when MCOs conduct attribution reconciliation on a quarterly basis. Reconciliation is based on where a member has received the plurality of their primary care visits. Some visits to an OB/GYN are coded with the same codes that PCPs use. EOHHS wants to ensure that members are not re-attributed to a new PCP and AE based on a specialty visit to an OB/GYN rather than a true primary care visit. While some Medicaid members have OB/GYNs as their assigned primary care provider, our understanding from discussions with the MCOs over time is that this is a small share of the membership. EOHHS does not believe that the definition of primary care provider for attribution purposes is having a negative impact of the accuracy/validity of AE attribution. |
| Certification | Attachment H | The intention of the changes to the AE Certification Standards was to create a clearer |

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| | 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.<br>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.<br>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 | framework that would facilitate appropriate delegation of certain functions from MCOs to AEs, and to begin strongly encouraging such delegation. EOHHS has determined, based on the public comment received and, on the circumstances, described, that Program Year 5 is not the right time to require AEs to take on new responsibilities.<br>Therefore, EOHHS has revised the AE Certification Standards so that all activities that were newly added in the earlier proposed Certification Standards are entirely optional for AEs in PY5. EOHHS has retained the new framework because it is easier to understand and implement. However, the required elements in the final version have all been present in prior years' AE Certification Standards. |

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| | significant expense associated with the new specifications while incentive funding tapers away. | |
| Certification | Care Management Delegation: BVCHC applauds the proposal to shift more care management activity outlined in previous versions of Domain 6 of certification. Although BVCHC recognizes discussions around this topic are ongoing, an unintended outcome of Attachment H is the implication that AEs are expected to conduct health risk assessments and compose individualized care plans for all attributed patients. Conducting these assessments not only duplicates current managed care organization (MCO) expectations, it looks to spread insufficient resources across populations not in need of this level of care. Likewise, the overly detailed manner in which AEs shall administer care management prohibits the ability to tailor interventions to our populations. Further implication that AEs must partake in an all-or-nothing approach in assuming the outlined responsibilities raises additional concern. Instead, BVCHC recommends participation in care management delegation for PY5 through individualized conversations with the MCOs. Identified activities will be those jointly agreed upon that are most sensible under primary care for our populations. BVCHC cautions EOHHS against conflating a MCO structure with the primary care setting. As part of prior year certifications, AEs have established themselves as capable of addressing targeted populations. However, the successes demonstrated in a multidisciplinary model of primary care lend themselves to care coordination through comprehensively managed patient panels as opposed to assignment of care managers to a sole function and/or sub-population. Recognition of the need for data deliverables drives BVCHC to look to the MCOs to devise outcomes-based reporting of care managed populations identified through joint exchange of information. Measures such as utilization frequency, trended costs, follow-up timeliness, and medication adherence for populations receiving AE care | EOHHS appreciates the support for care management delegation.<br><br>The intention of the changes to the AE Certification Standards was to create a clearer framework that would facilitate appropriate delegation of certain functions from MCOs to AEs, and to begin strongly encouraging such delegation. EOHHS has determined, based on the public comment received and, on the circumstances, described, that Program Year 5 is not the right time to require AEs to take on new responsibilities.<br><br>Therefore, EOHHS has revised the AE Certification Standards so that all activities that were newly added in the earlier proposed Certification Standards are entirely optional for AEs in PY5. EOHHS has retained the new framework because it is easier to understand and implement. However, the required elements in the final version have all been present in prior years' AE Certification Standards.<br><br>EOHHS understands that the new framework and the earlier proposed changes to the Certification Standards may have drawn more attention to these longstanding requirements. Historically, AEs that did not fully meet the Certification Standards in Domains 4-8 were asked to undertake HSTP Project Plans that would help the AE to meet the requirements. Going forward, EOHHS expects to |

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| | management can best inform the internal AE review of the overarching protocols highlighted in Attachment H. BVCHC fully expects AEs to participate in conversations around reimbursement for services commensurate to added responsibilities. BVCHC welcomes individualized negotiations with MCOs depending on what responsibilities are transferred. | use the Re-Certification process to monitor AE progress on these Domains.<br><br>EOHHS looks forward to collaborating with AEs and MCOs to plan for future progress in these areas. |
| Certification | Section 1.5: UHC: The Appointment Access Standard language here varies from EOHHS Contract Amend 5<br>- Under After-Hours Care Contact in amend 5 it references After hours care contact telephone, whereas this grid includes text, email<br>- This grid is missing emergency care appointment category which is captured in amend 5<br>- Under Non-emergent, non-urgent mental health or substance use the standard in amend 5 is within 10 calendar days, this grid references within 10 business days<br>Section 6 (page 23): While the AE's/PCP are the primary source of referral for most services, for the SMI population the primary point of care may be the CMHO<br>Section 6 (page 24): For the SMI population, the care may be coordinated by the IHH team rather than the AE, communication and collaboration with the AE/PCP is a priority. For members who are in OTPs, despite best efforts, member may not be willing for information to be shared with the PCP. the ICP may best site with the Cmho or the Otp and not in the AE chart for section 6.5.2.2- not sure if this is saying that the AE should be the lead CM- recommend that the CMHC be the lead, they are the provider the SMI member is most engaged with and should be leading the members care if the goal is to be member centric<br>Section 6 (page 24): This comment applies through Staffing section 6.4.3.4. 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 | EOHHS appreciates the recommended changes to the Appointment Access Standard and has implemented those changes.<br>EOHHS agrees that for some members, a community mental health center may be the primary point of care and acknowledges this role throughout Domain 6 especially in discussion of complex case management.<br>EOHHS appreciates the feedback regarding the value of PCMH status for AE practices and will consider this in future efforts to advance delegation.<br>It was not EOHHS's intention for an AE to necessarily subdelegate complex case management to an entity like a CMHO. Rather, the AE would identify the entity responsible for complex case management, by sub-population as applicable. If an AE and MCO agreed that the AE was not the best entity to be responsible for complex case management for the IHH/ACT population, the MCO would not need to delegate to the AE for that population. The intent of the language in the complex case management requirements is to emphasize the central role of the IHH/ACT provider for members engaged in those services and to strongly encourage active collaboration between the AE and the IHH/ACT provider. |

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| | health 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. Care Management as defined by the AE program will align with Care Management as defined by the MCO contract to ensure there is alignment in expected outcomes and staffing requirements. UHC is in agreement to include PCMH certification as the standard so the state, MCO, and the AE's are all aligned.<br>Section 6.2.4.5 (page 27): Please consider adding Choosing Wisely which is an initiative of the ABIM Foundation to this list.<br>Section 6.4.1.7 (page 29): EOHHS may want to add FFS Medicaid covered services to the list (e.g., adult dental)<br>Section 6.5 (page 31): Is it EOHHS's intent to have MCO's delegate complex care management when appropriate to AEs and the AE's in turn subdelegate complex care management when appropriate to CMHOs for the IHH/ACT population? There may be requirements for MCO NCQA accreditation at risk with this arrangement. It also adds complexity regarding delegated oversight to ensure that a high-quality programs continue to be offered to members. | As noted elsewhere, the new requirements previously proposed for AEs have been changed into optional activities for PY5. EOHHS looks forward to collaborating with AEs and MCOs to further explore the complex concerns and opportunities raised in public comment. |
| Certification | IT Infrastructure – Data Analytic Capacity and Deployment<br>We have invested in the implementation of a data analytics and care management platform, Cerner HealtheIntent, to support the management of our AE population under management. The utility of this analytics and care management system in managing our population is dependent upon the MCOs providing complete and transparent claims, quality, and eligibility data on a monthly basis without artificial restriction on transparency for any reason. | EOHHS appreciates the information regarding the value of claims, quality, and eligibility data from the MCOs.<br>The intention of the changes to the AE Certification Standards was to create a clearer framework that would facilitate appropriate delegation of certain functions from MCOs to AEs, and to begin strongly encouraging such |

