EOHHS Response to Public Comments on HSTP PY6 Requirement Documents

Focus Area	Comment	Response
TCOC	This AE commends EOHHS for the steps taken in PY5 to address year-end disparities among maternity events when calculating total cost of care. However, the recent decision to increase facility delivery fees to the hospitals may represent a direct transfer of dollars from AE shared savings pools to the hospitals due to the inclusion of including hospital delivery fees in AEs' TCOC. This enhanced payment will not be shared with the maternity providers, who haven't seen a rate increase for maternity care in many years. These higher fees certainly are not contained in the benchmark years and should be adjusted accordingly such that the AEs are not adversely impacted.	Changes to facility delivery fees are accounted for in both MCO capitation and TCOC targets; while they are not part of the benchmark year spending, they are accounted for in trend adjustments. The methodology to avoid disparities in the number of maternity events accounted for in capitation and TCOC targets does not affect this.
TCOC	P.8 - Calculate Shared Savings/(Loss) Pool - We would like to use actual member months (rather than an average multiplied by 12) the final calculation of savings. Actual member months data is available and should be used to produce a more accurate calculation.	The values for "average members" used in the TCOC calculations are equal to member months divided by 12, rather than a unique count of members. Therefore, we believe our calculations are already consistent with this suggestion.
TCOC	P.9 - Impact of Quality and Outcomes – The quality multiplier should be applied to the calculation of Shared Savings Payments and not narrowed to an application to the 10% of TCOC in the final calculation of shared savings. The quality multiplier should apply broadly and not after passing through a gate that serves to restrict the impact of quality.	The current methodology applies the quality score before the 1% TCOC savings cap.

TCOC	P.9 and P.29 - The definition of Provider Revenue does not address revenue from AE shared savings. We recommend the inclusion of shared savings reimbursement in the definition.	The definition of provider revenue does not include shared savings because in the context where a risk exposure cap is being used (that is, in a shared loss scenario) there would not be shared savings for the year in question. While MCOs and AEs use revenue from a previous year to estimate future provider revenue in order to estimate the risk exposure cap and complete the RBPO process, the final risk exposure cap will be based on the revenue from the year in which the shared loss occurred, at which time there would not be any shared savings.
TCOC	As we have in the past, we recommend EOHHS remove the minimum shared savings provision and allow AEs to share in first dollar savings.	EOHHS appreciates the feedback regarding the minimum savings rate. EOHHS believes that this provision is appropriate to ensure that savings are not due to random chance but rather due to AE performance. Please note that an AE that exceeds the minimum shared savings rate does share in the full shared savings pool; it is not the case that the minimum savings rate is exempt from shared savings for the AE. In downside risk contracts, where the AE takes on the risk of random chance leading to a shared loss, the minimum savings rate is not applied, and the AE would share in any amount saved.

TCOC	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.	In the case of a contract with a relatively low risk exposure cap, it is straightforward to identify the maximum financial exposure the AE could have and relatively easy for the AE to prove that they have that amount of money available to pay the loss without risking financial stability. In the case of a much higher risk exposure cap, it would likely not be reasonable for an AE to demonstrate that they have the "worst-case scenario" funds on hand or, if there were no exposure cap at all, it would not be possible to even identify the worst-case scenario in a straightforward way. That is the reason for an actuarial analysis in that situation; it allows the AE and EOHHS to obtain a reasonable estimate of the maximum financial exposure the AE could have so that the AE can demonstrate its ability to withstand such a loss. The independence of the actuary ensures that there is not a conflict of interest.
TCOC	**TCOC METHODOLOGY**. This AE recommends EOHHS strike the reference to "For PY6" in the introduction to Section D (page 3).	This reference was included to clarify that there have been adjustments made to the TCOC methodology for PY6. However, EOHHS has removed the reference in response to this request.

TCOC Technical Guidance	**AE SHARE OF SAVINGS/(LOSS) POOL.** We are pleased to see no change to the PY6 Savings/(Loss) Pool for AEs that participated in downside risk agreements in PY5 Section D.4. (page 5). We believe this will add some fiscal stability to the model.	EOHHS appreciates the support for the decisions on the PY6 shared savings/loss pool.
TCOC Technical Guidance	**MITIGATION OF IMPACT OF OUTLIERS: CLAIMS THRESHOLD FOR HIGH-COST CLAIMS.** This AE reiterates our recommendation that EOHHS calculate the claims threshold at the member level, not on the rate cell level outlined in Section 1.c. (page 4). An AE should be held accountable to a single claims threshold for high-cost attributed members, regardless of the member rate cell changes.	EOHHS appreciates the recommendation regarding the high-cost claims threshold. The impact of applying the threshold at the rate cell level is expected to be minimal and to be similar in baseline and performance years. The reason for the rate cell approach is that it reduces implementation difficulty and therefore reduces the likelihood of errors.
TCOC Technical Guidance	**DIVISION OF RESPONSIBILITIES BETWEEN MCOS AND EOHHS**. This AE recommends EOHHS establish a different timeline for the contract execution dates (page 14). MCOs should be required to simply point to the state guidance for TCOC/HSTP for the AE contact requirements, or as we have recommended, EOHHS should develop a contract boilerplate for the MCO/AE base contract. The long period of negotiation between MCOs and AEs can be dramatically shortened through more direct state participation. The MCO/AE base contracts should be due to EOHHS by January and should be executed by May.	EOHHS will identify areas where greater state specificity might be useful in the AE/MCO contracting process. At the same time, EOHHS understands that some stakeholders seek greater flexibility, and our goal is to allow for such flexibility where appropriate.
TCOC Technical Guidance	EOHHS should provide additional clarity on the specific dates that will be used for baseline years. We appreciate the variability needed, particularly with COVID dates of service, however it would be most useful for program participants to know specifically what dates will be used for baseline years. Moving forward, this additional clarity would be helpful for planning and program development purposes. As the dates would be the same for every participating MCO, this information should be shared publicly to ensure consistency across MCOs.	EOHHS understands the importance of knowing the baseline years that will be used to set each year's TCOC targets. The reason that information is not yet available is that the MCO cost reports anticipated to be used as base data for the SFY 2024 capitation rate development were due October 31 (and it is not unusual for there to be delays in

