EOHHS Response to Public Comments on HSTP PY6 Roadmap and Sustainability Plan

Topic	Focus Area	Comment	Response
Roadmap	Vision/Goals/ Approach	The document centers the AE initiative in the context of the existing managed care model: The Accountable Entity program is being developed in the context of Rhode Island's existing managed care model. The AE program is expected to enhance MCO capacity to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum. [Page 6] This statement should be revised to recognize the role of AEs and systems of care in the AE initiative. This statement should affirmatively reference the fact the program, thanks to state investment, has increased AE "capacity to serve high-risk populations by increasing delivery system integration and improving information exchange/clinical integration across the continuum."	It is important to recognize that the AE program has been developed in the context of managed care, and engagement with managed care is core to CMS's expectations for the program. However, EOHHS agrees that it is important to recognize the centrality of AEs and has made an adjustment to the text accordingly.
Roadmap	Vision/Goals/ Approach	We support the vision of EOHHS to promote patient-centered and value-based care, while testing market-driven reforms to drive quality, reduce costs and improve outcomes for the Medicaid population through the AE program. Continued collaboration between EOHHS, MCOs and AEs is the foundation for collective efforts to transition from volume-driven payments to value-based payments and improve health outcomes.	EOHHS appreciates the support for the state's value-based payment endeavors and the AE program in particular, and agrees that continues collaboration among EOHHS, MCOs, and AEs is vital to success.
Roadmap	LTSS APM	We commend EOHHS for exploring innovative payment models that further EOHHS's goal of encouraging and enabling LTSS-eligible and aging populations to live successfully in their	Detailed program requirements and an implementation manual for the LTSS APM are available on the EOHHS website:

		communities without the need for institutional care. Unfortunately, the current roadmap document does not provide enough information for us to fully understand the mechanics of this program, including how the program intersects with existing AEs and the timeline for implementation. EOHHS should provide additional detail on the following topics. EOHHS should clarify who the eligible beneficiaries are for the LTSS APM program in each phase of implementation. For example, will all dually-eligible beneficiaries be able to participate or is this limited to a subset of the population, such as the Medicare-Medicaid Plan (MMP)? Are there circumstances where MCO beneficiaries who are not dually eligible (e.g., those receiving non-LTSS home care services from an agency contracted with a participating MCO) would be eligible for the LTSS APM? Are there circumstances where services provided under the LTSS APM program would be provided to AE attributed members? If so, what level of coordination is envisioned for AEs and LTSS APM programs to ensure non-duplication of services? The roadmap has inconsistent dates for the expansion of the program. It is not clear if EOHHS will offer the LTSS APM to other managed care participants in January 2024 (as referenced on pages 6 and 7) or July 2024 (as referenced on page 8). We are also concerned that the proposed timeline of the initiative is too aggressive. As described on page 6, the LTSS APM pilot would operate under the MMP only, which is set to end in December of 2023. EOHHS anticipates that the	https://eohhs.ri.gov/initiatives/accountable-entities/ltss-apm. The LTSS APM is implemented through the Medicare-Medicaid Program managed care contract. However, participating home care agencies will include all Medicaid patients in their quality reporting, not only those enrolled in MMP, so EOHHS anticipates some positive effect on FFS beneficiaries as well. It is possible that some AE members also receive FFS LTSS and specifically receive home care services from agencies participating in the LTSS APM. This population would be limited to non-dual (Medicaid-only) LTSS beneficiaries, as dual-eligible individuals are not eligible for attribution to AEs. The focus of the LTSS APM is to improve the quality of home care services, as distinct from the comprehensive AE focus on population health management and care coordination across providers. In addition, the services in question are carved out of the core managed care contracts (and are either provided through FFS or the MMP). For these reasons, EOHHS is not concerned about service duplication. EOHHS appreciates the concern about the timeline and will consider potential