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| | We know this is possible because the largest health insurer provides that transparent data to us for their Medicare Advantage and Commercial populations...EOHHS and the State's AEs should expect and demand nothing less from the MCOs in Rhode Island. Unfortunately, that will not happen unless EOHHS requires them to do so. We attach our standard data requirements for risk contracts with MCOs as a reference which we receive from many health insurance partners already. AEs need full, regular, and timely access to standardized files/information including but not exclusively Member Attribution (member roster which contains information such as name, DOB, gender, health plan ID, PC) and claims information such as dates of service, diagnosis codes, procedure codes, place of service, rendering provider name, NPI and Tax ID. Our analysis would be further informed if we were provided billed, allowed, and paid amounts for all services.<br>Care Programs<br>Introduction<br>The Care Programs section, previously titled "Integrated Care Management," is a significant re-write of previous iterations of this section of the Certification Standards. The discussion of the System of Care, Care Continuum, and the new definitions of the major components of the Care Continuum are valuable in the way they seek to provide an updated overview of this aspect of the AE program. Given the fact we are preparing to enter Year 5 of the program, it is a good time to step back and creating a new, high-level overview that seeks to synthesize what is happening across the AE in terms of care programming. ...the AE Certification Standards are probably not the ideal location for this. By including this in the AE Certification Standards, it implies that AE certification and re-certification are dependent upon AEs meeting all of the requirements spelled out in this section. This also implies a uniformity of implementation across all AEs that does not align with the reality that each AE has tailored its approach | delegation. EOHHS has determined, based on the public comment received and circumstances described, that Program Year 5 is not the right time to require AEs to take on new responsibilities.<br>Therefore, EOHHS has revised the AE Certification Standards so that all activities that were newly added in the earlier proposed Certification Standards are entirely optional for AEs in PY5. EOHHS has retained the new framework because it is easier to understand and implement. However, the required elements in the final version have all been present in prior years' AE Certification Standards.<br>EOHHS understands that the new framework and the earlier proposed changes to the Certification Standards may have drawn more attention to these longstanding requirements. Historically, AEs were expected to undertake HSTP Project Plans that would help the AE to meet the requirements n Domains 4-8. Going forward, EOHHS expects to use the Re-Certification process to monitor AE progress on these Domains. |

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| | and programs based on its own strengths, philosophy, strategies, and – most importantly – the needs of its members. Nor does it recognize that without population-based payment (delegated utilization and care management and global capitation), the funding remains with the MCOs rather providing sufficient funding for these programs at the AE level. Additionally, a broad re-articulation like this is something should be the product of a collective, collaborative process. This could become a regular part of the collaborative work of AE stakeholders. To the degree this section seeks to outline expectations about the future evolution of the AE program, this language should be the foundation for the beginning of a collaborative conversation and design process and not put forward as a final regulatory statement. In terms of content, this revision significantly expands the expectations for AEs, with – it would appear –AE certification dependent upon AEs meeting these new standards. This includes assigning responsibility to the AEs or services and activities traditionally the purview of MCOs. These new expectations are not accompanied with the necessary delegation of authority or resources which would make this possible. The PHSRI-AE has long argued in favor of delegated care management and utilization management and driven by global capitation. When EOHHS forecast the potential for adopting these changes, it is our understanding this was met with substantial opposition from the MCOs. This document reads like an attempt at a compromise, but it is an untenable one where AEs are expected to assume responsibility for activities without the necessary delegation of authority or resources. EOHHS needs to outline its requirements based upon the most sophisticated AEs and their ability to assume global risk and manage delegated utilization, care, and SDOH management. These requirements will assure that approach is clear both in these new requirements and the upcoming procurement so that the MCOs and the less sophisticated AEs will continue to progress | |

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| | to greater accountability for the quality and cost for their population under management. | |
| Certification | Care Continuum: Working Definitions<br>Health Promotion<br>The definition of Health Promotion provided on page 23 (page 25 of the redline) includes the following:<br>The contractor shall work with accountable entities and providers, as appropriate, to integrate health education, wellness, and prevention training into the care of each Member. Health Promotion shall provide condition and disease-specific information and educational materials to Members based on their individual condition or disease. We assume the reference to the "contractor" refers to the MCO. If that is the case, this language implies that the MCO –and not the AE – is expected to take the lead on health promotion and yet the AE's certification appears to rely upon MCO capacity. This confusion needs to be resolved in the final document.<br>Care Coordination<br>The definition of care coordination includes a reference to the need for a "two-generation" approach to health-related social needs:<br>Care Coordination services should include connection with SDOH resources, utilizing a 2Gen approach where appropriate. [Page 25]. Additionally, any expectations set by EOHHS need to recognize there are very real limits to the ability of AEs to execute two-generation interventions in instances when only "one generation" is a member of that AE. To support this new priority, EOHHS should consider program changes such as increasing the attribution of whole families/households to the same AE, proactively identifying families/households when they are attributed to AEs.<br>Care Management<br>The most noteworthy part of this section is language which EOHHS struck from the original text used for this definition: CM | EOHHS appreciates the feedback regarding the Health Promotion definition and has revised that language.<br><br>EOHHS appreciates the insight regarding the two-generation approach. Because this is not required by the existing language, EOHHS has not revised it, but agrees that it may not always be feasible for an AE to work with individuals who are Medicaid members.<br><br>Under Section 6.1.2, EOHHS has stated the requirements for systematic identification of members who need care management, which are largely unchanged from the Program Year 4 requirements and which includes a non-mandatory list of factors. AEs are welcome to use variables that they find useful. The deletion of the specific reference to the top 1%-5% in each subpopulation is not intended to change the overall meaning of the requirement.<br><br>EOHHS appreciates the recommendation that DOC Discharge Planning staff have access to the Unite Us platform to support AE work with those recently discharged from correctional institutions. EOHHS expects that this will be feasible. |

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| | activities also emphasize prevention, continuity of care, and coordination for top 1% - 5% in each relevant subpopulation, including: of care. [Page 25 of 26 of redline]<br>For AEs, active care management is traditionally focused on the patients with the greatest need, where the impact will be the most significant. At this point, AEs have well-developed criteria and systems for identify those patients who should receive active care management. The defining variables include:<br>• Health status (e.g., chronic condition burden)<br>• Utilization patterns (high ED use)<br>• Risk (inpatient admission, BH/SUD inpatient admission, SDOH burden)<br>• Total cost of care<br>We urge EOHHS revise this definition to align with AE practice.<br>Complex Care Management<br>This new definition includes a reference to a new priority population: "those recently discharged from correctional institutions." [Page 24] This population is referenced several times throughout the document and this comment pertains to all references. We strongly agree that this is a population with particular needs and would even encourage EOHHS to broaden its scope with language referring to "justice-involved individuals and families/households." However, just like the new reference to a two-generation approach, this represents a significant new priority that needs more discussion, context, clarity, and – ultimately – active leadership of EOHHS if AEs are to succeed in meeting the needs of justice-involved members. If AEs are going to be more effective in engaging with returning ex-offenders and justice-involved families/households, EOHHS needs to secure the active engagement of the Department of Corrections, particularly Discharge Planning. One simple step that would greatly improve the life chances of returning ex-offenders and justiceinvolved families/households – including connecting | |

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| | individuals to AEs – would be for EOHHS to encourage DOC Discharge Planning to adopt the Unite Us platform. | |
| Certification | Certification Standards – General Comments<br>We urge the state to avoid excessive specificity in the certification standards...the state should speak to the goals and outcomes AEs should achieve and allow AEs – in partnership with MCOs – to design and develop the specific approach that suit their strengths, approach to population health strategy, and membership. Looking ahead to the annual Recertification process, we are also concerned how these requirements will impact the PY5 re-certification process. EOHHS has made progress reducing that burden, and we had hoped further progress would be made in PY5.<br>6.1 Care Program Design and Planning<br>Page 24 includes the following:<br>6.1.1. AEs must implement a Joint Operating Committee (JOC) management structure with each<br>contracted MCO to facilitate coordination as care programs are planned and implemented [Page 24]<br>It appears this a new requirement, in addition to the currently required quarterly AE/MCO Joint Operating Committee meetings. If this is the case, greater explanation is needed. We also question the degree to which this could be a counterproductive administrative burden that will distract AEs from direct engagement with members. This new requirement could be an example where the certification standards are overly prescriptive in terms of means and method, when they should be focused on results and outcomes. A new quarterly JOC may be the right vehicle to achieve more coordination of care programming, but it may not be the ideal solution for every AE/MCO dyad.<br>6.2 Health Promotion<br>This appears to be a significant expansion of the current standards for health promotion in terms of AE activity. ..it is not clear who is ultimately responsible for this activity, with EOHHS | EOHHS has removed several of the new details that had been proposed for the AE Certification Standards. EOHHS expects to work with AEs and MCOs to consider the most appropriate level of detail for these requirements in the future.<br><br>As noted elsewhere, the vast majority of the requirements proposed for the AE Certification Standards were not new, and the final Standards do not include new required activities. EOHHS is committed to minimizing administrative burden in the re-certification process and is developing a streamlined application. The new application will include an opportunity for AEs to report on their progress towards meeting the Certification Standards, which is expected to generate clearer information than the previous approach, under which AEs were expected to use HSTP Project Plans to work towards meeting the requirements. HSTP Project Plans are increasingly, appropriately, focused on efforts to improve outcomes for members and to measure that improvement directly, and therefore are less effective as a mechanism for sharing progress on meeting Certification Standards. |

