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C. General Comments

The following comments are provided in response to the ***AE Program Year Five Guidance Documents*** circulated and posted for public comment **Thursday October 7, 2021**:
https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents

We thank EOHHS and Medicaid for providing this opportunity to review the proposed changes and offer comments.

Fundamental Delivery and Payment Transformation is Necessary

As we have stated before, **the key to achieving the ambitious goals and sustainability of the AE program lies in fundamental delivery and payment reform, moving away from the current fragmented fee-for-service payment system to a population-based payment system that are ready and willing and should include delegation from MCOs to AEs for utilization and care management and global capitation from MCOs to AEs for both professional and institutional services**.

Most recently, we spoke to this in our comments on the Sustainability Plan where multiple strategies were proposed. This multi-strategy approach is largely necessary because the AE program has not adopted, or allowed for, an **accountable, population-based payment system** (delegation and capitation) at the AE/System of Care level. Under such an arrangement investment and activity would be driven by goals for improving quality in specific and overall measures, achieving payment effectiveness, and addressing health-related social needs.

And, to be clear, PCP capitation is not population-based payment and will not fundamentally transform AE accountability for quality improvement, resource re-allocation, and cost reduction by the AE systems of care in Rhode Island.

Without a fundamental change in the payment system, there will never be sufficient resources for Accountable Entities and Systems of Care to do what they can to serve their population under management and improve outcomes for that population.

At the same time, it is important to acknowledge there are very real limits to what can be achieved in even the highest performing, integrated healthcare/community system of care under a population-based payment system without significant new investments to address basic needs like housing and food insecurity.

We recently provided advice to EOHHS on how the $3.5M in AE funds reserved for increasing BH/SUD capacity could be leveraged to create a significant investment in the development of supportive housing [Memo of 10/13/2021]. **We urge EOHHS to take a leadership role in building the coalitions necessary to move ideas like this forward.**

C. Comments on Accountable Entity PY5 Guidance Documents

Attachment H – Accountable Entities Certification Standards – Comprehensive AE (Program Year 5)

IT Infrastructure – Data Analytic Capacity and Deployment

As we have commented before, the ability of AEs to conduct analytics is directly contingent on the quality, quantity, and timeliness of the data we receive from the MCOs.

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.

We know this is possible because the largest health insurer provides that transparent data to us for their Medicare Advantage and Commercial populations which we care for under a delegated risk agreement. CMS provides us that transparent data for the ACO population we serve.

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.

When data is incomplete, insufficient, or greatly delayed, we are severely hampered in our ability to conduct a robust, actionable analysis that would inform overall strategy as well as individual patient interventions such as proactive patient outreach, enrollment into Care Management services.

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.

The above comment is relevant to and applies in all instances where EOHHS delineates data management and analytics expectations of the AEs.

Care Programs

Introduction

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.

However, 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 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 to greater accountability for the quality and cost for their population under mansgement.

Care Continuum: Working Definitions

Health Promotion

The definition of Health Promotion provided on page 23 (page 25 of the redline) includes the following:

> *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.**

Care Coordination

The definition of care coordination includes a reference to the need for a "two-generation" approach to health-related social needs:

> *Care Coordination services should include connection with SDOH resources, utilizing a 2Gen approach where appropriate.* ***[Page 25]***

We agree with the wisdom of a two-generation approach, however this is a significant new focus for the AEs. Such a significant change, however, should not be introduced into the AE program with just a brief reference within a definition. **We urge EOHHS to build on this, perhaps in collaboration with CHCS, to**

ensure a common understanding exists across the AE partnership of what is meant by "two-generation approach."

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. In addition to increasing the impact of SDOH-related work, this would also enhance the impact of health promotion, prevention, care management, disease management, complex care management, and integrated behavioral health. When issues that can be addressed on the family level, are addressed within the context of the family, there is a greater likelihood our AE members will benefit.

Care Management

The most noteworthy part of this section is language which EOHHS struck from the original text used for this definition:

> *CM 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]***

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:

- Health status (e.g., chronic condition burden)
- Utilization patterns (high ED use)
- Risk (inpatient admission, BH/SUD inpatient admission, SDOH burden)
- Total cost of care

We urge EOHHS revise this definition to align with AE practice.

Complex Care Management

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.

To begin with, while ex-offenders returning to the community are probably most at need, a household with an incarcerated or otherwise "justice-involved" (e.g. probation, parole) member also experiences stresses that can undermine their economic security and adversely effect health outcomes. This is why we encourage EOHHS to broaden this language.

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 justice-involved families/households – including connecting individuals to AEs – would be for EOHHS to encourage DOC Discharge Planning to adopt the Unite Us platform. This would surely increase the overall effectiveness of discharge planning in connecting returning ex-offenders to community resources. This could also provide a way to connect this population with coordinated care and to ensure that the AE to which they might be assigned is informed of their health-related social needs, their justice-involved status, and carry forward any community connections originally brokered by discharge planning.

This is an ideal example of the way the Unite Us platform can, as we like to say, "break down silos" and put our members at the center of the work of multiple organizations and systems.