		full LTSS APM program may be extended to other managed care participants in January 2024 based on learnings from the pilot. One month will not be enough time to analyze the results of the pilot and extend the LTSS APM to other managed care participants. We recommend that EOHHS make a decision to offer the LTSS APM program to other managed care participants by July 2024 after analyzing the results of the pilot. We recommend EOHHS delay full implementation of LTSS APM Phase 3 until January 2025.	adjustments depending on progress of the pilot and also on the state's engagement with CMS on further extending the MMP through 2025 pending establishment of alternative dual-eligible managed care programs.
Roadmap	LTSS APM	We continue to support the potential specialized AE program and welcome the opportunity for additional collaboration between AEs and LTSS providers. And, as we have in the past, we support including the dual eligible population in the AE program. This population includes those patients with the greatest need who also have the opportunity to benefit the most with improved care, improved health, and smarter spending through comprehensive accountable care. Additionally, managing these population is what high-risk care management does; what our programs do. This is our focus and expertise.	EOHHS appreciates the support for the LTSS APM program. As the state works with CMS to determine next steps for the dual-eligible managed care programs, EOHHS does generally intend to create new managed LTSS options, and will take into consideration the potential for AEs to work with dual-eligible members.
Roadmap	TCOC	TCOC funds and maintaining the status quo will not be sufficient to compensate for the elimination of Infrastructure Incentive Payments. Significantly, AE funding needs will vary based on the roles and responsibilities taken on by the AE. Funding must follow function. For example, funding that is currently provided to MCOs should flow to AEs that take on delegated Utilization Management and Care Management.	EOHHS agrees that TCOC shared savings payments will not be sufficient to sustain AE activities. For this reason, a range of strategies are described in the sustainability plan, including delegation of care management with funding associated with that delegation.
Roadmap	MCO Oversight Meetings	We encourage EOHHS to share pertinent and relevant information from the MCO oversight meetings. This will advance transparency and further encourage the development of the multi-party partnership which is an essential part of the AE initiative.	EOHHS appreciates this feedback and will work to ensure that relevant information is shared with all appropriate parties.

Sustainability Plan	Vision/Goals/ Approach	The most critical consideration for PY6 is the financial sustainability of the program for AEs. In order for the AE program to succeed in the long term, the state must implement policies that allow AEs to continue to control cost, improve quality, and improve outcomes for members in years when HSTP incentive funding is no longer available. We have invested significant effort into the AE program with the goal of improving care and outcomes for our Medicaid populations at a lower cost. We are committed to continuing to further that work; however, we need to have confidence that we will continue to have access to sufficient funding to support these successful programs. We do not believe that EOHHS has articulated a strategy that will ensure that AEs have access to sufficient revenue to be sustainable without HSTP funding. We urge EOHHS to provide additional quantitative and qualitative detail within the sustainability strategies to ensure that strategies are realistic and achievable.	EOHHS appreciates the investments by AEs and MCOs in the effort to improve efficiency and quality in healthcare delivery. EOHHS intends to develop and share more detail regarding certain aspects of the sustainability plan in the months to come. Some information will become available over time and other information will not be predictable. For example, as discussed elsewhere, the precise amounts of funding that will be associated with care management delegation have yet to be determined, but ultimately will be available. By contrast, the details of future shared savings are not possible to predict in advance, and so some uncertainty is unavoidable.
Sustainability Plan	Vision/Goals/ Approach	We value the importance of a sustainable Accountable Entity Program as the AE program moves toward year six. We recognize AEs have gained experience related to risk-based concepts such as data analytics to improve performance. We also point out that we have invested heavily in resources and tools to support the AEs need for program guidance and support including quality, clinical, behavioral health and financial expertise with accompanying data. P.22 EOHHS states that “The purpose of this document is to describe EOHHS’ strategies to ensure that the AEs are sustained without DSHP funds.” We suggest that EOHHS does not adequately recognize that MCO sustainability is also important to the long-term success of the program.	EOHHS appreciates the contributions of MCOs as well as AEs to the Accountable Entity program. While the Sustainability Plan focuses on the need to sustain AE activities - as these most directly impact patients and are the primary area of HSTP spending - EOHHS agrees that it is important that the model work for MCOs going forward as well. EOHHS is considering the options for how best to ensure both stability/predictability and flexibility going forward.

		EOHHS needs to describe their vision beyond PY6 inclusive of MCO and AE expectations and requirements. As mentioned above, we encourage go-forward flexibility for MCOs and AEs to build customized payment and quality models to enhance the likelihood of ongoing sustainability. P.24 EOHHS points out that the impact of the COVID Public Health Emergency is an added complexity. We request that EOHHS provide more detail regarding the COVID impacts to the AE Program. Additional COVID impacts can be applied to an examination and correction of the Total Cost of Care Model which currently does not adequately account for COVID impacts on utilization. The NORC performance review should calculate and consider the specific impacts of the pandemic that can be used to make informed assessments and adjustments to AE Program Total Cost of Care modeling and requirements. P.25-29 - EOHHS appropriately identifies many investments/costs that are tied to care system improvements. It would be valuable to also identify the resulting impacts to the quality of care or the health of patients. This would help to validate the value of the investments made.	EOHHS does not have detailed analysis regarding the impact of COVID, but anticipates exploring whether such analysis may be available in the final evaluation waiver report. EOHHS agrees that it would be valuable to identify impacts of the system investments made through the AE program. Unfortunately, it may not be feasible to analyze these specifically due to data constraints; however, EOHHS will explore the options for the final waiver evaluation.
Sustainability Plan	Vision/Goals/ Approach	AEs should be at the center of policy and program decisions. The success of the AE program rests upon the ability of AEs to deliver the goals of the program. Given this, all policy and program decisions should be based on supporting the work of the AEs, the strategies of the AEs, and advancing the performance of the AEs.	EOHHS agrees that AEs are central to the AE program, which is why AEs are at the center of the sustainability plan. It is also necessary that EOHHS ensure that participation in the TCOC financial model is sustainable for managed care organizations.