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| | stating the division of labor here can be negotiated between the AE and the MCO. ...it appears that the AE's certification rests on the delivery of health promotion activities, whether by the AE or by the MCO. What corrective mechanism does EOHHS see for a situation where an MCO fails to deliver Health Promotion activities as agreed? When an AE fails to meet a performance expectation or target, the MCO – with the approval of EOHHS – withholds infrastructure funding to the AE. There is no similar mechanism for AEs. These issues need to be addressed in the final standards. The expectations, ultimate responsibility, and execution is further muddied by the language "contracted MCO." This seems to imply that AEs will contract with the MCOs for health promotion activities the MCO will conduct. This does not align with the actual reality of how the AE program is currently operated and the final standards should address this.<br>As an AE engaged in a Rhode to Equity project focused on environmental triggers to asthma, we were pleased to see the specific reference to evidence-based asthma control programs. We would urge EOHHS to consult the Rhode Island Department of Health (ashley.fogarty@health.ri.gov) so this section could also reference the asthma control programs supported by the DOH, specifically Breathe Easy at Home (BEAH) and HARP (Home Asthma Response Program). Both are evidence-based interventions with a well-established program delivery infrastructure in Rhode Island.<br>6.4 Care Management<br>Section 6.4.1.4, states the following:<br>A transitions of care approach for individuals who are moving between healthcare settings, applying evidence-based best practices. Should include an approach to coordinate with hospitals on discharge planning and follow up [Page 27]<br>We agree about the importance of strong Transitions of Care (TOC) services and that coordination with inpatient facilities at discharge is essential. Given that, we have steadily increased the | |

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| | scope and scale of our TOC programs. While we have been able to improve coordination with inpatient facilities, additional progress is needed and EOHHS could help here. ...We urge EOHHS to explore ways to increase hospital capacity for coordination around patient discharge. | |
| Certification | 1.3.1.1. Physical Health: service delivery/coordination capacity beyond the scope of PCP medical care, including specialty and inpatient care.<br>Please provide additional detail as to the expectation for non-hospital-based AE service delivery of specialty and particularly inpatient care. We would assume on both the minimum expectation is to be able to coordinate with specialty and inpatient care, not to have any responsibility for delivering it.<br>2.4.2. Comport with EOHHS defined delegation rules re: AE/MCO distribution of functions.<br>Please expand or explain this standard further.<br>4.1.1. Able to receive, collect, integrate, utilize person specific demographic (race, ethnicity, language, disability (RELD)), clinical, and health status information.<br>It appears what was previously identified as REL data is now transitioning to RELD data. Please clarify what reporting on Disability will look like/require.<br>5.2.2.4. Develop electronic reporting (electronic data exchange/QRS) or claiming mechanism through the use of diagnostic Z codes to allow social needs data to be systematically provided to MCOs/EOHHS.<br>This process has challenges both on the provider and MCO side. For example, many times SDOH screening is conducted by non-billable members of a care team (e.g., social service case managers, BH case managers, CHWs who can't be billed to MCOs in many cases, etc.). The vehicle to transmit the Z code is now not in place when the screening occurs detached from a billable visit. This would require an MCO to accept $0 claims, which may not result in the Z code, which is a diagnosis code being added. | EOHHS can confirm that AEs are not required to directly provide specialty and inpatient care, but rather to either provide them or to ensure smooth transitions.<br><br>AE Certification Standard 2.4.2 would apply to any requirements or rules that EOHHS sets forth regarding delegation, such as might appear in a contract between EOHHS and MCOs.<br><br>For AE Certification Standard 4.1.1, EOHHS considers AE ability to receive disability information from MCOs to meet the standard.<br><br>The language in AE Certification Standard 5.2.2.4, which is not new for PY5 but rather has been present for several years, is intended to encourage AEs to develop the ability to report data on social needs. EOHHS understands that this is a complicated issue and will consider revising this language in the future.<br><br>EOHHS believes that the requirements related to coordination with CBOs continue to be appropriate and hopes that the increase in incentive funds relative to prior expectations is helpful. EOHHS also expects that the availability of the Unite Us platform will assist AEs in meeting these requirements. |

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| | Please provide the timeline for expected implementation of this requirement. This will take substantial work, and it is unclear what funding mechanism would support this work. Our recommendation if this is going to remain in place would be that it is not expected until the end of PY 5 and that a substantial segment of PY5 incentive dollars be allocated to completion of this task, like the 10% designated to stand up REL reporting. This is far more complicated so I would recommend a larger segment be dedicated to this.<br>5.2.3. Coordination with CBOs. Establish protocols with CBOs to ensure that attributed members receive supportive services to address indicated social needs, such as: warm-transfers, closed-looped referrals, navigation, case management, and/or care coordination for appropriate care and follow-up. May be done in direct coordination with MCOs. 5.2.3.1. Develop a standard protocol for referral for social needs using evidence and experience-based learning and for tracking referrals and follow-up. AEs may leverage the Unite Us tool procured by the state to satisfy this requirement.....<br>This is overly prescriptive. EOHHS has not adequately addressed a plan for the rapidly diminishing financial support of case/care management activities. CSI/CTC termination/graduation led to dramatic decrease in financial support for ongoing case/care management activities. NHPRI is phasing out PMPM support of care management. As soon as that is gone, there is $0 of identified financial support for care management activities via any Medicaid mechanism, yet all the expectations for case/care management are increasing exponentially (coordinating social needs, coordinating transitions of care, rising and high-risk patient management). It is unclear in the State's vision where they expect providers to find the financial support for these activities when previously existing mechanisms have ended or are ending. We are rapidly approaching a time when we will not be able to afford the staffing to meet the ever-growing expectations. | The requirement at 5.2.3.2 refers to AE referrals to the MCO itself, in cases that the MCO is going to assist the member to address the social need. |

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| | 5.2.3.2. AE should have a documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include: - Standardized protocol for referral to social service provider - Methods for tracking referrals - Development of metrics to define a successful referral - Development and implementation of standards and reporting of metrics and referral information to MCO AEs may leverage the Unite Us tool procured by the state to satisfy this requirement.<br>Please explain the utility of this data to the MCO. Without a clear understanding of what the MCO plans to do with this data, it seems like a requirement that establishes data reporting for the sake of data reporting without a clear outcome. This is unduly burdensome to the AE without clear benefit. We are also unclear how we would treat referral to our community health team, which generally come in the form of a warm hand off and are not tracked in the same way as external referrals as the community health team is seen as an extension of the primary care team. | |
| Certification | 5.3. System Transformation and the Healthcare Workforce<br>Please add language requiring participation in all these initiatives when receiving direct financial support of HSTP workforce development dollars. There are dollars to support the training of the workforce we require. Unfortunately, many of the initiatives developed at the AEs have not been supported by these dollars, and many of the programs developed at the universities/partners have given no financial support to the AEs, have come with significant burdens, and have few beneficial payoffs.<br>Page 24 of standards - Examples include help scheduling appointments, arranging transportation, and referrals to community services, programs, and resources. Care Coordination services should include connection with SDOH resources, utilizing a 2Gen approach where appropriate<br>Please provide a definition of a 2Gen approach.<br>6.1.2. AEs must demonstrate capacity to systematically utilize analytics and risk segmentation to identify/target individuals for | The AE Certification Standards are not the appropriate location for requirements that apply to entities other than AEs. EOHHS is available to work with AEs to ensure that workforce projects are aligned with AE needs and encourages AEs to engage with EOHHS on these issues.<br><br>A 2Gen care coordination approach refers to working with both children and the adults in their lives together.<br><br>EOHHS has made optional the segmentation of the population for health promotion, care management, and complex case management and only retained the previously present requirement to identify members who need care management. |

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| | health promotion, care coordination, care management, and complex case management and demonstrate that they conduct these activities. The analysis may include indicators such as polypharmacy, behavioral health diagnosis, limits to physical mobility, release from corrections, neighborhood stress index, depression, hospitalization, clinical indicators (e.g., diabetes), gaps in care, etc.<br>Our concern is this is overly prescriptive essentially mandating AEs to organize their care management systems at 4 levels prescribed by EOHHS (Health Promotion, Care Coordination, Care Management and Complex Care Management). Additionally, as mentioned in earlier comments, we are concerned that all dollars to support these activities are receding, and the dollars available through the AE initiative are at risk: 1. At risk of not achieving HSTP goals, 2. At risk of not achieving utilization measures 3. At risk of not achieving shared savings 4. At risk of achieving shared savings and having amount reduced by a less than 1 quality score. There are no true infrastructure dollars to support the massive care management infrastructure that would be needed to adhere fully to these requirements.<br>6.2 Health Promotion<br>The entirety of this section is overly prescriptive and appears to be an attempt to drive patients to utilize CHN and other DOH funded health promotion initiatives, which are often not universally accessible because they are geographically specific. | The Health Promotion section, which is now optional for Program Year 5, lists evidence-based programs that the AE may educate members about and assist them to access. The list is intended to increase awareness of a range of important programs, but there is not a requirement that AEs refer to these, even if Health Promotion were required as an activity. |
| Certification | AE-MCO DIVISION OF RESPONSIBILITY. Throughout Attachment H, EOHHS outlines Certification Standards for the AE pertaining to network capacity and Care Programs. Sections of greatest concern:<br>Section 1. Breadth and Characteristics of Participating Providers:<br>o Behavioral Health capacity (page 7)<br>o Assertive Community Treatment (ACT) and Integrated Health Home (IHH) services (page 8)<br>• Section 6. Care Programs (page 23) | As discussed elsewhere in these responses, EOHHS has made any new Domain 6 activities optional for Program Year 5.<br><br>In general, the mechanism for enforcement of the AE Certification Standards will be the AE certification and re-certification processes. EOHHS understands that AEs may not meet all requirements in Domains 4-8 at this time but will |