		receiving that data), and after receipt it takes some time to process the information to make appropriate decisions. Therefore, the baseline years will generally always be confirmed in December, not before.
TCOC Technical Guidance	We also recommend EOHHS provide additional information around why the claims threshold is decreasing for PY6. In all previous years, the claims threshold has increased and PY6 would reverse that trend. Without additional guidance from EOHHS, it is difficult to understand impact of this change.	The reason that the high-cost claim threshold declined for PY6 is that the threshold for each year is developed based on the relationship between the baseline year(s) and the performance year, rather than a trend from one performance year to the next. First, the CY 2019 outlier limit was established by taking the average of the SFY 2019 and SFY 2020 outlier limits. We then trend this baseline year outlier limit to the performance year using the composite trend adjustment applied to the baseline year TCOC. For SFY 2023, the composite trend from the midpoint of the BY (July 1, 2019) to PY (January 1, 2023) was approximately 9.7% over 3.5 years (2.7% annual). This resulted in a SFY 2023 outlier limit of $117,700. For comparison, the PY4 trend from January 1, 2019 to January 1, 2022 was approximately 14.1% over 3 years (4.5% annual). When applied to the $104,800 outlier limit for SFY 2019, this resulted in a SFY 2022 outlier limit of $119,600. The reason for the lower annualized trend

		rate in the SFY 2023 capitation rate setting is primarily driven by utilization suppression due to COVID-19. In summary, while we would expect the outlier limit to generally increase over time, changes in rating assumptions and an overall low rate increase from SFY 2022 to SFY 2023 (0.6% composite increase) resulted in the lower SFY 2023 outlier limit.
Quality Methodology	We recommend that target thresholds for pay-for-performance measures continue to award points for improvement above prior year's performance.	EOHHS will continue to award points for improvement above a prior year's performance where appropriate.
Quality Methodology	For the two measures that are being removed from the attestation process between MCOs and AEs, diabetic eye exam and developmental screening in children, we recommend that high target thresholds be reviewed based on PY4 performance. We should not set higher targets that may not be achievable. One concern is counting DM eye exams that have results of no retinopathy during year prior to performance may not be captured.	Discussions on quality measure targets and methodology will continue to take place between EOHHS the MCOs and the AEs in the AE/MCO Quality Work Group meetings.
Quality Methodology	Agree with addition measures from the OHIC measure set for 2023. ○ Child and adolescent well care visit include all ages 3-11yo. ○ Chlamydia screening ○ Lead screening, however, the Kids net database continues to be inaccurate for children that live in other states on the border of Rhode Island (MA residents seeing RI clinicians lead screenings are missing even after being sent to Kidsnet numerous times). We do not agree with the proposal to add pre-natal and postpartum care measure for 2024. Primary Care Clinicians do not provide this care, many AEs do not have OB-GYN services as part of their organizations.	Discussions on quality measure selection will continue to take place between EOHHS the MCOs and the AEs in the AE/MCO Quality Work Group meetings. EOHHS has not proposed adding a pre-natal and postpartum care measure in 2024.

	This should be considered in contracting between MCOs and OB-GYN practitioners.	
Quality Methodology	Recommendations to add additional RELD segmentation is acceptable. However, it would be more important to dive into the first year of RELD data reported to understand the differences among AEs and MCOs and what are the goals for improving this existing data. If EOHHS is looking for recommendations for additional measures to add for segmentation, were commend adding: Breast Cancer Screening, Lead Screening	EOHHS is currently focused on the collection of RELD, and we are reluctant to draw any conclusions about AE and MCO performance until we have more complete data collection.
Quality Methodology	P.12 – We are concerned with the proposed EOHHS quality measures data collection requirements. We have expressed directly to EOHHS the issues associated with the new proposed assessments. We have shared the assessments are not necessary for the MCO to provide valid data collection and quality measurement. However, EOHHS' continues to require the use of the ECDE files for QPY5 and QPY6 files to produce a second set of HEDIS rates. This redundancy is of no value to us and serves to increase administrative burden and costs. The requirement requires a contract modification and additional costs for our HEDIS vendor. Concerns with the additional data files have been raised by us previously and we strongly encourage EOHHS to immediately reconsider this decision.	EOHHS remains committed to advancing towards electronically generated quality measures. As we progress towards this goal it will be necessary to verify that quality performance generated using electronic clinical data does not differ meaningfully from quality performance generated using traditional methodologies.
Quality Methodology	**Phase-Out of Self-Reporting & Chart Review** We understand and support the phasing out of self-reporting and chart review for select measures. However, the target should not be increased significantly until the second full year of self-reporting. This will allow time for reporting capabilities to be developed, tested, and refined where they do not currently exist. This suggestion is in keeping with other changes EOHHS has implemented where EOHHS has recognized a "transition period" of some sort was appropriate.	EOHHS will lower targets to account for the phase-out of AE self-report and MCO chart review, not raise them. The phase-out schedule will extend over three years, beginning with only two measures in QPY6 to account for this transition. EOHHS will also be performing a systematic variation analysis.
Quality Methodology	**AE Threshold for High Performance Targets** We believe that High Performance Targets should be attainable by at least 3 AEs. Setting a High-Performance Target only attainable by two AEs would be insufficient, while a broader base would likely yield	EOHHS has revised its guiding principles to specify that the high-performance target should be attainable by at least three AEs, defined as having at least one

	higher quality performance overall. The annual performance improvement percentage could then be tied to the most common improvement percentage achieved. Additionally, the High-Performance Target should not be raised in any instance where the majority of AEs do not achieve the lower target. Results like that would indicate fundamental challenges to achieving the measure and are not reflective of AE under-performance.	AE/MCO dyad from three different AEs with a rate above or within three percentage points. The guidelines also specify that the high-performance target should never be below the current performance of every single AE. EOHHS will continue to assess whether the improvement target is attainable each year and will also consider the Overall Quality Scores by measure when setting targets.
Quality Methodology	It appears that on Page 12 of Attachment J for the screening for clinical depression measure for QPY6 (2023), QPY4 (2021) is written as the base year. In 2021, that measure was a six-month measure and not comparable to a twelve-month measure in 2022. We request EOHHS align this change in the AE implementation manual as well.	EOHHS will look to align the baseline period during the next update of the Quality Implementation Manual (QIM).
Certification Standards	**AE-MCO DIVISION OF RESPONSIBILITY.** As we noted in response to the AE PY5 requirements, we are concerned that these Certification Standards include requirements over and above those required of MCOs in their contracts; this misalignment is likely to result in confusion as MCOs and AEs attempt to work together. We recommend that: AE Certification Standards only include the essential requirements of the AE; AE Certification Standards be consistent with, and not more onerous than, MCO contract requirements; EOHHS hold AEs responsible for outcomes, not processes; and Moving forward, EOHHS allow for concurrent review of the AE Certification Standards for public comment and the EOHHS MCO contract to promote alignment.	New Domain 6 activities will remain optional in Program Year 6, as they were in Program Year 5. EOHHS will continue to seek to further align AE and MCO requirements in the future.
Certification Standards	**CARE PROGRAMS.** In follow up to our comment above, Section 6 (page 22) outlines an exhaustive set of Care Program requirements. Our recommendation is that EOHHS narrow these requirements to those that are essential. If EOHHS intends to hold AEs to these requirements,	As discussed in the Sustainability Plan, EOHHS expects that delegation of these responsibilities will be accompanied by the associated funds.