		Adoption of an accountable, population-based payment system is essential. Fundamental delivery and payment reform is the key to achieving the ambitious goals of the AE program and for achieving sustainability of the AE program. Reforming healthcare delivery, and achieving long-term sustainability, requires an accountable, population-based payment system (capitation) at the AE/system of care level, with a robust risk-adjustment model to account for population differences between AEs. This is the only way to achieve the significant reallocation of resources from medical services – too often high-cost, unnecessary and inefficient services – to interventions that will fundamentally improve population health—clinical, behavioral and socially determined – in an accountable way. Provider accountability and payment system reform must be at top priority of the Medicaid transformation agenda. PCP capitation is inadequate and will not have the impact on TCOC for which EOHHS is looking. Fundamental reform, with population-based capitation and CM and UM delegation is the only way to achieve EOHHS's goals.	EOHHS agrees that prospective, global payment methodologies have potential to dramatically improve incentives and efficiency in healthcare. EOHHS also understands that for some providers, prospective global capitation is a feasible option, while for others it is not yet feasible. EOHHS looks forward to working with MCOs, AEs, and other market participants to move towards advanced value-based payment. EOHHS agrees that primary care capitation is only part of the payment reform picture and that including hospital and specialist spending will be important. EOHHS intends to pursue care management delegation as part of the next managed care procurement, and is open to utilization management delegation in the longer term.
Sustainability Plan	Vision/Goals/ Approach	We recommend that EOHHS continue to explore options for sustaining the AE program ahead of the Healthcare System Transformation Project (HSTP) funds ending. As intended, the AEs and MCOs should be self-sustaining through captured shared savings once HSTP funds are no longer available. With the changes in the quality gate methodology year over year, it will become more difficult to achieve shared savings and, therefore, more difficult to sustain the program.	EOHHS appreciates the support for the vision of the AE program and agrees that continued collaboration is vital. EOHHS believes that the quality measure targets should be set at a level that strongly encourages improvement while remaining achievable for AEs, so that sustainability comes in a context of improved patient care.

Sustainability Plan	AE Activities and Costs	In addition to the CHADIS system, we also implemented an abbreviated SDOH screening, performed during transition of care appointments in PY4, when patients are the most vulnerable We enrolled approximately 60 staff members from practices and clinical programs in the Mental Health First Aid training to better support our patients in crisis during PY4. During PY4 we initiated monthly care conferences with members of the MCO care management team to coordinate efforts for hard to reach or rising risk patients.	EOHHS appreciates the updated information regarding AE activities and will update the Sustainability Plan description accordingly.
Sustainability Plan	AE Activities and Costs	Based on EOHHS's findings on shared savings and expenses, and that total shared savings pools exceeded expenses, there is a very real incentive to find a way to sustain the AE program, but it must be done in a way that works for AEs on a case-by-case basis, not just in an abstract, aggregated way. EOHHS describes some shared savings success. This is encouraging, but one year is not a trend. And while we admire the optimism of EOHHS in the section below, we urge caution when predicting future success. EOHHS's confidence about increasing "AE capacity to generate savings" needs to be tempered with some other realities, namely: 1. Steadily rising quality expectations increase the demands on, and expenses of, AEs while potentially shrinking the savings AEs can earn. 2. Increased efficiency and overall return will be harder and harder to achieve over time. We are not suggesting the early	EOHHS agrees that shared savings payments are not guaranteed, and while the state is optimistic that AEs will continue to earn shared savings, this is only one part of the sustainability plan. Specifically, EOHHS agrees that rising quality requirements may cut into shared savings payments; however, EOHHS believes it is important to ensure that shared savings are earned together with quality improvement and in particular not at the expense of quality improvement. To the extent that quality is not achieved, EOHHS believes it is appropriate to reduce shared savings payments. Also, EOHHS agrees that over time, increased efficiency will likely reduce shared savings payments - as described in the sustainability plan, the long-term vision is of an efficient system where much unnecessary spending is removed and TCOC targets account for the