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| | o Section 6.2. Health Promotion (page 26)<br>o Section 6.4.2. Individualized Care Plans (page 29)<br>We appreciate the clarification that some of these requirements (e.g., Health Promotion activities) can be met through our MCO partners. However, if these standards are ultimately the responsibility of the AE, EOHHS should articulate a mechanism for AEs to ensure that their MCO partners are in compliance with these standards. If EOHHS intends for the AE to perform activities above and beyond required MCO activities, EOHHS should ensure that AEs are adequately funded to take on these new responsibilities.<br>There is also a lack of clarity as to what entity enforces these standards. Our current contracts with MCOs include a requirement that we achieve certification as an AE, but the contracts do not explicitly include all of the operational requirements contemplated by the standards. To be clear, we do not recommend that the AE/MCO contracts contain this level of specificity. We believe it is a mistake for EOHHS to be overly prescriptive with respect to population health programming requirements. In general, EOHHS should hold AEs (and MCOs) accountable for outcomes, within guardrails, but leave us the ability to innovate and develop programs that achieve program goals most efficiently. (If we are expected to fund our care management activities through shared savings that result from cost reductions and quality improvements, then we need the flexibility to determine which activities will result in the most shared savings.)<br>Our current reading of this draft suggests that it includes care management requirements over and above those required of MCOs in their contracts; this misalignment is likely to result in confusion as MCOs and AEs attempt to work together through our Joint Operating Committee structure. It would be very helpful to be able to review these drafts concurrently with any changes EOHHS is proposing to the MCO contract. | seek updates on AE progress toward these requirements.<br><br>EOHHS agrees that in general it will be useful to align expectations for AEs and MCOs. |

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| | We therefore recommend that:<br>• AE Certification Standards only include the essential requirements of the AE,<br>• AE Certification Standards be consistent with, and not more onerous than, MCO contract requirements,<br>• EOHHS clearly articulate the entity/entities responsible and the mechanism for enforcing and overseeing the standards,<br>• EOHHS hold AEs responsible for outcomes, not processes, and<br>• Moving forward, EOHHS allow for concurrent review of the AE Certification Standards for public comment and the EOHHS MCO contract to promote alignment. | |

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| Certification | CARE PROGRAMS: In follow-up to our comment above, the Care Programs requirements outlined in Section 6 beginning on page 23 are an example of where it is not clear how EOHHS expects an AE to implement a standard, and how EOHHS will provide oversight to ensure the standard is met. This language appears to create a set of new requirements that may require us to make costly changes to our existing programs, and potentially increase staffing to remain in compliance; this will be a difficult transformation to make in the later years of the program as HSTP funding begins to decrease.<br>We also note that EOHHS has proposed that delegation of care management activities from MCOs to AEs is a part of a long-term sustainability approach. It's unclear to us how these new requirements interact with potential future delegation. For example, do these requirements align with NCQA requirements? Our recommendation is that EOHHS narrow these requirements to those that are essential, clarifying what are requirements and what are examples. If EOHHS intends to hold AEs to these requirements, AEs must be funded to perform these activities and MCOs must be held to these standards in order to align MCO and AE requirements.<br>ACT/IHH SERVICES. The requirements in Section 1 on page 8 are another example of where it is not clear how EOHHS expects an AE to implement a standard, and how EOHHS will provide oversight to ensure the standard is met. The requirement states that "AEs serving individuals living with or at risk for developing a serious mental illness (SMI) or serious and persistent mental illness (SPMI) must ensure that Assertive Community Treatment (ACT) and Integrated Health Home (IHH) services are available to their members, either directly or through a Provider Partnership with a Community Mental Health Center (CMHC)."<br>First, there is still not a clear definition of what the capitalized term "Provider Partnership" means in the context of these standards. Is an AE required to enter into a formal agreement | EOHHS appreciates the feedback regarding aspects of Domain 6 that could be clearer, especially in terms of oversight mechanisms. As stated elsewhere, EOHHS expects to use the re-certification process to understand AE progress in Domains 4-8. EOHHS expects that by making the new activities optional, AEs will experience substantially less pressure related to these standards.<br>EOHHS views the requirement to ensure that individuals living with SMI/SPMI have access to IHH/ACT services as similar to the broader requirement that AEs ensure access to the full continuum of care even if the AE does not directly provide the service. Here, the partnership with a CMHC does not need to be especially formal, but EOHHS does expect AEs to at least establish informal referral relationships. AEs are not expected to create new CMHC capacity.<br>The JOC requirement is meant to mirror the requirement for MCOs to establish a JOC, not to be an additional committee. To allow more time for discussion on this, EOHHS has made this optional in the AE Certification Standards.<br>EOHHS agrees that health equity in health outcomes is vital and is pursuing this through the incentive program, under which AEs will work to stratify quality measure results by race, ethnicity, language, and disability. Over time, this work is intended to extend to incentivizing AEs to reduce disparities in these quality measures.<br>The requirement to have participating social support providers in the AE network can be met through the arrangements to use incentive funds |

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| | with a CMHC? Is there a set of minimum standards for what that agreement must contain? Or does "Provider Partnership" just mean that the AE and its participating providers have informal, referral-based relationships to CMHCs?<br>Second, our understanding is that access to ACT/IHH services is primarily limited at this point by the capacity of CMHCs and other ACT providers to accept referrals. We would appreciate clarification from EOHHS on the role of AEs to create additional capacity in these services over and above that funded through BHDDH.<br>JOINT OPERATING COMMITTEE. We ask EOHHS to clarify the proposed requirement for a Joint Operating Committee (JOC) implemented by the AE to facilitate coordinated care planning, with the existing requirement for a JOC (convened by the MCO) to oversee the MCO/AE relationship in general. The nature of our contractual relationships with our partner MCOs makes it difficult to contemplate an AE using this structure to hold an MCO accountable for care management activities.<br>HEALTH EQUITY. We agree with EOHHS that addressing social determinants of health is one way in which we can promote health equity (Page 8, "Improving health equity through enhancing capacity to address social determinants of health and health-related social needs"). We ask EOHHS to consider, however, that there are many other aspects to health equity, including addressing disparities in access to, and quality of, care. We recommend that EOHHS consider articulating specific goals and standards related to addressing disparities in health outcomes (for example, related to stratification of quality measure performance by race, ethnicity, and language).<br>SOCIAL SUPPORTS. On page 9 in Section 1, EOHHS states: "Capacity to address health-related social needs/social determinants of health shall be evidenced by the participation of providers of pertinent social supports within the AE." We ask that | towards CBOs and/or by having a referral relationship with a social service provider.<br>The language in AE Certification Standard 5.2.2.4, which is not new for PY5 but rather has been present for several years, is intended to encourage AEs to develop the ability to report data on social needs. EOHHS understands that this is a complicated issue and will consider revising this language in the future. |

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| | EOHHS define the term "participation," as we have limited ability to formally add social service providers to our provider network.<br>BOARD OR GOVERNING COMMITTEE MEMBERSHIP. In describing the voting membership of the Board or the Governing Committee in Section 2.2.2.1. on page 14, we believe that there is an "and" or an "or" missing between "primary care providers" and "behavioral health providers."<br>Z CODES. We ask that EOHHS clarify if the use of Z codes is a requirement, per Section 5.2.2.4. (page 20). We anticipate provider hesitancy to use Z codes consistently across all payers. Furthermore, use of Z codes needs to be coordinated with payers to ensure that the addition of Z codes to claims does not interfere with reimbursement. | |
| Incentive Program | Coastal has invested significantly to develop and enhance our population health management programs. These costs are predominately in staffing for positions such as pharmacists, nurse care managers, nurses, and behavioral health navigators who are essential members of our care teams. These costs carry a significant level of investment risk, and the infrastructure and quality incentives provided under risk contracts alone do not cover these costs. We must generate shared savings across our contracts to fund our investment risk. Any change in funding from infrastructure shared savings or quality incentives requires us to | EOHHS received significant stakeholder feedback before posting the proposed Program Year 5 Requirements and based on this feedback adjusted the per-member-per-month incentive program rate up to $6.49. EOHHS anticipates that this change will address the concern that the incentive funds were declining too quickly. |

