Date: 8 November 2021

To: Rhode Island Executive Office of Human and Health Services

From: Blackstone Valley Community Health Care Accountable Entity Program

Re: Program Year Five Public Comment

Blackstone Valley Community Health Care (BVCHC) thanks the Rhode Island Executive Office for Health & Human Services (EOHHS) for soliciting public comment prior to finalizing Accountable Entity (AE) program year 5 (PY5) decisions.

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 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.

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Quality Benchmarks

EOHHS has BVCHC's gratitude for the opportunity to discuss PY5 quality measure benchmarks as indicated at the AE-MCO Quality meeting held 10/25/21. 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:

	PY2			PY3		
Measure	Highest	Lowest	Net	Highest	Lowest	Net
Breast Cancer Screening	81.77	55.62	26.15	82.28	53.27	29.01
Controlling High Blood Pressure	83.45	35.14	48.31	67.18	36.69	30.49
Diabetic A1c Control	59.41	29.56	29.85	53.85	36.93	16.92
Diabetic Eye Exams	78.01	51.8	26.21	75.74	51.75	23.99
Depression Screening & Follow-Up	79.6	6.6	73	71.87	7.72	64.15
Developmental Screening	90.25	48.33	41.92	88.13	50	38.13
Well Child Visits 12-17				75.74	33.29	42.45
Well Child Visits 18-21				54.39	20.25	34.14
Well Child Visits 12-21				69.31	28.69	40.62
SDOH Screen	57.2	0.63	56.57	87.09	0.2	86.89
Follow-Up After Hospitalization for Mental Illness – 7 Days	62.2	42.5	19.7	62.07	48.33	13.74
Follow-Up After Hospitalization for Mental Illness – 30 Days	77.78	64.1	13.68	75.86	69.17	6.69

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."

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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.

Engagement with actuarial expertise to adjust quality targets 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.

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.

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.

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