		gains have been “easy,” but subsequent gains will be more difficult. 3. Lack of sustained dialogue on Global Capitation, a proven model to lower per capita cost and increase quality. The cost/savings analyses conducted by EOHHS to date have been incomplete. They have only compared shared savings to AE operational expenses. They have not included any surplus share distributions to the AE’s network of primary care providers, which is essential to the success of the program. Shared savings distributions to primary care providers are central to alternative payment models. The AE program sets high expectations for, and imposes additional burdens on, primary care providers. The incentive for PCPs to commit to these standards and expectations include improved care, better outcomes for patients, and compensation separate from and in addition to traditional fee-for-service payment. For these reasons, EOHHS should include shared savings distributions to primary care providers (distribution approaches will likely vary by AE) in future analyses.	inputs required to achieve that efficiency. As stated elsewhere, EOHHS agrees that global capitation may be a powerful tool, and looks forward to moving more Medicaid spending in that direction over time. EOHHS is open to requesting data on shared savings distributions in the future, to further account for "AE expenses." However, it will be important not to double count these payments, which in some cases may also be counted towards operational expenses. AEs may also differ in their willingness to share this information, which is potentially related to provider compensation and may be considered sensitive. It is also worth discussing among stakeholders whether for sustainability purposes it makes sense to consider payments to participating providers an AE expense in the same manner as operational expenses.
Sustainability Plan	AE-MCO Relationship	EOHHS operates its AE program through its MCO partners, but MCOs may be limited in their ability to provide AEs the full support they need for the program to be successful and sustainable. EOHHS should consider supplemental means of support for AEs outside of MCO contracts or add specific protections for AEs into EOHHS’s contracts with MCOs. As we have noted in the past, we recommend that EOHHS explore new ways to ensure AE sustainability via the MCO relationship. As a part of Strategy D (page 41), we ask that EOHHS:	As described in the Sustainability Plan, EOHHS has identified several strategies to support AEs after the conclusion of incentive funding. Of these, care management delegation and the associated funding from MCOs to AEs to support that work is one essential element. EOHHS appreciates the interest in receiving more detailed information on future resources. At this time, there is not an

		• Outline specific ways to ensure AE sustainability via the MCO relationship. We recommend a framework through which MCOs commit to pay an administrative fee to AEs to fund AE operations on a prospective basis. • Require MCOs to outline how they will support AEs financially as part of the PY6 planning process.	intent for MCOs to provide a general "administrative fee," but as described in the sustainability plan, there is an intent for MCOs to provide payment to AEs to cover delegated care management activities. EOHHS will be providing more information on the implementation of care management delegation when the state is closer to implementing the managed care re-procurement. The final requirements will be outlined in MCO contracts with EOHHS and EOHHS will also work with MCOs and AEs to properly document the requirements of both MCOs and AEs in the MCO-AE contracts.
Sustainability Plan	AE-MCO Relationship	We recommend that after Program Year 6, EOHHS provide greater flexibility for MCOs and AEs to establish independent and customized value-based agreements. These arrangements will be built on the knowledge and experience gained through the AE program but will be negotiated between the MCO and AE. In a post-HSTP environment, EOHHS will continue to play an important role in setting program goals and outcome targets. EOHHS has successfully used the HSTP funding to create a diverse and meaningful AE infrastructure and the next step is for the MCOs and AEs to further develop and innovate through customized quality and financial models which will also strengthen sustainability for all stakeholders. P.40 - For Care Management, we recommend a shared accountability approach using established criteria that would be implemented in phases. Shared accountability is based on the AE and MCO's capabilities and strengths, and ensures a	EOHHS will consider opportunities to provide greater flexibility in AE-MCO contracting, while maintaining stability and predictability, and avoiding excessive administrative burdens on AEs in managing to different contracts. EOHHS agrees that it is important to ensure clear roles and responsibility for care coordination. EOHHS expects that future managed care contracts (post-re-procurement) will be supportive, and also expects to engage with MCOs and AEs to ensure that the MCO-AE contracts are very clear on these points.