	AEs must be funded to perform these activities and MCOs must be held to these standards to align MCO and AE requirements.	
Certification Standards	**SDOH CARE NEEDS SCREENING.** Revised language in section 5.2.2.2 indicates that, beginning in PY6, there will be a process by which AEs must have their SDOH Care Needs Screeners approved by EOHHS, and AEs must inform EOHHS of any changes to the screener (page 20). We ask that EOHHS provide additional detail as to what this approval process may look like and what the approval criteria will be.	The requirement that EOHHS approve SDOH screening tools used by AEs was in place prior to PY6. The change in PY6 is a requirement that any changes to the screening tool be reported to EOHHS so that EOHHS has an up-to-date version of each AE's screening tool on file and can verify that the tool being used complies with all of the requirements of our SDOH screening quality measure specifications.
Certification Standards	**TRACKING AND REPORTING OF REFERRALS FOR SOCIAL NEEDS.** To inform our future program planning, we ask that EOHHS provide specific examples as to how AEs are using Unite Us to fulfill the obligations outlined in Section 5.2.3.2 (page 21), which requires AEs to have a documented plan for the tracking and reporting of referrals for social needs to MCOs.	The Community Resource Platform tracks referrals for social needs through a closed-loop referral system. The tracking capabilities can be leveraged to meet requirements on SDOH referrals and tracking.
Certification Standards	**BOARD OR GOVERNING COMMITTEE MEMBERSHIP.** In describing the voting membership of the Board or the Governing Committee in Section 2.2.2.1. on page 14, we believe that there is an "and" or an "or" missing between "primary care providers" and "behavioral health providers."	EOHHS has corrected this typo.
Certification Standards	IT Infrastructure – Data Analytic Capacity and Deployment As we stated last year, 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.	EOHHS is continuing to work towards improved HIT infrastructure in the hopes of more easily facilitating care delivery. EOHHS appreciates these concrete examples of types of data that would be of use to the AEs.

	The above comment is relevant to and applies in all instances where EOHHS delineates data management and analytics expectations of the AEs.	
Certification Standards	Commitment to Population Health and System Transformation Section 5.2.3 includes the following revision: *Coordination with CBSs. Establish AEs will 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.* We support the ultimate goal of this requirement. It is ambitious, but essential. We urge EOHHS to take an active lead in building the framework that would make this possible. EOHHS has taken a major step to advance this goal by rolling out the Unite Us platform for all AEs. The next step in the process is developing a way to ensure CBOs receive the necessary financial support to meet the service demand AEs will be sending to them. A large-scale Unite Us Payments pilot, as we advocated in our comments on the Roadmap & Sustainability Plan, would be an ideal way to advance this goal.	EOHHS understands the need for continued work and support to provide AE members with the necessary supportive services.
Certification Standards	*Care Coordination* The definition of Care Coordination retains a reference, introduced last year, to 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. 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." 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.	EOHHS appreciates this comment and agrees with the need to provide more clarity around terminology and expectations for care coordination. EOHHS will continue to reevaluate program methodologies – such as attribution – in order to maximize beneficiary well-being and program sustainability.

	Therefore, to support this new priority, EOHHS should consider program changes that would increase the attribution of whole families/households to the same AE, proactively identifying families/households when they are attributed to AEs.	
Certification Standards	*Complex Care Management* This definition retains the reference, introduced for the first time last year, to a new priority population: "those recently discharged from correctional institutions." [Page 25] As we did last year, we encourage EOHHS to broaden its scope with language referring to "justice-involved individuals and families/households." 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 affect health outcomes. 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.	The list of populations that might benefit from Complex Care Management (CCM) that is listed in the certification standards was meant to be neither restrictive nor comprehensive. AEs are permitted to identify different groups of populations to target for CCM. EOHHS welcomes the opportunity to engage with AEs on ways to support AEs in this work.
Certification Standards	EOHHS, MCOs and AEs have an opportunity to invest in strategies that make a significant difference in the quality of care of adults, children and families. With the present model, achieving shared savings is a foundational driver which requires AEs to first and foremost focus their attention on the adult patients with complex needs. The AE Year 6 standards and incentives could do more to ensure focused attention and improvement on the health of children, families and adults.	EOHHS continues to be interested in incentivizing AEs to focus on the health of children, families, and adults, and going forward we will continue to leverage the certification process and the quality program to achieve those goals.
Certification Standards	P.26-32 - Care Program Design and Management – We endorse EOHHS taking steps to require AEs and MCOs to enter delegated care management arrangements. It is important to acknowledge that MCOs have a primary contractual responsibility with EOHHS for care management and has the ultimate responsibility for all delegated activities associated with the further responsibility to meet NCQA accreditation standards. There needs to be flexibility in structuring care	EOHHS plans to be flexible as we move forward with delegated care management. We understand that the responsibilities of the MCOs and the differing capacities of AEs will mean that care management delegation will look different for different AE/MCO dyads.

	management programs, with universal definitions and expectations to account for the variation in capacity and capabilities of each individual AEs care management structure. It is critical for MCOs and AEs to have wide latitude to allow for customizable flexibility in alternative arrangements.	
Certification Standards	Agreement	EOHHS appreciates the support for the PY6 Certification Standards.
Attribution	P.3 - We recommend removal of language that states "PCPs are permitted to affiliate with at most one AE" at any given time. The outdated language does not serve any clear benefit or value to the AE program. Attribution is member specific therefore members will align to their appropriate AE regardless of whether providers are affiliated with multiple TINS. There are more negative impacts to the program than positives if this rule remains in place. P.6 - The dates that have been edited on this page need to be updated.	After review, EOHHS has decided that in PY6, MCOs may choose whether to permit PCPs to affiliate with multiple AEs through different TINs. MCOs must apply the same policy for baseline and performance data, and must apply the same rule to all AEs with which they contract.
Attribution	**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	EOHHS understands that the nature of the attribution model can lead to some patients' costs being attributed to an AE that did not care for them when the costs were incurred and to some benefits of an investment in a patient accruing to an AE that did not make the investment. However, EOHHS has not seen evidence that suggests systematic advantage or disadvantage for any AE as a result. Just as an AE might "gain" a member who had higher costs before being attributed to that AE, so too might that AE "lose" a more expensive member and thus not have those costs count toward the AE's TCOC. Just as an AE might "lose" a member in whom the

