COASTAL MEDICAL

March 16, 2019

I am writing to offer public comment on behalf of Coastal Medical regarding two of the managed care strategic goal setting policy statements released by EOHHS on March 7. We appreciate the intent of EOHHS to accelerate progress on its Medicaid program priorities with these new policy statements. We are excited to be a part of the Accountable Entities (AE) program.

Over the last seven years, Coastal has become a local and national leader amongst provider entities that are embracing care transformation and alternative payment models. We currently serve seven distinct populations of original Medicare, Medicare Advantage, and commercial insurance beneficiaries under ACO contracts. Based on that experience and our collaborative conversations with like organizations across the country, we believe that **the willingness and ability of *providers* to transform care and succeed under value-based payment will determine the success or failure of the AE program.**

We join EOHHS in affirming that the primary relationship for any individual Medicaid beneficiary is with their provider, not their insurer. We further observe that while populations of beneficiaries were defined primarily by enrollment with specific insurers under fee-for-service, in value-based payment, populations of beneficiaries are defined primarily by attribution to providers. We assert that **the relationship of the population to the provider entity - not the insurer - becomes paramount once providers have made the transition to accountable care**.

Member assignment

With respect to the statement on member assignment, we whole heartedly support the assertions in the document that

> "…the preservation of the beneficiary/provider relationship—particularly as it relates to the primary care provider (PCP) relationship—is paramount and central to a patient-centered delivery system."
>
> *and*
>
> "…because PCP assignment serves as the primary basis for attribution to an AE, preserving the beneficiary/provider relationship is central to an AE's ability to fulfill its management responsibility for both cost and quality."

Coastal has a specific recommendation with respect to the draft policy statement as written, and it relates to **the problem of small population sizes** in the delivery of population health management services and the evaluation of performance under payment models based on total cost of care. We have had real-world experience with this challenge in our work over the last seven years, as well as some familiarity with how payers and providers nationally have tried to address this issue.

The EOHHS draft policy statement reads:

> "If a provider participating as an AE elects to terminate its provider contract with a single MCO, EOHHS will reassign Medicaid beneficiaries who are members of the terminated MCO equally to the remaining MCOs with which the AE has an AE contract in place."

Coastal agrees that this policy is reasonable and equitable, but **we recommend that EOHHS add a stipulation to prevent the unintended consequence of creating single payer population sizes that are too small to allow a rational approach to population health management**. The problem of small population sizes in the delivery of population health management manifests itself in at least two different ways. The first problem is that when populations are too small and random variation exerts too much influence, provider entities are unable to interpret the impact of their new clinical initiatives or expanded clinical services, because they can't make sense of volatile utilization and outcomes data. The second problem is that when populations are too small and random variation exerts too much influence, it also becomes problematic to identify and be rewarded for improvements in cost efficiency of care, because the cost performance data likewise exhibits too much volatility.

These challenges with small populations weaken the business case for providers to take on population health management, because provider organizations cannot justify the incremental effort and investment if clinical and financial outcomes are going to be too much a matter of chance.

It is true that payment models can be adjusted in several different ways to mitigate the risk that payers might find themselves paying extra for chance outcomes rather than substantive increases in value of the care that is delivered. There is an undeniable logic to doing this, but for providers it only compounds the problem with the business case, because it further erodes the financial opportunity. Two additional factors are worthy of mention here. The first is that providers who make a legitimate commitment to population health management will incur significant investment risk in standing up new initiatives and workflows. The second is that provider entities that begin from a baseline of cost efficiency are already disadvantaged by payment models that set cost benchmarks based on historical performance. The AE program does address this issue, but the adjustment is capped at 2%.

The Medicare Shared Savings Program (MSSP) offers a high-profile example of an accountable care initiative that has addressed the issue of small population sizes. The MSSP has set minimum population size of 5,000 members as a requirement for participation. A closer look reveals that in some tracks of the MSSP, even with a population of 10,000 members, participating provider entities have still been required to meet a minimum savings rate of around 3% in order to earn a shared savings payment. These decisions were based on statistical modeling, and they provide a rationale for trying to avoid applying such models to populations of less than 5,000. Coastal has managed populations smaller than 5,000 under total cost of care contracts with other payers, and we have come to understand the uncertainties and drawbacks of doing so, as alluded to above.

Coastal recommends that EOHHS allow for exceptions to the equal reassignment of beneficiaries attributed to an AE if such reassignment to the remaining MCO's would create MCO-specific and AE-specific populations with significantly less than 5,000 members.

Risk Adjustment

Coastal supports the assertion in the draft policy statement that

> "EOHHS seeks to employ a risk adjustment formula to rebalance incentives for MCOs and providers to not only ensure high-risk, high-cost beneficiaries are enrolled in MCOs and attributed to AEs but to also ensure that MCOs and providers accelerate efforts to impact the factors that contribute to a beneficiary's risk, as feasible."

Our experience in working with payers on risk adjustment over the last seven years has yielded a number of "take-aways":

- Arcane details of risk adjustment methodology can be determinative of success vs. failure under a total cost of care model
- Transparency is essential, and asymmetry of information in this domain can erode trust. Providers cannot accept risk models that function as a "black box" that only the payer can see into
- Working through the details to get these models right takes time and experience

In light of these considerations, we have some concern the stated timelines in the draft document may be too aggressive.

Conclusion

We are grateful for the diligent work of EOHHS in creating the AE program, and want to acknowledge the many thoughtful provisions we see in how the program is designed. We appreciate the opportunity here to voice our general support of the draft policy statements on member assignment and risk adjustment and to make the recommendation and comments above.

We also want to express our gratitude to our payer partners and to OHIC for supporting what has been a remarkable collaborative effort with providers over the last ten years to advance care transformation and payment reform on behalf of the citizens of Rhode Island.

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