		clear delineation of where an MCO, AE, other provider or program is taking the lead in coordinating a member's care. Shared accountability reduces duplication of effort, inefficiency, and incentive misalignment.	
Sustainability Plan	AE-MCO Relationship	Funding needs to follow function when AEs take on duties currently carried out by the MCOs. The PHSRI-AE has long argued for delegating Utilization Management and Care Management. Both are essential under a population-based payment model. If a system of care is going to take downside risk, the SOC should have all the tools available to manage that risk and to positively impact utilization, costs, and outcomes.	EOHHS intends to pursue care management delegation - with funding following function - in the next managed care procurement. Delegation of utilization management is an item for discussion.
Sustainability Plan	AE-MCO Relationship	We recommend that EOHHS support opportunities for greater AE sustainability, such as delegating to AEs that are Patient-Centered Medical Home (PCMH) certified by the National Committee for Quality Assurance (NCQA). This certification is key to making sure high-quality, accessible programs continue after the end of HSTP funding. This strategy will also help maintain the highest quality standards in the Medicaid program broadly. We appreciate EOHHS' continued flexibility with MCO and AE collaboration, and we encourage continued innovation through customized VBP models. Focusing on outcomes-based models will ensure members' needs are addressed and providers are appropriately supported and incentivized. We recommend that EOHHS continue to review the Total Cost of Care (TCOC) model at least annually to make any necessary adjustments based on new learnings and financial changes. To continually assess progress and foster innovation, we recommend that EOHHS consider TCOC improvements, outcomes and uptake from MCOs and AEs as part of this annual review.	EOHHS appreciates this feedback regarding delegation and anticipates working closely with MCOs and AEs to ensure that delegation is implemented so as to ensure the highest quality standards. Delegation requirements such as PCMH certification may play an important role. EOHHS will consider opportunities to provide greater flexibility in AE-MCO contracting, while maintaining stability and predictability, and avoiding excessive administrative burdens on AEs in managing to different contracts. EOHHS will continue to consider improvements to the TCOC methodology and welcomes feedback from MCOs and AEs on this methodology.

Sustainability Plan	Multi-payer Approach	Medicaid AE covered lives represent approximately 1/3 of our overall covered lives. Therefore, we agree that cross-payer value-based approaches have the potential to align goals and achieve greater success than payer-specific programs. To strengthen strategy E (page 42), we would recommend that EOHHS, in partnership with key stakeholders, develop a tactical menu of multi-payer approaches that allow AEs to participate in the programs that work best for them.	EOHHS appreciates the support for cross-payer value-based payment and the recommendation to develop a menu of such approaches. EOHHS anticipates that following the managed care re-procurement, there will be more opportunity to engage in prospective payment methodologies consistent with those supported by OHIC.
Sustainability Plan	Multi-payer Approach	This is a valuable path for EOHHS to pursue given the fact that much of what has been pioneered within the AE model will benefit patients across the spectrum in Rhode Island.	EOHHS appreciates the support for a multi-payer approach to APMs.
Sustainability Plan	Reimbursable Services	Reimbursement of CHW services is an essential element to sustaining the CHW workforce, but it is insufficient in itself to support the other aspects of our programming. We believe that there are other high-value services that warrant reimbursement under strategy C (page 40) in a value-based payment model. For example, we recommend that EOHHS explore reimbursement opportunities for certain care management encounters, e-consults, innovative behavioral health models, and social services.	EOHHS is grateful for the information regarding other high-value services that should be prioritized for reimbursement. It will be helpful to consult with AEs and other providers to gather more detailed information on these services in order to identify the best path to add them as Medicaid benefits, and EOHHS looks forward to conversations on these topics.
Sustainability Plan	Reimbursable Services	We are pleased at the progress that has been made in the past year regarding billing for CHW services. We are in the process of developing the processes and systems required to bill for CHW services. We concur that the “value-add” and “in-lieu of” MCO contract options are under-utilized in Rhode Island.	EOHHS appreciates the support for CHW billing and is grateful for the effort put in across the system to implement it. EOHHS looks forward to ongoing engagement around opportunities for value-add and in-lieu of services.
Sustainability Plan	Community Resource Platform	We are firmly committed to partnering with the community to address the social needs of our members, as demonstrated by our robust Community Health Worker team and our contracts with community-based organizations. We remain skeptical, however, of the community resource platform’s (CRP’s) role in	EOHHS understands that the statewide CRP may not be the optimal choice for all AEs and encourages AEs to make the choices that best meet their needs.

		the sustainability strategy (page 34). As previously noted, while switching to the CRP from our own contracted platform would reduce budgeted costs, the reduction would be time-limited and not significant enough to have a material impact on our sustainability strategy. In fact, switching to Unite Us now would likely entail more implementation costs (technical updates to EMR systems, retraining staff, etc.) at a time when there is less HSTP funding available for this kind of investment. We believe that one of the more effective paths to sustainability is more concrete exploration of MCO reimbursement for CBO services in Strategy D (page 41).	
Sustainability Plan	Community Resource Platform	As the first AE to adopt Unite Us, we strongly support the steps EOHHS has taken to expand and strengthen this invaluable resource. In partnership with Unite Us, EOHHS has done an excellent job increasing the number of community-based organizations using the platform, expanding adoption of the platform across state agencies and departments, and supporting AEs who have adopted the platform. We encourage EOHHS to find additional ways to promote the use of the platform. For example, the data and analytics functions of Unite Us align with monitoring and reporting needs across state government contracting and grant-making. Embedding Unite Us into state grants and contracts as the means by which recipients can track and report activity and outcomes would help make the CRP a central part of the state's greater social services landscape. But this is just the beginning of what Unite Us makes possible. Unite Us can provide a means for the healthcare system, on the macro level, to strategically invest in the very social services and organizations whose activity is improving health outcomes. For this reason, we encourage EOHHS to pilot an ambitious Unite Us Payment initiative. A	EOHHS appreciates the support for the effort to implement the Unite Us platform. EOHHS welcomes the opportunity to discuss future opportunities with stakeholders.