	data. We encourage EOHHS to engage AEs and MCOs in ways to address these issues.	AE had invested, so too might an AE "gain" a member in whom a different AE had invested. EOHHS modeled the results of different attribution models (including a monthly attribution method) before implementing the current method, and did not find significant or systematic differences in outcomes. Also, note that the quarterly TCOC reports are based on attribution in the final month of each quarter, so it is not the case that all the changes in attribution throughout the year are "saved up" for the final quarter. At this point in the program, there is also substantial value to stability in methodologies. Therefore, EOHHS intends to continue the current approach.
Attribution	**ATTRIBUTION FOR TOTAL COST OF CARE ANALYSIS.** As we have previously noted, we have concerns about the decision to assign all costs for a member during the performance year to the AE to which the member is attributed in the final quarterly update (Attribution for Total Cost of Care Analysis, page 6). In addition to TCOC implications, this approach has data implications. We expect claims data sent to us by the MCOs to align to the attribution methodology (that is, we expect to receive claims data covering the entire population, and only the population, for which we are accountable). Retroactively changing attribution at the end of the year will add considerable complexity to the claims data feed. We therefore recommend that EOHHS develop an approach where costs are assigned to an AE based on the member's monthly attribution (that is, the AE would be accountable for costs for	Please see the row above for EOHHS's response regarding the general attribution methodology.

	services provided during member-months when the member was attributed to the AE).	
Attribution	We ask that EOHHS clarify the effective date of an attribution change resulting from a member requesting a non-AE PCP. • Step 1 of the "Methodology to Attribute Members to AEs" on page 3 states: "When a member has requested that the MCO change their PCP to one that is not participating in the AE to which the member is currently attributed, the MCO shall update the member's AE attribution no later than on the next attribution report that incorporates quarterly reconciliation." • Whereas the "Attribution to Inform AEs Which Patients They Are Accountable For" section on page 4 states that the "monthly [attribution] report will be updated to reflect changes that have taken place since the previous monthly list, including… persons who have requested a PCP not included in the AE…" We ask EOHHS to clarify whether the change is effective the following month, as reported on the next monthly attribution report, or upon receipt of the next attribution report that incorporates quarterly reconciliation. Our preference is that the change is effective as soon as possible and incorporated into the monthly attribution report, as we should only receive data for and manage the care of members seeing our PCPs.	EOHHS appreciates the opportunity to clarify the effective date of an attribution change resulting from a member requesting a PCP that doesn't participate in the member's current AE. The MCO must update the attribution no later than the next report that incorporates reconciliation, although it is permissible and encouraged for the MCO to update attribution more quickly in this circumstance. If any such change has been made since the previous monthly attribution report for AEs, it must be reflected in the next monthly attribution report. The intent of the language on page 4 is solely to note that this would be one situation in which attribution changes should be reflected in the monthly report to AEs, not to state a different timeframe for the change to be made.
Attribution	This AE 's provider network is comprised of many TINs. Each year, we have found the processes for adding and dropping TINs, and the effective dates of those changes, to be cumbersome and confusing. A process whereby TCOC calculations are based on April TIN rosters, outcome and quality calculations are based on December TIN rosters, and attribution lists are based on monthly updates is complicated and inconsistent with other Medicare and commercial value-based contracts in which we participate. This methodology makes it incredibly	EOHHS understands the challenge of different timeframes for attribution. These are driven by underlying differences in various aspects of the program, which are not feasible to change. The TCOC program year is necessarily aligned with the managed care rate-setting year – specifically, the

	difficult to structure our participating provider agreements around key dates. It also presents a challenge in terms of ensuring that reporting received during a performance year is accurate with respect to the practices and patients for which the AE is actually accountable. Moving forward, we ask that EOHHS consider a simplified and consistent approach to attribution for incentive funding, TCOC, and quality.	state fiscal year of July through June. The quality program year is the calendar year because the NCQA HEDIS measures are required to run on the calendar year. EOHHS will be happy to engage in discussion about how these could be aligned, but notes that it is a genuine challenge.
Attribution	During patient enrollment to Medicaid it is crucial that existing primary care clinicians are carried over for the new product, this would improve accurate attribution methodology.	EOHHS is working to identify opportunities to improve member selection of primary care providers, and welcomes the opportunity to discuss AE ideas.
Attribution	For Attribution reconciliation logic bullet #2: ''for members who have not received any primary care services during the period, AE attribution will be unchanged". We agree with the AE patient not being seen in the existing performance year to still be attributed to the AE. However, for patients that have been attributed for 2 consecutive years in a row, with documented outreach and still have never engaged with the AE there should be a process to dispute attribution. Insurance plan requirements state that a patient not seen in the previous 36 months would be considered a new patient, most organizations inactivate patients following this process. We have contacted the MCOs regarding the numerous patients lost to outreach, to be informed by them that they cannot reach these patients either. We have approximately 234 patients attributed to us who have had multiple outreach efforts and have never been seen from PY2-PY4 and are still on our monthly attribution list in PY5.	EOHHS understands that it is challenging to engage patients who have not been seen in some time. Generally, we believe that it will be more productive to work towards engagement, including by sharing best practices among AEs that have had more success, rather than – as seems to be suggested here – dropping from the AE program those members who have not been seen.
Incentive Program	Our main feedback is about the continued reduction in the PMPM for HSTP funding and the new global cap on shared savings, this continued	The reduction in the PMPM for PY6 is a necessary part of the progression of the

	loss of revenue makes it more difficult for us to maintain the infrastructure that we have developed for the AE Medicaid Program. Sustainability beyond PY6 depends on consistent funding to support HSTP projects and program development. Creating a mechanism to identify behavioral health patients for AEs during hospitalization and providing notification for follow up care is essential to performance on TCOC.	Health System Transformation Project. From the beginning of this program, we have had a fixed amount of money to spend on provider incentives, and as we near the end of this phase of the program, those funds will continue to taper off and will ultimately cease. AEs will be responsible for identifying which of their programs they wish to prioritize funding with shared savings payments and other resources.
Incentive Program	Allowable and Disallowable Use of AEIP Funds *General Disallowable Uses* This revision strikes "To pay for construction or renovations" from the list of disallowed expenditures. Does this mean that AEs are now able to use infrastructure funds for construction and/or renovation projects? If so, what if any limits are in place?	The language referring to construction and renovations was removed because it was redundant. Other language in Attachment K requires that any incentive funds spent on capital investments – which EOHHS considers to include construction and renovations – must be approved by EOHHS.
Incentive Program	**PMPM.** We are pleased to see that the Accountable Entity Incentive Pool (AEIP) PMPM for PY6 set at $5.52. We strongly object to the following proposed language in the AEIP description (page 4): "This PMPM Multiplier is based off the current number of Accountable Entities and projected attribution for PY6. EOHHS may reduce the PMPM if total PY6 AE attribution exceeds projections." This AE builds our operating budgets based on this funding allocation. Any unplanned funding decrease jeopardizes our ability to operate the program.	EOHHS has added the referenced language as a result of the limited budget of the Health System Transformation Project. The total amount of money that EOHHS has to spend on the AE Incentive Program is limited and there may be a need to adjust PMPM multipliers if current multipliers result in a total incentive pool that exceeds the money available for the incentive program