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| | re-evaluate our investments. Based on the provided technical guidance, the AEIP PMPM will decrease 19% from the previous year's rate and approximately 38% from PY3 ($6.84 vs. $5.54). This decrease in funding will start when EOHHS has also proposed increasing the responsibility of the Accountable Entities around care management and care coordination. Reducing the AEIP PMPM will require Coastal to re-evaluate our investments and make changes in our population health management programs to allocate our resources appropriately. The reduction in the AEIP PMPM may limit the development or expansion of clinical initiatives in the AE population. While it is reasonable to assume that the investments in value-based care will lower the cost of care and in turn pay for the sustainability of clinical initiatives, the time frame for the expected return on those investments is unrealistic. | |
| Incentive Program | ATTACHMENT K – INFRASTRUCTURE INCENTIVE PROGRAM: REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND CERTIFIED ACCOUNTABLE ENTITIES<br>TCOC- For Program Year 5, the AE-Specific Incentive Pool Program Year 5: AEIP AE-Specific Incentive Pool (AEIP) Calculation PMPM Multiplier x Attributed Lives x 12 $6.49 at the start of each Program Year in accordance with EOHHS defined requirements. IHP appreciates the additional funding to reinvest in our AE. | EOHHS appreciates the support for this change. |
| Incentive Program | Attachment K<br>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. | EOHHS appreciates the support for this change, which was made to slow the decline in incentive payments as stakeholders indicated was very important to their ongoing work. |

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| Incentive Program | ROI Project (page 13): Should the description of Minimum Milestones on page 6 mirror the language included in this section (i.e. MCO is also eligible for up to 5% of the savings)?<br>ROI Project (page 16 - Table): Suggestion to insert " AEIP and MCOIP " incentive funds | EOHHS appreciates the request for clarity regarding the MCOIP and Minimum Milestones and has updated the language to state that the MCO is also eligible to receive 5% of the MCOIP based on the AE's performance. To ensure clarity, please note that the MCO will always earn incentive funds in fixed proportion to what the AE receives. |
| Incentive Program | We believe the current requirements around AE/MCO dyad collaboration are sufficient. If this language is imposing additional steps in the HSTP Plan development process, we urge the state to find a way that this requirement does not needlessly over burden AEs in what is already a demanding process. | EOHHS does not intend to add new requirements to the existing process by which AEs and MCOs collaborate on HSTP Project Plans. Through PY3, AEs and MCOs worked on the plans before submitting to EOHHS, and in PY4 EOHHS tried a new process to include the HSTP Project Plans in the AE (re)-certification process. This meant that in many cases, MCOs were less involved in PY4 than in previous years because AEs are solely responsible for their own certification. EOHHS intends to return to the original process of AE-MCO collaboration, where MCOs see the plans before they are submitted to EOHHS later in the spring rather than as part of re-certification. |
| Incentive Program | PMPM. We are very pleased to see that the Accountable Entity Incentive Pool (AEIP) PMPM for PY5 will only decrease to $6.49 (Section 2, page 4). We would appreciate EOHHS's best estimate of what the intended HSTP PMPM for PY6 will be to support longer-term planning around sustainability.<br>NEWLY COVERED MEDICAID SERVICES. We request that EOHHS clarify the opportunity to continue to use HSTP funds to cover services that are newly covered Medicaid services to bridge the effort to be able to bill. The standards are clear that HSTP funds cannot be used to cover "RI Medicaid Covered Services including, State Plan services and 1115 demonstration services" (Section 7, page 11). However, when a service that was previously not | EOHHS appreciates the support for the increased incentive pool PMPM. Prior to the recent adjustment, the incentive pool PMPM was set to decrease by 19% year-over-year, beginning with PY4. The PY5 PMPM now reflects a 5% decrease from PY4. The preliminary PY6 PMPM is set to decrease by 10% from PY5, resulting in a $5.85 and $1.11 PMPM for AEs and MCOs, respectively. Note, this PY6 PMPM will not be finalized until fall 2022. |

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| | covered becomes covered, providers will not be able to immediately bill for reimbursement for these services. As an example, it will take considerable effort to shift Community Health Worker services to a fee-for-service model. It would be terribly disruptive if we were simply unable to pay for our Community Health Workers during the transition period.<br>TEMPLATE MODEL AMENDMENT. As stated in our comments on the PY5 Roadmap and Sustainability Plan, we strongly recommend that EOHHS develop a “model amendment” boilerplate for MCOs and AEs to use to for the HSTP program. Standardized language will expedite the contract negotiation process for the MCO and AE and better position the parties to meet the contract submission deadline. (Section 6, page 7)<br>TIMELINE FOR PAYMENT TO MCO. We appreciate the changes EOHHS has made to the payment and reconciliation process. We are concerned that the language “EOHHS shall process this submission and distribute earned AEIP and MCOIP funds to the MCO on an agreed upon schedule” (Section 6, page 9) does not indicate the timeline that EOHHS will make the payment to the MCO. The MCO will make the payment to the AE thirty days from the receipt of payment from EOHHS. We recommend EOHHS include a date by which EOHHS will process the payment to the MCOs. | HSTP funds cannot be used to fund services that are, at the time of being funded, also Medicaid-covered services. EOHHS is available to discuss concerns and potential solutions with AEs.<br><br>EOHHS appreciates the recommendation to create "boilerplate" contract language and will consider this option for the future.<br><br>EOHHS appreciates the request for more information on the timeline for payment to the MCO and has added a statement that payment will be made to MCOs within 30 days of EOHHS receiving accurate Milestone Performance Reports from the MCO. |
| Quality | We agree with the decision to collect race, ethnicity, and language (REL) for all patients as a current practice. For disability (RELD), we would need to rely on the MCO’s to provide this information. Additionally, we agree with including four Quality Measures (DM A1c, DM eye exam, BP control, developmental screening in the first three years of life) with a breakdown by RELD. Coastal also agrees with the reweighting of outcome measures for payment of incentive dollars as listed below:<br>· All-cause readmission= 20%<br>· ER utilization for patients with Mental Illness = 12.5%<br>· Avoidable ER visits = 12.5% | EOHHS appreciates the support for the RELD measure and the re-weighting of the outcome measures. EOHHS agrees that MCOs will be the source of information on disability status in PY5. |

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| Quality | Attachment A - Quality Framework<br>**Target setting**: IHP recommends that EOHHS consider the ongoing pandemic and staffing challenges arising as a result and revise (lower) both the threshold and achievement targets for the three measures to 15% each.<br>**New metrics:** EOHHS is considering dropping the childhood BMI/nutrition/activity metric and replacing it with an alternative pediatric measure.<br>**Lead screening**: IHP is concerned about how we would data capture. Please clarify how we would report out for this measure. IHP would recommend Lead screening as the replacement measure. | EOHHS will work closely with the AEs and MCOs to set targets for quality and outcome measures for PY5. The goal is to tie payment to achievement of meaningful progress while also ensuring that the targets are fair.<br>EOHHS interprets the reference to 15% in this comment as related to the allocation of incentive funds across the three outcome measures. To clarify, the three outcome measures - All-Cause Readmissions, Potentially Preventable ED Visits, and ED Visits for Members with Mental Illness - collectively account for 45% of an AE's incentive fund pool. EOHHS proposed that AEs will be able to earn 20% of funds by achieving targets on All-Cause Readmissions and 12.5% of funds for each of the other two measures. This allocation is not related to the actual performance targets, which EOHHS will set in collaboration with AEs and MCOs.<br>EOHHS appreciates the support for the Lead Screening measure and expects to work with AEs and MCOs on data capture as needed. |
| Quality | 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%. | EOHHS has sought to set quality improvement targets at a level that strongly indicates that the AE has achieved a true improvement rather than a random variation - that is, an AE should earn improvement points for significant improvement only. When an AE is close enough to the high-performance target that any significant improvement in performance on the measure would mean achieving that target, it is appropriate for the AE to receive credit when it reaches the target. |

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| Quality | Prior to the pandemic, EOHHS sought to move benchmark setting from AE-MCO dyads to standardized targets. The pandemic's interruption in care for most of 2020 and into 2021 has only deterred proper benchmarking for such standardized targets. Further complicating the process are social determinant disparities among RI Medicaid populations that continue to go unrecognized. Housing, transportation, language, and literacy affect provision of care more profoundly than a single screening tool can capture. Nor does the approach itself contribute to a consistent method of evaluation; standardizing quality measurement without adjustment contradicts a total cost of care (TCOC)methodology that assesses performance based on the unique activity for an individual AE. For AEs contracted with Neighborhood Health Plan, obvious performance gaps existed in both PY2 and PY3 among measures still slated as pay-for-performance in PY5 (See Comments - Table included with their PY2 and PY3 performance). Accepting such statistically significant pre- and post-pandemic differences at face value strips away the context of providing care to vulnerable populations whose socioeconomic risk exposure is not reflected. At best there are only clinical risk scores that are as much a product of coding and utilization as they are actual morbidity. Practices saw drastic risk score decreases across the board in 2020 in models capable of accounting for less than half of cost variance even during the "best of times." On the other hand, there are still untapped data sources regarding social vulnerability. These include the Uniform Data System Mapper, the Economic Innovations Group's Distressed Communities Index, Surgo Venture's COVID-19 Community Vulnerability Index, and data shown through Neighborhood Health Plan's contract with Algorex. Each of these holds, consensus on where Rhode Island's most vulnerable populations reside, a factor that became all too apparent in the disparities of outcomes highlighted by the pandemic.<br>Engagement with actuarial expertise to adjust quality targets | At this time EOHHS is not considering individually adjusted high-performance quality measures targets for AE/MCO dyads. EOHHS believes that the high-performance targets are achievable for all program participants and that all AEs should strive to meet them. The availability of "improvement" in addition to "achievement" points should mitigate any concerns about different AEs being in different situations. |

