

Comments on Accountable Entities Program Year 5 Requirements

Integra appreciates the opportunity to provide comments on the program requirements for PY5 of the Medicaid Accountable Entity (AE) program. We remain committed to participating in the Medicaid AE program and continuing to work with EOHHS and our MCO partners to move towards value-based models of care. We offer the following comments in the spirit of collaboration to ensure that the AE program is as successful as possible. Our most significant concern pertains to the lack of clarity from EOHHS about the nature of the relationship between the MCO and the AE. If EOHHS is adding requirements for the AE, such as the new requirements outlined within the Care Programs section in Attachment H, we ask that EOHHS think critically about how these requirements will be funded and enforced.

Note: Integra's comments are ordered by Attachment. Page numbers referenced throughout refer to the Microsoft Word "Track Changes" version of the PY5 Requirements, dated October 7, 2021.

Attachment H: Accountable Entities Certification Standards

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 are as follows:

- Section 1. Breadth and Characteristics of Participating Providers:
 - Behavioral Health capacity (page 7)
 - Assertive Community Treatment (ACT) and Integrated Health Home (IHH) services (page 8)
- Section 6. Care Programs (page 23)
 - Section 6.2. Health Promotion (page 26)
 - Section 6.4.2. Individualized Care Plans (page 29)

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.

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.)

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.

We therefore recommend that:

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

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.

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.

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)."

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 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?

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.

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.

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).

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 EOHHS define the term “participation,” as we have limited ability to formally add social service providers to our provider network.

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.”

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.

Attachment J: Accountable Entity Total Cost of Care Requirements

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.

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.

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.

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 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.)

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.

Total Cost of Care 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.”

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).

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.

RISK ADJUSTMENT. While we recognize that a final risk score is not available until the end of the Performance Period (Section 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.

Attachment K: Infrastructure Incentive Program Requirements

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.

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 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.

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)

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.

Attachment M: Attribution Guidance

ATTRIBUTION FOR SETTING INCENTIVE FUND POOLS. 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."

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.

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 are accepted, and when both "adds" and "drops" of TINs will be effective.

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.

ATTRIBUTION FOR TOTAL COST OF CARE ANALYSIS. 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).

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.

ATTACHMENT C. 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.