Incentive Program	**ANNUAL OUTCOME MEASURES.** We support the proposed reweighting of the Outcomes Measures that apply a 15% weight across all measures in Section 5 (page 8).	EOHHS appreciates the support for this weighting.
Incentive Program	**TEMPLATE MODEL AMENDMENT.** As stated previously, we strongly recommend that EOHHS develop a "model amendment" boilerplate and require MCOs to use it in their contracts with AEs. Standardized language will expedite the contract negotiation process for the MCO and AE and better position the parties to meet the contract submission deadline in Section 6 (page 9).	EOHHS will identify areas where greater state specificity might be useful in the AE/MCO contracting process. At the same time EOHHS understands that some stakeholders seek greater flexibility and our goal is to allow for such flexibility where appropriate.
Incentive Program	**AEIP FUNDING REQUIREMENTS.** This AE is seeking clarification of the language, "AEs shall be required to demonstrate that at least 10% of Program Year 6 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants. Funds that are not completely exhausted in the program year can be earmarked for other contracts in support of SDOH and BH This AE integration and/or for the following program year." This AE requests confirmation that the funds can be used when the HSTP program ends after PY6 in Section 6 (page 10).	Funds that have not been completely exhausted during Program Year 6 can be spent towards the achievement of the 10% requirement after the end of the program year.
Incentive Program	**ALLOWABLE & DISALLOWABLE USE OF AEIP FUNDS.** This AE applauds the proposed change in the Allowable & Disallowable Use of AEIP Funds in Section 7 (page 11) to strike the prohibition of using incentive funds "To pay for construction or renovations." We believe this will allow the AE to support remediation of housing issues expeditiously to ensure beneficiaries can remain safely in the community.	The language referring to construction and renovations was removed because it was redundant. Other language in Attachment K requires that any incentive funds spent on capital investments – which EOHHS considers to include construction and renovations – must be approved by EOHHS.
Incentive Program	Decrease in PMPM and potential further reduction due to exact number of covered lives in AE program, this will reduce incentive dollars for HSTP For PY6 the PMPM multiplier reduction to $5.52 from $6.49, and potential of even less PMPM, will impact the sustainability of the infrastructure we have in place that support the AE Program. We	The reduction in the PMPM for PY6 is a necessary part of the progression of the Health System Transformation Project. From the beginning of this program, we have had a fixed amount of money to

	agree with the Outcome Metrics measures being equally weighted at 15% Each. Since the onset of the AE program, HSTP funding was a cornerstone to assist AEs with building their clinical infrastructure to care for highly complex patients. The investments made by AEs using HSTP to help fund the human capital needed to create these care teams is unprecedented. The continued reduction and possible elimination of HSTP will make it even more difficult to continue to invest in these care teams in the future and could possibly precipitate the end of AE participation in the program. AEs are not flush with funding to front load costs for a period of at least eighteen months (the time it takes for final run out and settlement of a risk agreement) in hoping that they are able to achieve shared savings. In order to make this program sustainable, HSTP funding needs to be part of the funding equation.	spend on provider incentives, and as we near the end of this phase of the program, those funds will continue to taper off and will ultimately cease. AEs will be responsible for identifying which of their programs they wish to prioritize funding with shared savings payments.
Overall	As we approach PY 6, we recommend EOHHS begin to transition elements of the AE Program from the state to the MCOs. For example, AE Certification remains largely unchanged and requirements could be minimized or the review conducted with the MCOs. We encourage EOHHS to provide greater flexibility for MCOs and AEs to establish independent and customized value-based arrangements, which could be actively developed during the PY 6 transition period. In the post-HSTP environment, we encourage EOHHS to focus on overall delivery system transformation through value-based payment goal setting and outcomes expectations. 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. Our feedback encompasses both comments and recommendations for changes to the proposed PY 6 Requirement documents.	EOHHS intends to significantly streamline certification requirements after PY6. Post-PY6, EOHHS will continue to maintain certification requirements and to certify AEs and will not be transferring this work to the MCOs. EOHHS will be sharing further details about future program structure in the coming months.

Overall	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 an effective transition from volume-driven payments to value-based payments to improve health outcomes. We support the direction and continuation of the program as outlined in Attachments H (AE Certification Standards), K (Incentive Program Requirements), and M (Attribution Guidance) and believes the changes as proposed are consistent with the ongoing growth and implementation of the program. We appreciate the opportunity to review and provide comments on the Program Year (PY) 6 Required Documents and the continued engagement with EOHHS throughout the life course of the AE program. We applaud the state's commitment to the program and encourage EOHHS to maintain the trajectory of the program as outlined in these program documents. However, we do have questions with regards to some of the proposed changes contained in Attachment J Total Cost of Care Requirements and Attachment J Total Cost of Care Technical Guidance. We welcome the opportunity to discuss these with you further.	EOHHS appreciates these comments and looks forward to continued collaboration.
Greater inclusion and accountability: prenatal/post-partum population	Greater inclusion and accountability for meeting needs of prenatal/post-partum population: We recommend A/E standards provide greater emphasis on this population given that 49% of people who are pregnant in RI are covered by Medicaid and that itis an area with glaring health disparities. As examples, OB/GYN providers are not included in the section of minimal representation or in sections addressing behavioral health or health related social needs. There are no quality measures, improvement targets for providing prenatal or postpartum care. EOHHS has invested in improving women's health by extending insurance coverage for women during the postpartum period to twelve months of coverage and requiring coverage for	As AEs are not currently required to directly provide OB/GYN services EOHHS does not feel that it is appropriate to measure AEs on the quality and outcomes of OB/GYN provided services. EOHHS is open to the idea of leveraging certifications standards and the quality program to incentivize AEs to focus on opportunities to improve health in the perinatal population.