		Unite Us Payment pilot would require scale, and sufficient scale will only be realized with leadership from EOHHS	
Sustainability Plan	Community Resource Platform	We recommend that EOHHS consider incentives for MCOs to use profits toward community investments and look for other innovations that result in more AEs using SDOH screenings and use of the community resource platform (CRP). Incentives for MCOs could include preferential enrollment based on plan community investments or positive incentive payments to plans based on SDOH screening completion. Other AE-focused incentives could include reimbursing for screenings conducted or reimbursing for SDOH support services provided by community-based organizations (CBOs). The EOHHS should also verify plans are not required to oversee the technical, administrative and operational capabilities of the CRP and linked CBOs but rather set clear metrics and incentives. The EOHHS could leverage existing health information exchanges and incentivize providers to include SDOH in reported data to make a more comprehensive data set. Beyond just tracking referrals and wraparound service delivery, moving forward Rhode Island should leverage the CRP to assist with ongoing program integrity initiatives and potentially even as a reimbursement platform for service delivery.	EOHHS appreciates the support for MCOs to use profits for community investment and recognizes the potential role for incentives to encourage this. It is helpful to receive input on possible AE-focused incentives as well. EOHHS generally finds that AEs are currently seeking to conduct SDOH screenings, motivated in part by the current quality measure on these screenings. However, EOHHS agrees that it is important to also focus on ensuring support for the underlying services provided by CBOs. EOHHS does not currently intend for MCOs to oversee the CRP. EOHHS is exploring opportunities to leverage the CRP as a source of SDOH information. At this time there is not an intention to use it as a reimbursement platform, but EOHHS appreciates the idea for future consideration.
Sustainability Plan	Quality Reporting System	It is in the interest of EOHHS for more practices adopt the QRS. This will not happen without administrative, project management, and financial support. Onboarding practices was more complicated, time consuming, and expensive than originally anticipated. Adding new practices to the QRS, and	EOHHS understands that QRS onboarding was a major effort, and it is important to recognize the costs imposed by the EHR vendors themselves. EOHHS hopes that there will not be "constant" changes in

		maintaining the involvement of those already enrolled, will require funding. Some EHRs are charging exorbitant annual fees, an expense practices are not prepared to bear. Additionally, the long-term success of the QRS will require constantly adding practices, EHRs, and adjusting for EHR upgrades.	EHRs, though we understand it will continue to be an issue. EOHHS will consider and explore any new resources that can be brought to bear, however the limitation of finite HSTP funds is a real constraint and this funding may not be able to come from the state.
Sustainability Plan	Global Savings Cap	While not included in this roadmap document, we strongly recommend the withdrawal of the proposed "global shared savings cap" presented by EOHHS on September 22, 2022. An unpredictable, retrospective claw-back of AE shared savings based on TCOC performance outside of the AE's control runs counter to all of the sustainability efforts outlined in the roadmap. In the context of a conversation about the long-term financial sustainability of the AE program, it is deeply distressing that EOHHS would propose to shift resources from AEs to MCOs. We will be submitting additional feedback on the shared savings cap, which we believe cannot be part of the PY6 program.	EOHHS will address this concern in more detail in the response to comments on PY6 Program Requirements. In general, EOHHS notes here that it is necessary for the program to ensure sustainability for both AEs and MCOs.
Sustainability Plan	Global Savings Cap	While the Global Cap on Shared Savings proposed for PY6 is not part of the sustainability plan, it is significant enough that any discussion about the future viability of the AE program needs to address it. It is impossible to analyze this sustainability plan in a vacuum. We recommend an impact analysis be completed and shared with key stakeholders. Shared savings do not reliably and predictably cover AE operational expenses currently. The proposed global cap on shared savings jeopardizes the financial viability of the AEs and the overall AE program, the extent of which should be reviewed in an impacted analysis. We will comment on this during the upcoming PY6 comment period, but we urge EOHHS to seriously reconsider this proposal.	EOHHS understands that there are concerns about the impact of the global savings cap, which will be addressed more fully in responses to comments on the PY6 Program Requirements. Note that if the cap applied, it would be because the shared savings pool actually exceeds the benefit expense "savings" of the MCO. If MCOs pay out in shared savings more than they themselves saved, the overall viability of the program will be directly threatened - and then there would be no future shared savings programs.