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| | would lead to more meaningful assessment of quality of care delivered to AE populations whose COVID-19 recovery is not equal among all geographic areas. The adoption of adjusted targets creates more realistic program evaluation while fostering continuity with the principle of individualized adjustment set forth by the TCOC model. | |
| TCOC | Coastal Medical agrees with the proposal for recertification of the AE's fully certified in PY4 for downside risk. AE's may not know their financial performance for PY4 agreements when it is time to begin negotiation for PY5. Final financial performance reports for the conclusion of a performance year may come up to ten months after the performance year has ended, leaving the AE at a disadvantage. Receiving final financial performance sooner than ten months after the end of a performance period would allow AEs to make changes in program plans more effectively and to the mutual benefit of the Accountable Entities and the MCO's. | The ten-month timeline allows for six months of claims runout, two months for MCOs to prepare final cost data, and two months for EOHHS to complete adjustments and finalize reports. EOHHS anticipates that the fourth quarter TCOC performance report will give AEs a reasonable sense of the scale and direction of their final TCOC results. The intent is for the fourth quarter report to include risk adjustment information, which will address a major factor not accounted for in Q1-3 reporting (the remaining outstanding items are the remaining three months of IBNR and the final FQHC wrap payment reconciliation used for the FQHC adjustment, although there will be a preliminary value for that adjustment in the Q4 report). Fourth quarter reports are expected to be available approximately 5 months after the end of the program year.<br>To the extent that final program year TCOC can be reported sooner than ten months after the end of the year, EOHHS will seek to do so. |
| TCOC | ATTACHMENT J - ACCOUNTABLE ENTITY TOTAL COST OF CARE REQUIREMENTS<br>C.4. - Attribution: TCOC performance period data must account for and be aligned with the list of attributed members MCOs are required to generate monthly, as described in the attribution requirements. | EOHHS modeled the results of different attribution models (including monthly attribution) before implementing the current method and did not find significant or systematic differences in outcomes. At this point in the program, there is also substantial value to stability in |

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| | IHP recommends EOHHS consider assessing TCOC based on "monthly" attribution. | methodologies. Therefore, EOHHS intends to continue the current approach. |
| TCOC | 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.<br>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.<br>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 | The trend adjustment that EOHHS applies in the MCO capitation rate setting process is the same as the trend adjustment applied to TCOC targets. EOHHS is available to walk through the data upon request.<br><br>EOHHS has set the minimum savings rate (MSR) based on the level of membership needed to ensure that savings are not the result of random chance. The rationale for a MSR in a one-sided risk model is that the false positive payouts are not offset by false negative recoupments, so it is important that payouts are only made when there is confidence that true savings have been achieved. Under a two-sided model, this issue is largely mitigated by the potential for shared loss payments. In addition, it is possible within the structure of the AE program that the maximum loss for some AEs with low provider revenue may actually be lower than the MSR/MLR would be that is, the risk exposure cap would already be below an MLR (minimum loss rate).<br>EOHHS appreciates the recommendation to include risk adjustment in the quarterly TCOC reports. EOHHS has sought to balance the sometimes-competing goals of providing more information with providing timely information; implementing the risk adjustment can take significant time. However, EOHHS is seriously considering providing more risk adjustment |

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| | EOHHS/Milliman quarterly reports. There is currently no attempt made to estimate this change and that can be misleading by unintentionally misrepresenting results.<br>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.<br>Total Cost of Care Technical Guidance Program Year 5<br>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. | information during PY5, at least for the third and fourth quarter reports.<br><br>EOHHS agrees that a more detailed definition of AE revenue for risk exposure cap purposes will be helpful and has added this to Attachment J and the TCOC Technical Guidance.<br><br>The timing for final TCOC results is driven by the six months of claims runout (necessary for accuracy) and two months each for the MCOs to deliver performance data to EOHHS and for EOHHS to make final adjustments to generate the final reports. EOHHS would welcome the MCOs to submit final PY3 cost data earlier than the current deadline at the end of February but did not require this because of a goal to allow sufficient time for the MCOs to do their work carefully, especially given that the first PY4 quarterly TCOC report is due from MCOs at the end of January. EOHHS will seek to complete adjustments and produce the final reports as quickly as possible following receipt of the final cost and attribution data. Because EOHHS is intending to include risk adjustment for the PY3 Q4 TCOC report, it is hoped that AEs and MCOs will have a reasonable estimate of the final results earlier than ten months from the end of the year.<br><br>EOHHS has a very high threshold for changing targets for "extraordinary and unforeseen circumstances" and does not believe that this should introduce significant uncertainty for AEs. |

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| TCOC | According to AE PY5 supporting documents presented to FQHCs on September 24, 2021, EOHHS has obtained confirmation from the Centers for Medicare and Medicaid Services (CMS) FQHCs cannot be at risk for less than the PPS rate. EOHHS also stated CMS allows states to make payments in excess of PPS, and those additional payments may be put at risk. EOHHS is proposing the delta between the Principles APM and the PPS would be the amount to be at risk. The proposal by EOHHS relies on a PPS rate for each FQHC that is known only by EOHHS. For FQHCs to evaluate a downside risk as a viable option, they would require a PPS rate calculated in conformance with federal law. Using the MEI alone is not sufficient under federal statute; the state must also consider any change in scope, which includes a change in the type, intensity, duration, or amount of services. We would encourage the state to undertake the appropriate process to determine the correct PPS rate for the FQHCs and to defer the downside risk option until that is completed. It is impossible for the FQHCs to evaluate a risk option without the correct PPS rate. Finally, we raise the question of whom is taking downside risk in your construct, the AE or the FQHC? For the individual health centers that have been certified as AEs, this may not be an issue depending on the corporate structure of the respective AE. However, for the AE that has five FQHCs and other types of providers as members, it is a critical question. Why would the FQHC partners assume risk and not the other members of the AE? | EOHHS appreciates the feedback and stakeholder engagement on the issue of downside risk for FQHC-based AEs.<br><br>If an FQHC wishes to work with EOHHS to identify scope changes in the years since 2006 and is able to share appropriate data to support that effort, EOHHS would take the necessary steps to establish a PPS rate based on both the MEI and scope changes. EOHHS has thus far not chosen to require FQHCs to undertake what could be a very administratively burdensome activity. At the same time, EOHHS did not feel it was appropriate to permanently block an FQHC-based AE from taking downside risk if that AE wished to do so in order to obtain the potential benefits of those contracts, and therefore EOHHS identified an MEI-based analysis as a reasonable approach to identify a PPS rate and allow such an AE to move forward. No FQHC-based AE is required to take on downside risk and by retaining the ROI Project as an option, no FQHC-based AE is disadvantaged by the existence of the option.<br><br>TCOC contracts are between an MCO and an AE. It is the AE that takes on risk and is eligible to earn shared savings. An AE that is composed of both FQHC and non-FQHC organizations would take risk at the AE level and could determine internally how to allocate any shared loss. In the previous stakeholder meetings, EOHHS focused on the role of the FQHC members of any AE because it is those members for whom the PPS could be an issue. |

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| TCOC | Cost Assignment: The TCOC model assigns all fiscal year costs to an AE based on the last date of attribution, leading to added TCOC expenditures incurred outside of the AE's purview. AEs are relatively blind to a historical look-back of member activity given the omission of claims for members' experience outside of attribution. The practice has contributed to substantial fourth quarter cost growth in successive years. BVCHC continues to advocate that costs only be assigned to AEs under post-enrollment member attribution. | EOHHS modeled the results of different attribution models before implementing the current method and did not find significant or systematic differences in outcomes. Also, note that the quarterly TCOC reports are based on attribution in the final month of each quarter, so it is not the case that all the changes in attribution throughout the year are "saved up" for the final quarter. At this point in the program, there is also substantial value to stability in methodologies. Therefore, EOHHS intends to continue the current approach. |
| TCOC | Common Measure Slate (page 14): This table should be updated to reflect the same table from the September 23, 2021 version of the Implementation manual. | The information regarding quality measures will be the same in both the Implementation Manual and Attachment A to Attachment J; EOHHS expects to issue a revised Implementation Manual to reflect the final Measure Slate shown in Attachment A to Attachment J. |
| TCOC | 1) There should be no increase in the minimum risk level required of AEs until EOHHS mandates that MCOs must delegate care management and utilization management to AEs that are ready, willing, and able to perform these functions.<br>2) EOHHS should reduce the financial solvency requirements on the AEs. We believe they are excessive and burdensome. Currently, PY4, AEs have been required to create a financial reserve or obtain letters of credit equal to 1% of the AE's Total Cost of Care (TCOC) or 3% of the AE Provider revenue, whichever is less. We recommend that this be reduced to 0.5% of AE's TCOC or 2% of AE Provider revenue, whichever is less.<br>TCOC Methodology<br>We recommend EOHHS remove the minimum shared savings provision and allow AEs to share in first<br>dollar savings. | EOHHS agrees that delegation of care management is appropriate in many cases and that some AEs may be able to also take on utilization management - although this is a very complex task and readiness will vary. To the extent that an AE and an MCO are so inclined, there is nothing in EOHHS regulation stopping them from arranging for such delegation now. EOHHS believes that the level of risk sharing proposed for PY5 is appropriate even without delegation of care management and/or utilization management. The level of risk sharing, both in terms of the risk exposure cap and in terms of the share of any shared loss pool that the AE would |