	Doulas. We recommend that the AE standards provide focused attention on opportunities to improve screening for depression, anxiety, substance use disorders and health related social needs for the perinatal population and improve care coordination efforts for post-partum women to primary care.	
Greater inclusion and accountability: children and families	AEs clearly must be accountable for the quality of care they provide including children and families. We recommend AE standards provide greater emphasis on this population given that over 50% of children are on Medicaid. AE standards could require a focused quality improvement program specific to improving the health of children and families as a "gate" for obtaining shared savings. We recommend reviewing each domain identified for certification with the intent to clearly specify how child health expertise will be included and clearly identify transitions from pediatric to adult care as an area of focus. In the section that addresses individuals with or at risk for developing serious mental illness, identify how needs of children with SMI will be addressed. Our recommendation is that AE standards more proactively and intentionally address the needs of children and families to ensure AE accountability to this important population.	EOHHS is committed to focusing on the care of children who are enrolled in the AE program. In recent years EOHHS has been using the quality program to incentivize high quality care for pediatric AE members, but we are limited by the number of applicable and viable quality measures focused on children.
Greater inclusion of children and youth with special health care needs	According to the RI Kids Count 2022 report, children with special health care needs (CSHCN) are those who have a chronic disease or disability that requires educational services, health care and/or related services of a type or amount beyond those required generally by children. Special needs can be physical, developmental, behavioral and/or emotional. An estimated 19% of U.S. and 22% of children in RI have at least one special health care need. In RI, 15% of CSHCN have needs that are more complex. Data from the National survey of Children's Health reflects a low percentage of youth with and without special needs receiving adequate preparation for transition to adult care. According to 2005/2006 National Survey of Children with Special Health Care Needs youth with special health care needs who received the services necessary to make appropriate transitions to adult health care, work,	As we move towards greater delegation of care management responsibilities to the AEs, EOHHS will evaluate its care management standards to determine where the program could benefit from greater detail. Definitions for who requires care management have been left at a high level as we do not believe that we would be able to accurately capture all of the different groups that may need these services.

	and independence were 37.6% in Rhode Island compared to 41.2% nationally. More recent data from 2019/2020 National Survey of Children's Health finds a continued gap in care with: 80% of RI Youth with Special Health Care Needs (YSHCN) and 84% of RI non YSHCN do NOT receive transition preparation from their health care providers (compared with 76% and 82%respectively in US); Among adolescents ages 12-17, RI has a higher prevalence of special needs (29%) compared with US (26%). The AE standards need to be strengthened in this area as presently they speak to defining methods to care for people with complex needs but accountability for effectively addressing the needs of children and youth with special health care needs is not defined, assured or adequately financed. Additionally, it would be helpful to have more definition on which AE members require care coordination. The current language "members with chronic, acute, specialty, BH and social needs" is vague.	
Provider capacity	We appreciate the inclusion of behavioral health capacity in the AE standards. We suggest more acknowledgement of the BH workforce crisis as part of this section. AEs can play an important role in workforce development activities such as serving as training sites for new clinicians. Without an adequate BH workforce, AEs will be challenged to meet the BH service capacity requirements as outlined in the certification standards. If AEs partner with CMHCs for this capacity, what is the responsibility of the AE when the CMHC cannot meet the needs of the members?	EOHHS continues to work through multiple avenues to address shortages in the healthcare workforce in general and the BH workforce in particular. The Health System Transformation Project has had a focus on workforce development from its inception and continues to acknowledge that the workforce is and will be a critical part of any efforts at system reform.
Specialists	There is limited mention of AE requirements around specialty care: "Make and track referrals for specialty care, other medically necessary services such as dental care and services to address social determinants of health". Use of subspecialty medical services has risen rapidly in the United States and in Rhode Island with referrals with specialists more than doubling in just a decade. Between 2002 and 2016, direct spending for specialists accounted for 18% of total annual health care	The focus of the Health System Transformation Project and the AE Program is currently on the types of care that fall under the TCOC model. To the extent that a subspecialty care type falls under TCOC the AEs are strongly incentivized to coordinate care in such a

	spending increases while primary care accounts for 4% of health care expense increase (Martin, 2016). Could care coordination and accountability be more effectively included in the AE certification standards?	way as to increase quality while controlling cost.
Health equity	We appreciate the recognition of the role that health-related social needs pay in health outcomes. We suggest language that strengthens the AE responsibilities to invest in capacity building efforts. AEs should be required to do more than "form defined affiliations and working arrangements with CBO's". Health systems must invest in CBO capacity building efforts in order to have an infrastructure to adequately address HRSNs. Additionally, it is unclear what the role of the MCO is for addressing HRSNs. The role, the responsibilities and the potential impact of the Community Advisory Committee (CAC) is vague except for its inclusion of people who are on Medicaid and a representative of the HEZ. We recommend that language be strengthened to include AE accountability. We recommend that greater emphasis be given to patient engagement, patient experience and across all the domains, consider the active inclusion of persons with lived experience to better ensure that needs are understood and that AE strategies are responsive to the needs of patients served. There should be inclusion of language needs for after hour standards. In section on behavioral health capacity, include the need for language and cultural inclusion commensurate with the size and the needs of the attributed population. Performance improvement plans and actions should use risk stratification and inclusion of voice of persons with lived experience to improve care based on need and health disparities (such as but not limited to race, ethnicity, age, gender, insurance type, zip codes).	EOHHS is committed to building community/clinical linkages through the AE program but does not feel it is appropriate to be overly prescriptive in what relationships exist and how they are formed.
Resources provided for primary care	We recommend greater emphasis on ensuring that primary care providers and their teams are well supported and resourced (financial, human technology, data) to deliver high quality care. There needs to be active engagement with primary care team members to find out	EOHHS has made significant investments in the AEs through the Health System Transformation project and the AE Incentive Program. We continue to work

	what data they need to provide high quality care, and provide teams with timely access to that information.	to improve HIT infrastructure to allow for more better data sharing.
Socioeconomic Risk Adjustments	This AE continues to advocate for cost of care and quality benchmarking methodologies that incorporate socioeconomic vulnerability. An absence of this critical element inadequately informs needed resources and less effectively measures quality of care delivered in underserved areas. Several indices exist to evaluate geographic vulnerability, including The University of Wisconsin's Neighborhood Atlas1 that will serve as the premise for socially-driven benchmark adjustments in CMS' latest ACO track: Realizing Equity, Access, and Community Health (REACH) model.	EOHHS understands the desire to incorporate socioeconomic vulnerability into the TCOC and Quality systems. EOHHS is looking into various ways that this might be done in the future, but currently we do not have sufficiently accurate address data to implement such a program.

EOHHS Response to Public Comments on HSTP PY6 Requirement Documents: Global Shared Savings/Loss Cap

EOHHS received a number of comments on the proposed addition of a Global Shared Savings/Loss Cap to the Total Cost of Care (TCOC) methodology. Those comments can be found below, followed by EOHHS' consolidated response.

