LTSS APM Program Requirements

Response to Public Comment

Please note that EOHHS has made two changes to the LTSS APM Program Requirements based on recent guidance from CMS, which requires EOHHS to distribute funds based on the volume of services provided by participating home care agencies. The incentive pool calculation method for agencies and managed care organizations has been updated accordingly to be based on units of home care delivered. In addition, the Readiness milestone requiring the submission of an incentive pool membership report has been eliminated from the measure set for agencies and managed care organizations as it will no longer be needed as an input to the incentive pool calculation.

Focus Area	Comment	Response
Background and Goals	UnitedHealthcare supports EOHHS efforts to keep members in the community which improves their quality of life and allows more interactions with friends and family. As addressed in the Program Requirements, Rhode Island will face challenges in the current environment, one of those being long term sustainability. In order to ensure long term success of the program, one of the bigger challenges Rhode Island and all states will face is a rate structure which will be able to attract a well-trained workforce. Without long term sustainable rates, the ability to attract and maintain a skilled workforce, could result in the inability to meet the demand for services	EOHHS is committed to the development and implementation of strategies that enable providers to attract and retain appropriately trained workforce. This program is intended to build on and advance broader state efforts to address HCBS workforce shortages.
Background and Goals	We applaud this proposal to invest additional funds in critical Home and Community Based Services (HCBS). Even before COVID, years of underinvestment were creating substantial workforce challenges that resulted in too many Rhode Islanders in need going without appropriate services, and in too many Rhode Islanders receiving care in institutional settings. Those challenges have become a crisis, and we support any investments that will allow home care agencies to provide the pay, benefits, and training necessary to recruit and retain staff. We especially support this program's flexibility with respect to agencies' use of these	EOHHS intends to work with managed care partners and providers to ensure this program enables providers to make investments in workforce that improve workforce performance and increase member access to HCBS services. EOHHS will continue to work on identifying sustainable pathways to

	funds. As the program is rolled out, it will be important to make these revenue streams as stable and predictable as possible, while still in-keeping with CMS HSTP rules, to allow providers to maximize effective investments in their workforces.	support HCBS workforce and services, within and beyond, this program.
Program Structure and Measures	Neighborhood feels strongly that the responsibility for implementation of the model needs to rest with the managed care organization. While communication and collaboration with EOHHS are essential to provide effective guardrails for the program, entrusting the MCO to administer the program, define metrics, perform readiness assessments and other key functions will make the program efficient and adaptable. Neighborhood suggests maximum flexibility be extended to the plan and our provider partners during the readiness phase to support as much experimentation and adjustment as possible. One of the most crucial areas for experimentation is in the area of metrics due to the readiness of the provider community, the lack of established baselines of LTSS measures and the uncertainty regarding the ability to report certain measures. Flexibility in this area will allow the organizations to define, in consultation with EOHHS measures that are both meaningful and not overly burdensome. A particular concern is the expectation that the provision of non-clinical home health services will have a significant on high-level patient outcomes such as total costs of care and utilization of hospital inpatient and emergency room services.	EOHHS will use the lessons learned from the Comprehensive AE implementation and will aim to strike a balance between standardization and flexibility. EOHHS intends to play a significant role in defining a standard set of program requirements and measures, while allowing managed care partners the flexibility to be fluid and adaptive to provider needs during the pilot phase of the program. EOHHS agrees that time will be needed to develop and implement a quality measure strategy. As such PY 1 (CY 2023) is pay for reporting only. EOHHS anticipates that this one year (at minimum) will be used to test and refine the identified set of metrics for the program.
Program Structure and Measures	We are concerned, however, that some of the performance measures may have negative consequences for populations who are not covered by this program. The Medicare-Medicaid Plan (MMP) only covers about half of Rhode Island's roughly 40,000 duals. Certain types of incentives (especially service hours delivered vs. approved) could encourage providers to prioritize MMP patients over others. Simply shifting resources from one population to another will not solve Rhode Island's HCBS crisis. While we appreciate EOHHS's commitment to measuring similar metrics in the fee-for-service (FFS) population, we fear that simply measuring is not enough.	EOHHS will take the recommendations provided into consideration and continue to work on strategies to align measures across delivery systems. The recommendations around measure definitions will be considered as part of the development of measure specifications to be included in the Program Implementation Manual.

	We strongly recommend that EOHHS adopt one or a combination of the following revisions to the program requirements, listed in rough order of preference from our perspective: 1. When providers are reporting patient service-related measures to the MMP (e.g. consistent staff assignment and service hours delivered vs. approved), require submission of data for a provider’s full patient census (rather than just MMP patients) and connect any incentives to that all-patient definition. While it may seem unusual for the program to provide incentives through the MMP for measures that involve non-MMP patients, it is not unprecedented, and it makes sense in this context. For example, many payers use HCAHPS survey results to administer incentives for contracted hospitals. Our understanding is that the HCAHPS survey is based on the patient experience of all patients discharged from a given hospital, and therefore is not limited to those patients who are members of the health plan using the survey results in its contracts. The approach we propose here would be analogous, though admittedly for somewhat different reasons. 2. Avoid the use of measures that create the create the greatest risk for this negative unintended consequence, especially consistent staff assignment and service hours delivered vs. approved. Instead, focus more on measures that apply to whole provider agency’s operations or workforce, such as retention rates, implementation of training programs, or workforce diversity targets. 3. Provide State Medicaid funding in the FFS system to mirror the incentives being provided within the MMP.	
Program Budget and Funding Allocation Methodology	Neighborhood respectfully requests a realignment of funding distribution as well as increasing the duration of the readiness phase. Implementation of this program will require a substantial up-front investment in foundational infrastructure including staff time and resources. While EOHHS wisely acknowledged the need for a flat amount in the funding allocations, Neighborhood recommends that initial phases be focused on guaranteed funding contingent only on MCO and agency participation. We recommend shifting the trajectory of the funding as well, providing higher early investments of $500,000 and $750,000 to managed care during the readiness period and PY 1 and then reducing resources as the program moves towards PY 5. This change would acknowledge the up-front investment required and the need to transition to sustainable independent financing in the	The by year budget allocation is intended to balance meaningful start-up funding in early program years against the expectation of a growing number of managed care participants and members under the full program, beginning in January 2024. EOHHS is retaining the total managed care funding allocation as originally proposed to ensure that a meaningful level of funding is available to

	long-term. Additionally, Neighborhood recommends the readiness period start as soon as possible and last for at least one full year. Home care providers, in Rhode Island and nationally, are not versed in all of the competencies necessary for success in an alternative payment model and greater time preparing may be necessary.	participating entities as the program transitions to recognizing performance under the full program. EOHHS recognizes that implementation of this program will require up-front investments in infrastructure. Although the Readiness phase is specifically dedicated to recognizing the achievement of program readiness milestones, EOHHS expects that program implementation activities will occur throughout the pilot program period (2022-2023).