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| | Impact of Quality Outcomes<br>In last year's document, EOHHS stated that "EOHHHS intends for the Shared Loss Pool adjustment based on Overall Quality Score to be applied in PY4 only." This statement is now struck from this provision and what was envisioned as one-time adjustment is being repeated, and now with no end-date provided. We would appreciate an explanation from EOHHS why the decision was made to carry forward what had originally been a one-time adjustment. Additionally, is it EOHHS's current intention for this provision to be permanent? Finally, it would be helpful if EOHHS could provide detail on how this formula was developed, what models informed the creation of this formula, and to what degree this adjustment aligns with any national standards.<br>Risk Exposure Cap<br>As we did last year, we recommend EOHHS remove the requirement for the AE and MCO to obtain an independent actuarial analysis for pursuing a downside risk contract agreement. If the AE and MCO are aligned with the desire to move to higher than the 10% risk exposure cap, so the AE and MCO should jointly engage a 3rd party actuarial analysis or EOHHS should allow the MCO's actuarial staff to develop this same report. We recommend that EOHHS allow the AE and MCO to present their mutually developed and agreedupon financial analysis of their proposed downside risk contract arrangement to substantiate the risk mitigation.AE Share of Savings/(Loss) Pool.<br>We believe it is premature for EOHHS to raise the risk requirement. PY4 is the first year in which AEs have assumed downside risk. The results are not yet in. The risk requirement should only be adjusted after PY4 results are in hand and we can all see how AEs performed. We recommend EOHHS retain the current risk level from PY4. Additionally, before EOHHS sets a new risk requirements, all AE stakeholders would benefit from EOHHS disclosing the methodology used to set the current | take on, is generally lower than in similar programs.<br><br>EOHHS believes that the current requirements for Financial Solvency Filings are appropriate to ensure that any AE taking downside risk can bear the full extent of such a potential loss. Please note that the maximum potential loss is not the risk exposure cap itself (in PY4, 1% of TCOC or 3% of AE revenue) but rather 30% of that exposure cap (in PY4). In addition, please note that there is flexibility in the requirements: "OHIC will allow for flexibility in AEs' approaches to managing their risk exposure as long as the AE can document a thorough strategy for obtaining protection from estimated maximum potential losses. If an AE has a strong balance sheet, its strategy for covering maximum potential losses due to downside risk could include documenting that it has sufficient existing secured liquid assets and reinsurance to cover the maximum potential losses, with evidence that these funds are secured in a controlled or custodial account. Other organizations without available liquid assets to cover the maximum potential losses may need to develop a risk strategy portfolio consisting of several different approaches. Strategies could include, for example, aggregate and individual stop loss insurance, corporate investors, provider partner organization contributions, insurer withholds, delegation of risk to contracted provider organizations, insurer-provided capital, securities in trust, and letters of credit." |

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| | requirements and the methodology that will be used for future requirements.<br>Finally, as stated above, we do not support increasing the minimum downside risk requirement absent providing AEs more tools to manage that risk – namely Delegated Utilization and Care Management. These tools are essential in a true at-risk care contract. We have extensive experience locally and nationally conducting these functions and realizing positive returns for payers and patients when we do. Increasing the risk requirement while not expanding authority for AEs is a one-sided modification of the overall risk calculation in the AE program. | EOHHS appreciated the feedback regarding the minimum savings rate. EOHHS believes that this provision is appropriate to ensure that savings are not due to random chance but rather due to AE performance. Please note that an AE that exceeds the minimum savings rate does share in the full shared savings pool; it is not the case that the minimum savings rate is exempt for shared savings for the AE. In downside risk contracts, where the AE takes on the risk of random chance leading to a shared loss, the minimum savings rate is not applied, and the AE would share in any amount saved.<br><br>EOHHS had initially decided to adjust the shared loss pool based on quality performance in one year only but found that stakeholders strongly supported that adjustment. As PY5 included an increase to AE risk-sharing already, EOHHS decided that it was appropriate to maintain that quality adjustment. At this time, EOHHS expects to maintain the adjustment. The original intent was to only adjust shared savings for quality, such that underperformance would have a negative impact on savings. As EOHHS prepared for PY4, and as stakeholders expressed concern about the requirement for downside risk, EOHHS decided to add an adjustment to shared losses. However, this adjustment was designed to be only one quarter as significant as the shared savings adjustment because otherwise it could vitiate the already fairly limited shared risk amount. |

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| | | In the case of a contract with a relatively low risk exposure cap, it is straightforward to identify the maximum financial exposure the AE could have and relatively easy for the AE to prove that they have that amount of money available to pay the loss without risking financial stability. In the case of a much higher risk exposure cap, it would likely not be reasonable for an AE to demonstrate that they have the "worst-case scenario" funds on hand or, if there were no exposure cap at all, it would not be possible to even identify the worst-case scenario in a straightforward way. That is reason for an actuarial analysis in that situation; it allows the AE and EOHHS to obtain a reasonable estimate of the maximum financial exposure the AE could have so that the AE can demonstrate its ability to withstand such a loss. The independence of the actuary ensures that there is not a conflict of interest.<br><br>EOHHS believes that the progression to downside risk is appropriate. The reason for the progression is that AEs gain experience and skills over time and are able to take on more risk, which in turn is an important element of continuing to incentivize performance. The progression is not based on an assumption or requirement that AEs will all succeed in every contract every year, and so there is no reason to wait for results before continuing the planned progression. |
| TCOC | Required Progression to Risk-Based and Value-Based Arrangements<br>We request that EOHHS provide additional detail regarding the following in the table on the bottom | EOHHS agrees that it is a good idea to include more detail regarding the risk exposure cap calculation and has added this to Attachment J and the TCOC Technical Guidance. |

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| | of page 5:<br>A cap on the Shared Loss Pool, expressed as a percentage of a) the total cost of care, or b) the annual<br>provider revenue from the insurer under the contract<br>Please provide a detailed explanation of how the AE and MCO would calculate both Option A and Option B. The specific calculation should be included in the final document. And, as stated above, we do not believe the increases proposed for PY5 and PY6 should take effect. In fact, we believe these should be decreased to 0.5% of AE's TCOC or 2% of AE Revenue, whichever is less. Increasing the risk requirement on AEs while not expanding the mitigation tools at their disposal is not a balanced. AEs that are ready to assume Utilization Management and Care Management should be allowed to do so and MCOs should be required to contract with those AEs. When that development is in place, the risk level can be increased, but until then this should not be ratcheted up. EOHHS should not increase risk levels until the results in hand from the first year of the risk arrangements. Increasing risk absent that information is not prudent.<br>Financial Solvency Filing<br>We believe that AEs that have already met the pre-qualification standards should not be required once again to submit a Financial Solvency Filing.<br>EOHHS/OHIC should not require AEs that have made financial reserve/mitigation commitments in PY4 (such as Letters of Credit) to submit any additional documentation. The approval granted for PY4 should be carried forward. Instead, EOHHS/OHIC would only require the AE to provide evidence of financial risk mitigation each year as part of the AE/MCO downside risk arrangement.<br>Impact of Quality Performance on Shared Savings and Losses<br>Please provide detail on how EOHHS developed the formula described in the fourth bullet of this section. | EOHHS believes it is important to do a full financial solvency filing each year. The application includes information on past years' results, which allows for a broader context for the AE's financial situation, and also allows for updates to the AE's contract plans, which may change, especially as an AE might pursue contracts with downside risk above the minimum requirements for the program. EOHHS believes that eliminating the pre-qualification step for AEs qualified in PY4 is a useful reduction in administrative complexity. Over time, EOHHS will continue to evaluate the RBPO process to identify other opportunities for simplification. |