Comments
After careful review of the PY6 program requirements and the possibility of the AE demonstration period ending after PY6, *this AE* feels that the introduction of a global cap on shared savings for AEs in PY6 is not the right time to implement this proposed requirement. The AEs are already subjected to a cap on shared savings of 10% of TCOC and *this AE* is concerned that further truncating shared savings for the AEs based on the MCOs profit or loss will negatively impact the AEs. With the uncertainty of the AE demonstration ending after PY6, *this AE* feels that delaying the global cap on shared savings requirement until we know more about what comes after PY6 is in the best interest of all parties and requires much further discussion.
This AE wholly rejects the proposed cap on shared savings introduced by EOHHS at the September 22nd PY6 Development and Design discussion. This AE disagrees with the premise that the profitability of Managed Care Organizations (MCOs) supersedes return on investments earned by organizations providing the care upon which they rely. Such a decision, which has not been backed either by data or precedent, would contradict EOHHS' commitment to value-based arrangements while jeopardizing program sustainability.
We fully endorse VBP arrangements but the current EOHHS-administered methodology for total cost of care (TCOC) calculations create positive AE saving allocations in the absence of actual demonstrable non-Covid related utilization decreases. As a result, the Program Year (PY) 3 calculated savings paid to AEs and the projected PY4 savings is placing significant financial pressure on the MCO. We are concerned that EOHHS has not adequately addressed the viability of managed care to sustain year-over-year losses created by TCOC methodology choices exercised by EOHHS. We request an immediate remedy from EOHHS for the incurred and projected losses in the Medicaid line of business.
P.5 - Global Cap- We recommend changing the name from Global Cap to Shared Savings/Risk Cap to avoid confusion between a global capitated payment model and a cap on shared savings/risk. (Also applicable to P.10 in the Total Cost of Care Technical Guidance.)
We strongly oppose the imposition of a Global Cap on the Shared Savings/(Loss) Pool for the MCOs and oppose the implementation of this cap for PY6.

This Cap has been developed as a response to a "problem" that has not been fully explained. If there is a problem – faced by one or both MCOs – that undermines sustainability and financial solvency because of a "imbalance" in incentives, this issue should be reviewed comprehensively, by all partners, in an open forum where there would be an opportunity to fully understand the real nature of this challenge. As it is now, AEs have been presented with a finding, without any substantiating detail, and presented with a unilateral "solution," which we had no voice in developing, that will inflict a financial penalty through no failure of performance on our part. Furthermore, this Cap is proposed at the very time AEs are facing decreased infrastructure funding, with a resulting need to sustain operations via Shared Savings. AEs are, essentially, confronted with a change in the rules which will combine a cut in funding with, effectively, a penalty. This is not an equitable solution. We urge EOHHS to retract this proposal and to instead convene a working group that would include MCOs, EOHHS, and AEs to study the challenge and to develop a comprehensive response that does not privilege one partner while penalizing others. This working group must be transparent so that all MCOs, all AEs, and EOHHS can fully understand the situation and develop a response that is fair to all and sustainable. Additionally, EOHHS should incorporate insights gleaned from this experience into the forthcoming re-posting of the Managed Medicaid Solicitation. Finally, we will point out that an arbitrary cap like this would not be necessary in a global capitation model.
Our most urgent feedback is related to the proposed global cap on AE shared savings. We strongly oppose the proposed global shared savings cap proposal and call on EOHHS to eliminate the proposed cap for PY6, and work with AEs and MCOs on alternative approaches to ensure the sustainability of the program for all participants. This proposal will function as a disincentive for AEs to continue their hard work of reducing the total cost of health care while improving the quality of care. It imposes an unpredictable, retroactive financial penalty on AEs who have successfully generated cost savings in their contracts, by inappropriately shifting financial risk from well-funded MCOs to primary care providers. It makes AEs financially accountable for health care cost performance that is entirely outside of their control, including the financial performance of other AEs, and it ignores the reality that MCOs have significantly more tools at their disposal to control costs through their provider networks, utilization management functions, and provider rate negotiation. Philosophically, this proposal seems to be completely at odds with EOHHS's stated commitment to accountable care, and Rhode Island's long-standing commitment to the importance of primary care. This shared savings cap is simply a mechanism to shift resources from primary care providers to MCOs. In the long run, constraining the resources available to primary care networks will not help providers to reduce costs and improve quality. MCOs are much better positioned to manage and adapt to variation in health care expenses and risk than primary care providers and health systems. For an MCO to experience a potential financial loss is unfortunate, but it should not be unexpected, and it is very concerning to conclude that a

health insurer should be made whole at the expense of health care providers. Our assumption is that this policy was developed because one or more MCOs expressed concern about their financial performance through the AE program. If an MCO is experiencing financial losses while AEs are earning shared savings, it suggests a material misalignment between the MCO capitation rates and the AE TCOC targets. If this is the case, it would represent a structural flaw in the design of those rates, which EOHHS should urgently address with their actuary, rather than attempt to claw funding back from AEs. We have not seen any data that supports the need for such a dramatic change to the AE TCOC program. That EOHHS would propose to institute a policy like the shared savings cap proposal with no input from the AEs suggests that it was prompted by a significant financial concern: EOHHS should share that rationale with the entities that will be affected by the proposed policy. The timing of this proposal could not be worse: PY6 will also see a significant reduction in funding available to AEs through the HSTP AEIP program. The combination of a predicted loss of HSTP payments and an unpredictable loss of shared savings payments could catastrophically reduce an AE's revenue. This is exactly the wrong kind of change to make to the program in a year in which sustainability of the program is a primary concern. AEs can only be successful if they can reasonably project, with some degree of confidence, that they can earn sufficient revenue through the program to cover the expenses of the population health work that benefits their members; this proposal will force AEs to call into question their ability to sustain participation in the program.
This AE strongly opposes the proposal where, in aggregate, if the AEs' Shared Savings/(Loss) Pool for a particular MCO is materially misaligned with the MCO's financial gains or losses related to benefit expenses, the Shared Savings/(Loss) Pool for the AEs may be adjusted as outlined in Section D.3.d. (page 5). An unpredictable, retrospective clawback of AE shared savings based on TCOC performance outside of the AE's control runs counter to all of EOHHS's sustainability efforts. We contend that the risk corridors outlined in the MCO contracts, and the financial oversight of MCOs provided by OHIC, should be sufficient to manage MCOs' financial exposure. A global cap with clawback provisions does nothing to advance or promote value-based payment arrangements. This proposal, in concert with the proposal outlined in Attachment K to reduce the PMPM if the total PY6 AE attribution exceed projections (page 4), does not promote AE sustainability. The inclusion of either of these proposals in the final guidance will impact our decision-making about our continued participation in the AE program.
This AE reiterates our strong objection to the proposal to implement a global cap on AE shared savings in Section 5.d. (page 10).
We believe that the addition of the Global Cap on the shared savings/loss pool disadvantages the AE. For years, premium dollars have gone to the MCOs to use to pay for care. Any excess premium after covering medical costs went to cover the MCOs administrative costs and their profit requirement. Profits were accumulated by MCOs to assist with offsetting years where there was no surplus. These surpluses were not put into physician reimbursement as Medicaid fee for service reimbursement in Rhode Island (as of 2019) was 37% of the Medicare index which is the lowest rate when compared to any other state in the country. AEs that are bending the cost curve, albeit when being compared against their past performance, should not have their shared surplus pool discounted based on the overall performance of the MCO. AEs that are providing high-quality, low-cost care, and an exceptional patient experience should not have the value of their efforts discounted based on the MCOs poor performance.