Sustainability Plan	Behavioral Health	We are encouraged by BH Investments made by EOHHS including onboarding BH facilities to the Quality Reporting System and furthering investments in discharge coordination between inpatient BH facilities and AEs and CMHCs and AEs. We request the opportunity to participate with EOHHS in the development of the remainder of the BH Investment Plan. We also encourage EOHHS to focus on a plan to accelerate the integration between Primary Care and Behavioral Health that is capable of prevention and early intervention and can provide a full continuum of mental health and substance services and recognizes that recovery is not linear and should be flexible enough to meet an individual's needs regardless the severity or stability of their illness. We continue to be concerned that the AE and CCBHC initiatives are promoting a model with 2 very separate systems that is not addressing the core issue which is a lack of openness and collaboration between BH and Primary Care. We request that EOHHS convene CBHCs, AEs and MCOs to address integration. We further encourage EOHHS to consider using HSTP incentive funds to support new clinical models for taking care of adults. In light of the adult BH crisis, we would like to promote new models of integrated BH care using a psychiatrist, multiple APRN, and social workers to provide a more available and flexible model. AEs may have experience with a similar model for pediatrics but without appropriate funding structures or new payment models, we are hampered from advancing this to adults.	EOHHS appreciates the support for the state's efforts to onboard BH facilities to the QRS and for the other BH initiatives. EOHHS welcomes feedback on the remainder of the BH Investment Plan. As EOHHS agrees that collaboration between primary care/AEs and behavioral health providers/CCBHCs is very important, the investment plan as drafted and shared with stakeholders does include a learning collaborative intended to support integration of primary care and behavioral health, specifically including CCBHCs. EOHHS is open to receiving information about new clinical models and considering opportunities to support them in the context of limited remaining HSTP dollars.
Sustainability Plan	Behavioral Health	As we have stated in other submissions, we strongly support the steps the state has taken to support the work of AEs to address the BH and SUD needs our members.	EOHHS appreciates the support for the state's efforts to address behavioral health needs.

Sustainability Plan	Behavioral Health	Based on our experience in Rhode Island, we believe there are opportunities to improve the integration of behavioral health care providers in the AE program. The program is currently structured around primary care providers (PCPs) who receive direct funding; however, this same direct funding does not exist for behavioral health providers. To truly improve integration of behavioral health within the AE, we recommend that EOHHS explore ways to align incentives to create bidirectional collaboration across PCPs and behavioral health providers. Historically, AEs report that the biggest clinical problem resulting in inpatient and emergency department use is "Restricted Diagnoses," and the vast majority of that use is due to alcohol use disorders (AUDs). Recognizing federal law requires providers to receive consent to share information on treatment or referrals for alcohol and substance use disorders, we recommend that EOHHS explore opportunities to support whole person care and meaningful coordination, including creating a standard, statewide patient consent form for the sharing of health information specific to behavioral health and substance use treatment. We also encourage EOHHS to work with the MCOs to pursue opportunities to develop and implement innovative models of care for AUD that emphasize access to coordinated care across physical, pharmaceutical and behavioral health domains and connect members to care before their disorder has increased in severity.	EOHHS agrees that it is important to support bidirectional collaboration across PCPs and behavioral health providers. The behavioral health investment plan, shared recently with stakeholders, includes a learning collaborative for this purpose. EOHHS also remains open to feedback on other opportunities to support this work. Also as described in the behavioral health investment plan, EOHHS anticipates working with behavioral health facilities and inpatient facilities to support each in development appropriate patient consent forms to facilitate information-sharing with primary care/AEs. Based on past experience, EOHHS anticipates that it will be more efficient to take this approach rather than creating a statewide form that everyone agrees to use. EOHHS welcomes the opportunity to engage with MCOs on innovative models of care for AUD. While HSTP funds are limited, there may be a number of options to pursue such models.
Sustainability Plan	SDOH Strategy	We encourage EOHHS to include initiatives like Rhode to Equity and to identify ways to finance projects like this in the years ahead.	EOHHS appreciates the support for the Rhode to Equity project. While there are not currently plans for HSTP to finance this

