Thundermist HEALTH CENTER

DATE: October 28, 2021

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

FROM: Matthew J. Roman, LICSW, MBA
Acting Director
Thundermist Accountable Entity

RE: Response to Comments Request on Proposed ATTACHMENT H - Accountable Entities Certification Standards – Comprehensive AE (Program Year 5)

On behalf of Thundermist Health Center, thank you for the opportunity to comment on the Executive Office of Health and Human Services (EOHHS) Proposed ATTACHMENT H - Accountable Entities Certification Standards – Comprehensive AE (Program Year 5).

We are happy to discuss our comments with EOHHS, answer any questions, and provide further information.

1.3.1.1. Physical Health: service delivery/coordination capacity beyond the scope of PCP medical care, including specialty and inpatient care.

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.

2.4.2. Comport with EOHHS defined delegation rules re: AE/MCO distribution of functions.

Please expand or explain this standard further.

4.1.1. Able to receive, collect, integrate, utilize person specific demographic (race, ethnicity, language, disability (RELD)), clinical, and health status information.

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.

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.

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.

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.

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. Social needs assistance shall include: - Referring to providers, social service agencies, or other community-based organizations that address the Attributed Member's needs - Providing support to maximize successful referrals, which may include: o Actions to maximize the outcome that the Member attends the referred appointment or activity, including activities such as coordinating transportation assistance. Attending appointment with members & following up after missed appointments;

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.

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.

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.

5.3. System Transformation and the Healthcare Workforce

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.

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

Please provide a definition of a 2Gen approach.

6.1.2. AEs must demonstrate capacity to systematically utilize analytics and risk segmentation to identify/target individuals for 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.

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.

6.2 Health Promotion

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.

Thank you for the opportunity to submit comments on the proposed PY5 AE Certification Standards. Please do not hesitate to contact me for further information.

Sincerely,

Matthew J. Roman, LICSW, MBA
Acting Director
Thundermist Accountable Entity
MatthewRo@thundermisthealth.org
401-615-2800 ext. 2102