Certification Standards – General Comments

We urge the state to avoid excessive specificity in the certification standards. Rather, 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.

Depending upon how this new language is translated into the recertification requirements, the administrative burden of recertification could increase significantly. Time, effort, and attention devoted to recertification is directly taken away from active program management and improvement.

6.1 Care Program Design and Planning

Page 24 includes the following:

> *6.1.1. AEs must implement a Joint Operating Committee (JOC) management structure with each contracted MCO to facilitate coordination as care programs are planned and implemented* **[Page 24]**

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.**

6.2 Health Promotion

This appears to be a significant expansion of the current standards for health promotion in terms of AE activity. Additionally, it is not clear who is ultimately responsible for this activity, with EOHHS stating the division of labor here can be negotiated between the AE and the MCO. However, 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.**

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.

6.4 Care Management

Section 6.4.1.4, states the following:

> *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]**

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 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.**

To begin with, as has been stated in other contexts, EOHHS leadership is needed to overcome the barriers to communication and coordination exacerbated by 42 CFR Part 2 and even further complicated by Rhode Island's mental health law. Until AEs have regular, reliable, complete, timely, and direct communication with BH inpatient facilities, AEs will be handicapped in our ability to provide robust TOC services to members.

Additionally, based on our recent experience, we believe that hospitals need to devote additional resources to discharge coordination. Through our AE, and other coordinated care arrangements, we have staff and other tools required to coordinate at discharge when hospitals are similarly prepared. **We urge EOHHS to explore ways to increase hospital capacity for coordination around patient discharge.**

We urge EOHHS to drop the following requirement:

> 6.4.3. Staffing: Care management activities shall be carried out by staff located in Rhode Island to ensure staff have a working knowledge of local resources and are able to carry out care management activities face-to-face as appropriate. ***[Page 28]***

This is counterproductive and not appropriate in a time when we have increasingly realized the benefits of remote work. Allowing remote work is an essential part of any employer's current recruitment and retention strategy.

Additionally, while it has not been a factor for any members of the AE care team, the healthcare workforce overall has been severely depleted because of the pandemic. Burnout, stress, family disruption and – most recently – vaccine resistance have resulted in significant numbers of healthcare professional resigning or retiring early.

We agree that knowledge of local resources is essential, but this obligation falls on the AE overall and should not be applied to each and every member of an AE care team.

This is another example of where ethe certification standards are overly prescriptive about details of program implementation. EOHHS's focus should be on setting a performance standard – the ability to connect members with local resources – and not on directing the finer points of AE staffing.

We do not believe that our AE members have, in any way, suffered from diluted service provided by our remote staff. We are confident saying this due to our robust on-boarding and training, the benefits of the Unite Us platform, and – most significantly – the fact the AE Care Team ***works as a team***. If we encounter a situation where a locally-based person is essential, we have the human resources to meet that need.

<u>6.5 Complex Care Management</u>
The language in this section is what we would expect to see in instances where Care Management (and Utilization Management) were delegated, something we have consistently argued in favor of.

Given the fact Care Management is *not* delegated, the language here imposes a burden on AEs they do not have the authority to guarantee or the resources to conduct.

For example:

> 6.5.1. Provide (or otherwise facilitate access to) Complex Case Management services to the highest risk members with complex or multiple conditions and to high-risk populations, based on AEs' assessment of population risk and needs. **[Page 28]**

In this situation, will the AE risk assessment trump the risk assessment of the MCO? Will MCOs still conduct risk assessments? Will AEs be guaranteed full and timely data required to perform a robust risk stratification? If AE risk assessment replaces MCO risk assessment, will AEs receive the administrative funds currently allocated to MCOs for that activity?

Continuing:

> The AE may facilitate access to Complex Case Management by working with contracted MCO(s) and/or IHH/ACT providers, for example, to ensure that members identified by the AE as needing Complex Case Management are engaged with services offered by the MCO and/or IHH/ACT provider. **[Page 28]**

As discussed above, the language "contracted MCO(s)" is odd. A typical reading of that sentence – absent a knowledge of how the AE program is structured – would imply that AEs could contract with MCOs and those contracts would define the expected performance by the MCOs. That is not how the AE program is structured.

It is also not within an AE's authority to guarantee ("ensure") that a member is "engaged with services offered by the MCO and/or IHH/ACT provider." To begin with, we do not have any tools to enforce that requirement on MCOs or IHH/ACT providers, and patients retain choice and can refuse engagement.

A similar responsibility – without authority – is imposed on AEs in the following section, 6.5.2, emphasis added:

> *Even for AEs that do provide Complex Case Management directly, AEs may not have the capacity or specialized expertise to assume Complex Case Management functions for all specialized sub-populations. As such,* ***the AE shall define the lead entity (e.g., MCO or IHH/ACT) for specific subpopulations and have clear protocols for referral, tracking, and shared management of care as appropriate****.* **[Pages 28-29]**

AEs do not necessarily have contractual relationships with the IHH/ACT providers serving their members.