This AE strongly disagrees to propose, or worse, implement a cap on the amount of shared savings an AE provider can receive, after it has been earned, directly conflicts with the program goals and the ability to sustain this level care for patients. Shared savings is just that- total savings that is shared between parties. To propose a limit to this amount only favors the MCOs who are neither coordinating nor providing the direct care, is disheartening and irrational.
We appreciate the flexibility EOHHS continues to provide MCOs when working with AEs under the Total Cost of Care (TCOC) and the continued fostering of innovative VBP design that it allows. Currently, shared savings are the only identified source of funding for the AE program in the short term. For the program to be successful and sustainable over time, it must continue to benefit both the AEs and the MCOs while producing improved outcomes for consumers. We appreciate the need to help achieve greater balance in downside risk, but we believe the proposed global cap may negatively impact AEs and ultimately the long-term sustainability of the program. We encourage EOHHS to explore alternative mechanisms to the global cap. We are concerned how the global cap will impact MCO-AE provider partnerships and that it may negatively impact the sustainability of program investments. As written, the global cap appears to benefit participating MCOs by limiting our exposure versus supporting AEs. However, for this program to achieve success, AEs must be sufficiently enticed to participate. We encourage EOHHS to look for ways to balance the sustainability of the program with the need to moderate shared savings paid to AE partners and to avoid relying on a global cap to balance the limited downside shared risk. As a critical component of the program, AEs must be a part of the proposed solution to the long-term sustainability of the program. The AEs have offered alternative recommendations that achieve the same results as intended by the global cap. They have also identified concerns with the global cap that should be considered and addressed before changes are implemented. We encourage EOHHS to engage with AEs to identify the most feasible alternatives beyond the global cap. Within the PY6 Program Documents, there is little data and information that articulates the need for and supports the move to a global cap. Without this information, it is difficult to understand the genesis for the global cap and how it fits into the larger program context, particularly its long-term sustainability. EOHHS should clarify the specific problems that will be solved with the global cap and how this solution fits into the sustainability plan for the program. We look forward to continued engagement with EOHHS on this issue. The management of shared savings, whether through a global cap or other alternatives will have impacts across the entire Medicaid managed care program. We strongly support program designs that enable a robust range of VBP options and AEs are a crucial component of implementing an array of VBP arrangements within Rhode Island Medicaid.

EOHHS Response
The Global Shared Savings/Loss Cap is a way to ensure that no MCO is left with a major gap between their total benefit expense surplus and the amount they're expected to pay out in shared savings. Conversely, the Global Shared Savings/Loss Cap also works in the opposite direction, limiting the AEs aggregate shared losses in excess of the MCOs actual benefit loss. It is best understood as an outer limit or guardrail to prevent unreasonable outcomes in unusual circumstances. Without such a cap to protect against these circumstances, it is possible that some MCOs would conclude that the program is not sustainable for them and choose not to participate, or not to contract with as many AEs. After further review of TCOC methodology, EOHHS is making one change to the Global Shared Savings/Loss Cap methodology in the final PY6 program documents. EOHHS will add a floor for the global cap value equal to 0.5% of the MCO's annual benefit expense portion of the capitation rates. This will mitigate the risk of the global cap having an outsized effect on AE shared savings payments in years where the MCO has a relatively small loss. EOHHS understands that it is important to provide some further details on the reasoning behind the Global Shared Savings/Loss Cap. While we expect to continue stakeholder discussions in future meetings, we are also sharing more explanation below. EOHHS designed the TCOC methodology to track as closely as reasonably possible to managed care capitation rate-setting methodology, so that outcomes for MCOs and AEs would be closely tied. However, there are a few areas where this alignment cannot be perfectly achieved due to competing AE program priorities, such as creating incentives for broad AE participation. After resolution in PY5 of the misalignment related to SOBRA payments, the remaining concerning area of misalignment is "base data relativity." When EOHHS sets capitation rates for MCOs, the first step is to identify the "baseline period costs," following which EOHHS applies prospective adjustments (trend, program changes, etc.) and risk adjustment to arrive at a total per member per month capitation rate. Structurally, this is very much like the process for setting AE TCOC targets. The major difference is that the "baseline" costs for each MCO is the average across all Medicaid managed care members, rather than the costs for each MCO's own members. This means that if one MCO has higher costs in the baseline period and another has lower costs, their baseline costs used to set capitation rates will still be the same. By contrast, in the AE program, an AE's baseline costs are specific to the AE's spending for members enrolled in the specific MCO for which the target is being developed. So, an MCO with higher baseline costs will not see those higher costs fully reflected in its capitation rates, but the

AE contracting with that MCO will see those higher costs fully reflected in its TCOC target, making that target easier to hit. As a result, the same underlying costs for a given set of members can create shared savings for the AE but not yield a surplus for the MCO.

EOHHS considered changing the TCOC methodology so that AE targets would be based on spending for all Medicaid members. However, we decided not to take this approach for two main reasons. First, the AE-MCO contracts are between each AE and MCO and the intent is to measure improvement in each MCO's own costs driven by the AE. Second, this change would alter the contracting incentives for AEs in a way that could easily undermine the program. With AEs facing the same target for both MCOs, but also facing the same underlying cost patterns as they do today, AEs would be incentivized to only contract with the MCO with lower underlying spending, where it would be easier to hit targets (which would also reflect the higher costs of the other MCO). By retaining the current structure, EOHHS ensures that AEs can do well under contracts with any MCO, so long as the AE is able to move the needle on that MCO's spending for the AE's members.

EOHHS indirectly addressed this issue in PY5 when it implemented a statewide market adjustment to compare the AE to its peers across all MCOs in the AE program. This had the effect of increasing the targets for the MCO with lower underlying spending and decreasing the targets for the MCO with higher underlying spending. However, because the weight given to the market adjustment is no more than 35% even in PY6, this will only limit the "base data relativity" effect, not eliminate it. EOHHS is comfortable with this approach, as it maintains incentives for broad AE participation while mitigating some of the misalignment with capitation rate setting. Note that by improving AE-MCO alignment, the implementation of the statewide market adjustment, as well as the adjustment related to SOBRA payments, reduce the likelihood of the Global Shared Savings/Loss Cap being triggered in any given year, and its magnitude if it is triggered.

EOHHS has concluded that the Global Shared Savings/Loss Cap is the best option to mitigate the issues caused by base data relativity. Of course, we remain attentive to changes in circumstances and are always available to receive information that could impact program decisions.