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| | Pre-Qualification of and TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk<br>We refer you to our comments above about adjusting the requirements to account for those AEs that have already qualified for and taken on risk. We believe that EOHHS/OHIC can sufficiently evaluate AE risk-bearing capacity through requiring evidence the AE has specific arrangements in place for financial risk mitigation. This could be done by requiring submission of Letters of Credit or documentation of other forms of financial reserves. | |
| TCOC | "PRE-QUALIFICATION. We appreciate the new language in Section 5.a. on page 6 that confirms that AEs who were pre-qualified in PY4 to assume downside risk do not have to renew the pre-qualification in PY5.<br>INCREASES TO SHARED SAVINGS AND LOSSES. We ask that increases in shared losses be proportional to increases in shared savings (Section 3, page 5). Therefore, if the share of losses is increasing from 30% to 40%, we recommend that the share of savings increase proportionally from 60% to 80%. As currently written, disproportionate increases in shared losses have the potential to unfairly disadvantage AEs, who do not have sufficient influence to negotiate a higher shared savings rate in agreements with partner MCOs. Ensuring that AEs are appropriately incentivized to take on additional risk is a crucial consideration for the future sustainability of the program.<br>MINIMUM SAVINGS RATE (MSR). Although it is clarified in the "Total Cost of Care Technical Guidance" document, we recommend that EOHHS clarify in Attachment J on page 4 that the MSR applies to AEs in one-sided risk arrangements only.<br>PERFORMANCE AND CALENDAR YEAR ALIGNMENT. We ask EOHHS to consider aligning the performance year with the calendar year (Attachment A, Section B, page 9). This change would promote alignment with quality and outcomes measurement periods, a source of considerable confusion in the | "EOHHS appreciates the support for the administrative simplification to the RBPO process.<br><br>EOHHS believes that a 40% downside-60% upside risk share arrangement is appropriate for an AE's fifth year in the program. In many total cost of care contracts, the risk share is 50% downside-50% upside, and while Rhode Island has not expected AEs to bear 50% downside risk, EOHHS does not believe it is unreasonable to increase to 40% while maintaining the favorable 60% shared savings rate.<br><br>EOHHS appreciates and will implement the recommendation to be clearer in Attachment J that the Minimum Savings Rate only applies to upside-only contracts.<br><br>EOHHS agrees that it would be better if the Program Year and Quality/Outcome Program Years were on the same schedule (all state fiscal or all calendar year). The challenge is that the managed care capitation rates are tied to the fiscal year and total cost of care targets are |

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| | current program. It would also align the Medicaid performance year with our other risk contracts, which would greatly simplify our multi-payer approaches to closing quality gaps, for instance. (While we recognize that it is not possible to change the state's fiscal year, it should be possible to design a risk program that spans two fiscal years.)<br>CLAIMS DATA REPORTING. We appreciate the quarterly financial reports that we receive from EOHHS as a part of our participation in the AE program. However, these claims-based reports come to AEs with such a delay (typically a seven-month lag) that they are not actionable. While we recognize that a three-month claims data lag is inevitable and appropriate, we encourage EOHHS to work with contracted MCOs to reduce the lag of claims-based reporting to closer to four months.<br>Total" | aligned with managed care capitation rates. Meanwhile, quality measures, especially HEDIS measures, run on the calendar year. EOHHS will consider if there are ways to work around this and reduce complexity. However, EOHHS believes it is more important to ensure alignment with the MCO contract year and capitation rates than it is to avoid the complexity and will continue to do everything possible to minimize the burden and confusion associated with the multi-calendar nature of the program.<br><br>EOHHS agrees that the goal should be to get quarterly TCOC reports to AEs expeditiously. In quarters without unexpected problems, EOHHS generally expects to provide the quarterly reports about five months after the end of the quarter." |
| TCOC Technical Guidance | Impact of Quality and Outcomes: IHP is concerned that Quality scores cannot wipe out Shared Losses and would propose that the Quality influence/impact be consistent, regardless of savings/loss? Or can quality measures be tied to certain categories of care for TCOC gain/risk share purposes?<br>EOHHS reserves the right to include other adjustments as necessary based on program changes or emerging issues.<br>Though the aforementioned statement is seemingly meant to, in good faith, "protect" EOHHS with unforeseen catastrophe (e.g., COVID), concern remains for the AE and any potential fallout. For example, the membership base may be artificially inflated during times when the State slowed on terminating eligibility. Moreover, if/when the State begins to ramp up terminating members, there is the potential that the average cost will rise to the degree that those leaving Medicaid eligibility are healthier and lower cost users. This, in turn, would impact TCOC outcomes. Additionally, to the degree the economy recovers, and people | "The primary purpose of the quality program in TCOC is to ensure that AEs pursue quality performance in tandem with cost improvement. EOHHS received feedback in previous years that it would be appropriate to reward AEs with excellent quality performance with a reduction in any shared losses and EOHHS agreed with this. However, in keeping with EOHHS's position that meaningful downside risk is an important tool to incentivize improved cost performance, EOHHS does not intend to use quality to vitiate the significance of downside risk.<br>The TCOC Technical Guidance provision referenced here (adjustments based on program changes or emerging issues) is specific to the quarterly reports on TCOC performance. If there is a program change that would impact final TCOC |

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| | return to work, that would also affect eligibility, likely for a healthier segment of the population. Perhaps the actuarial/risk adjustments take such into account such changes during "normal" healthcare turnover, but do these models take into the dramatic influences of the pandemic and unemployment…and the influences of SDOH that undoubtedly play a major role. Clarity of the statement is appreciated.<br>Covered Services: Services included in the managed care program in the Baseline Years that are not covered under the MCO contract in the Performance Period. IHP recommends that perhaps the inverse should be included as well…that is: Services included in the Performance Years that are not covered under the MCO contract in the Baseline Years." | targets and that is known midyear, it is the intention to include that in the quarterly reports as soon as possible. It is likely that the concern in this comment is mainly related to the TCOC Technical Guidance language that EOHHS ""reserves the right to modify the Final AE-specific TCOC Expenditure Target after the Performance Period for extraordinary and unforeseen circumstances."" This provision is not intended to be used under any normal circumstances or to disadvantage AEs. This option is intended only to be used in extreme circumstances that EOHHS considers very unfair to the AEs or MCOs. The Technical Guidance offers one example of such a situation: if MCO reimbursement for non-AE providers materially changes, it may have unintended consequences on the TCOC Expenditure Target. Another example would be an MCO that had a large change in the volume of provider settlements or other payments that did not flow through the claims system. This language is intended to increase stability in the model (not uncertainty), since it is not possible to anticipate all possible scenarios and this language allows EOHHS to insert guard rails when necessary.<br>In general, EOHHS does believe that risk adjustment will account for the potential impact of disproportionately healthy members leaving Medicaid as the state and economy recover from the PHE. EOHHS is continuing to evaluate opportunities to include some SDOH factors in risk adjustment. It is important to ensure that any adjustment function as intended; there is some |

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| | | risk that some SDOH adjustment methods could inadvertently measure access to care, such that members with more social needs would appear less, rather than more, expensive. Accordingly, EOHHS is taking a cautious and careful approach. To the extent that new services are available in the Performance Years that were not included in the baseline years, the expected costs would be accounted for in the trend adjustments. " |
| TCOC Technical Guidance | TCOC Technical Guidance (page 13 - table at bottom of page): Missing the final submission for the PY data needed. TCOC Quarterly Report covering claims incurred July 2022 through June 2023 and paid through December 31, 2023. | EOHHS appreciates the suggestion to add the timing for the final performance year data and has added this information to the TCOC Technical Guidance. |
| TCOC Technical Guidance | "STOP LOSS. We recommend that EOHHS remove the following language in Section 1.b.iii. on page 3, as the stop loss provisions have been removed from the EOHHS/MCO contract: "Services covered under stop-loss provisions between EOHHS and the MCO in the Performance Period, as specified in the EOHHS/MCO Contract for Medicaid Managed Care Services."<br>CLAIMS THRESHOLD APPLICATION. As previously noted, we strongly recommend that the claims threshold for high-cost claims be applied at the member level, not at the member-rate cell level (Section 1.C., page 4).<br>BELOW MARKET WEIGHT ADJUSTMENT. We encourage EOHHS and Milliman to evaluate that the below market weight is appropriate for PY5 (Section 2.e., page 6). This factor is a critical component in an AE's ability to achieve shared savings, which becomes increasingly important as other sources of revenue begin to ramp down. In past comments, we recommended that the weight for PY5 be as high as 50 percent; our goal is to ensure that we are able to continue to achieve shared savings year over year.<br>RISK ADJUSTMENT. While we recognize that a final risk score is not available until the end of the Performance Period (Section | "The stop-loss language is reasonable to retain in the TCOC Technical Guidance because in the case that future circumstances warrant new stop-loss provisions, the language will not need to be changed. The current language allows for the possibility that there are no such provisions.<br><br>EOHHS appreciates the recommendation regarding the claim's threshold. The impact of applying the threshold at the rate cell level is expected to be minimal and to be similar in baseline and performance years. The reason for the rate cell approach is that it reduces implementation difficulty and therefore reduces the likelihood of errors.<br><br>There is some tradeoff between receiving quarterly reports more quickly and receiving more information on risk adjustment, however, EOHHS understands and agrees that having interim risk adjustment information would be |

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| | 3.b.), it would be extremely useful to be able to track how our risk score is changing. We ask that quarterly reports include interim, best estimate projections, of the aggregate risk score of our attributed population, and an estimate of the impact of risk adjustment on our performance." | very useful. For PY4, EOHHS intends to add some information on risk adjustment at least for reports on quarters 3 and 4, where the data allows this to be done in a timely fashion. " |