		EOHHS has expanded the scope of AE investments to include social drivers of health (SDOH). This is an excellent addition and an important statement by EOHHS about the value and importance of SDOH investments. The return on investment in SDOH – in terms of health outcomes, utilization, efficiency, and quality of life – is often greater for health-related social needs than it is for traditional clinical activities and interventions. The roadmap also describes EOHHS's goal to increase MCO investment in addressing health-related social needs. We support this goal, but EOHHS should not stop here. EOHHS needs to proactively convene the diverse stakeholders required to develop and implement transformational initiatives such as developing long-term affordable, supportive housing. Projects like this require significant investment and collaboration. Making them happen will take leadership. They will not occur naturally, but if EOHHS takes the lead and brings together other parts of state and local government, community-based organizations, systems of care, higher education, social impact investors, and philanthropy, significant projects could be advanced. One option, discussed above, is a Unite Us Payments project. It is imperative for the social service providers in Rhode Island to see tangible benefits to participating in the Community Referral Platform. CBOs must begin to realize benefits, sustainable benefits, for engaging with the healthcare system, for addressing health-related social needs in a systemic way. The information that will be collected as part of the Social and Human Service Program Review recently begun by OHIC could	project after June 2023, EOHHS will work with RIDOH to consider all opportunities to support this work. EOHHS appreciates the support for the HSTP focus on SDOH and agrees that the return on investment can be significant. EOHHS is open to discussion about ways to leverage the Unite Us platform to further support social service providers and will confer with OHIC. EOHHS appreciates the information about the Medicaid Innovation Collaborative.

		help inform a Unite Us Payment initiative and the overall goal of building a dynamic system uniting healthcare and community service providers in a sustainable and strategic way. We urge EOHHS to be actively engaged in the SHSRC. The PHSRI-AE Director serves on the SHSPRC Advisory Committee because of our recognition of the intersection of this review with the long-range goals for collaboration between systems of care and community-based service providers. We encourage EOHHS to consider applying to participate in the 2023 Medicaid Innovation Collaborative Cohort which will be devoted to Social Determinants of Health. We would be happy to support the state's application and to participate in the MIC activities should the state be selected. To learn more: https://www.medicaidcollaborative.org/	
Sustainability Plan	SDOH Strategy	We support EOHHS' recognition that social determinants of health (SDOH) are primary drivers for health outcomes, health care costs and quality as indicated in the PY6 proposed Roadmap and the requirement of AEs to screen for SDOH needs. Strategically investing in communities allows MCOs to target social needs to improve health outcomes, reduce costs and improve quality. We agree with EOHHS on their proposal to include community investments in the numerator of the MLR calculation and further recommend that EOHHS allow MCOs maximum flexibility in determining community investments, including investments that influence socioeconomic factors that affect populations and communities and are intended to impact quality and access. To establish a sustainable, scalable funding stream for SDOH initiatives, we recommend that EOHHS consider maximizing their use of federal waiver authority. Leveraging 1115 research and demonstration waivers — as North Carolina has done and	EOHHS appreciates the support for the state's intent to work with MCOs to strategically invest in communities, and the support for some of the mechanisms available for this purpose such as including community investments in the MLR numerator. EOHHS looks forward to reviewing comments on the 1115 waiver extension request, including as related to SDOH. EOHHS appreciates the support for the Rhode to Equity project. EOHHS agrees that accurate and well-populated data on race, ethnicity, language, sex, sexual orientation, gender identify,

		New York has proposed — could facilitate ongoing funding to support the CRP and the CBOs who serve as the foundation for SDOH efforts. Populations covered by Medicaid are often among the most economically and socially marginalized. UnitedHealthcare is committed to addressing our members' health disparities, and we applaud EOHHS for its continued focus on equity and for its ongoing alignment with the Rhode to Equity as part of PY6. Integration of health equity into the AE strategy will focus specific attention on reducing health disparities and addressing conditions that create health inequities. UnitedHealthcare currently collects race, ethnicity and language data for many members, but the completeness and accuracy of that information varies as there is no standardized set of data that AEs are required to collect. As a result, this data collection varies across AEs. We recommend that EOHHS strive to collect a standardized set of data to include race, ethnicity, language, sex, sexual orientation, gender identity, income, employment status and enrollment in other programs. Reliable data allows EOHHS and AEs to better understand the unique needs of the population served and target strategies to address disparities. In addition, MCOs need the ability to reliably disaggregate and monitor social risk factor metrics to identify trends in care quality and support AE progress toward reducing disparities. By understanding where specific disparities exist, MCOs can work with AEs and communities to develop targeted interventions that are locally relevant and responsive to the needs of members and communities. These efforts can result in	income, employment status, and enrollment in other programs would be helpful for many goals. In particular, collecting data on race, ethnicity, and language is challenging. EOHHS is actively examining options to improve this effort.

		improved member health outcomes and improved partnerships between MCOs, AEs, other health care providers and CBOs.	