What EOHHS envisions – both here and in 6.5.2.1 and 6.5.2.2 – is not outside the possible, and there is much to recommend this approach. **The problem is that absent other changes, and without active engagement of and leadership from EOHHS, a burden is being imposed on AEs they may not necessarily be able to fulfil.**

Each AE separately pursuing contracts with each IHH/ACT provider separately is not the most efficient way to achieve that even if that were a desirable goal. In addition to the practical implications of AEs pursuing the necessary agreements/ frameworks independently, we are concerned how AEs will be expected to speak to this in the recertification documents that will be required to submit a few months.

We also have concerns that language in Section 6.5.2.2 contradicts or contravenes the recently adopted change in AE attribution for the IHH/ACT population. When originally launched, individuals receiving IHH/ACT services were attributed to the AE of their IHH/ACT provider. EOHHS was clearly not satisfied with the results of this attribution policy and recently adjusted this so that all attribution is now based on a member's PCP.

The following section is incompatible with that change:

> *6.5.2.2. For members enrolled in IHH/ACT,* ***the coordinator for that program should be the lead care manager****. The AE should establish formal agreements detailing protocols for shared care/case management, and the AE case manager should closely communicate and partner with the ACT or IHH team to wrap around the ACT/IHH services with additional support services.* ***[Page 32]***

Attribution implies – and language in this document in fact confirms it to be the case – primary responsibility for care management. This sentence reverses that, with the IHH/ACT provider designated as "the lead care manager." However, the AE remains responsible for quality performance, outcome measures, total cost of care, and other AE performance measures. Absent new regulatory requirements

from EOHHS that obligate IHH/ACT providers to perform in alignment with the measures for the AE program, AEs have no leverage to ensure the designated "lead" is working in a way that meets AE program goals.

Again, a situation where all AEs are separately and simultaneously trying to develop these new arrangements with multiple IHH/ACT providers is far from ideal. As we have said in other contexts, we urge EOHHS to take the lead in developing a more productive, cooperative working partnership among all the AEs and all of the IHH/ACT providers.

Attachment J – Accountable Entity Total Cost of Care Requirements

We make specific comments below, but first make the following two general statements:

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.**

Absent this change, AEs are being required to assume increased risk with no expansion of their ability to control and mitigate that risk.

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.

Prospect has obtained letters of credit for the UHC and NHPRI contracts for PY4. We do not believe it is equitable or necessary to be required to increase these letters of credit for PY5 and again in PY6 without full delegation of utilization and care management.

We believe that expectations should be raised in a symmetrical, or parallel, way. Increasing the required minimum risk level and increasing the solvency requirements – while providing AEs with no new/additional tools to mitigate/control risk – is a one-sided approach that is not in the long-term interest of the AE program.

<u>TCOC Methodology</u>

We recommend EOHHS remove the minimum shared savings provision and allow AEs to share in first dollar savings.

<u>Impact of Quality Outcomes</u>

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.

Risk Exposure Cap

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 agreed-upon financial analysis of their proposed downside risk contract arrangement to substantiate the risk mitigation.

AE Share of Savings/(Loss) Pool

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 requirements and the methodology that will be used for future requirements.**

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.

Required Progression to Risk-Based and Value-Based Arrangements

We request that EOHHS provide additional detail regarding the following in the table on the bottom of page 5:

> *A cap on the Shared Loss Pool, expressed as a percentage of a) the total cost of care, or b) the annual provider revenue from the insurer under the contract*

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.

Financial Solvency Filing

We believe that **AEs that have already met the pre-qualification standards should not be required once again to submit a Financial Solvency Filing.**

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.

Impact of Quality Performance on Shared Savings and Losses

Please provide detail on how EOHHS developed the formula described in the fourth bullet of this section.

Pre-Qualification of and TCOC Financial Solvency Filing for Accountable Entities Bearing Financial Risk

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.

Attachment K – Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities

Accountable Entity Incentive Pools

We welcome the new language stating that the MCOs shall "implement and operate the AE incentive pool in coordination with EOHHS." We believe this will lead to smoother and more predictable distribution of incentive funds.

Collaborative Development of HSTP Plans

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.

Attachment M – Accountable Entity – Attribution Guidance (PY4)

Attribution for Total Cost of Care Analysis

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.

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 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.

D. Concluding Comments

We thank EOHHS for the opportunity to provide comments on the proposed PY5 Guidance Documents.

We also want to applaud EOHHS for the stability and continuity that has been achieved and carried forward in the AE program of late. This reduces the administrative burden – and frankly distraction – of managing the AE program, allowing us to devote our attention to implementation and to improving the outcomes for our members. It also allows for a better understanding, over time, of the impact we are making.

EOHHS has also made significant strides streamlining the overall administration of this initiative. We urge EOHHS to continue to build on this progress and to continue to seek additional ways to reduce the time and energy devoted to administrative requirements. Instead, EOHHS, AEs, MCOs, and other stakeholders should be devoting their time and energy to realizing the long-term goals of the AE.

While the AE program is certainly the product of a whole team, we do want to take this opportunity to thank Libby Bünzli for her leadership during the past two, very challenging, years.