PROSPECT HEALTH SERVICES RI, INC.
Quality Service – Quality Care

RI Medicaid AE Program
PY4Guidance Documents
Comments

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C. General Comments

The following comments are provided in response to the ***AE Program Year Four Guidance Documents*** (**LINK**) circulated and posted for public comment **Wednesday October 14, 2020**.

We thank EOHHS and Medicaid for providing this opportunity to review the proposed changes and offer comments.

Fundamental Delivery and Payment Transformation is Necessary

As we stated in our comments on the draft *SDOH Strategy* and our comments on the draft *Sustainability Plan*, we believe the key to achieving the ambitious goals of the AE program ***and*** for achieving sustainability lies in fundamental delivery and payment reform. We must move away from the current fragmented fee-for-service payment system to a **population-based payment system**.

The COVID crisis has revealed many weaknesses in the current health care and social service system. In addition to highlighting health inequities and barriers to care experienced by the most vulnerable in society, this crisis has also demonstrated the ways that fee-for-service payment is fundamentally incompatible with the goals of population health. Providers have been severely restricted in their ability

to meet the needs of their patients in the middle of a pandemic because they have been, largely, operating within a billing and coding system unsuited to the moment.

This should not be surprising. Fee-for-service was not effective in a pre-pandemic environment. COVID has only served to heighten our awareness of the shortcomings of the current financial and incentive structure.

The overall strategy for this initiative continues to be built on a fee-for-service foundation when it is necessary to move to an **accountable, population-based payment system** (capitation) at the AE/System of Care level to accomplish the goals of all AE stakeholders.

This system must be one where investment and activity are driven by goals centered around improving quality, achieving payment effectiveness, and addressing health-related social needs in the population being served by an accountable system of care, or Accountable Entity. To be clear, PCP capitation is not population-based payment and will not in any way fundamentally transform the accountability and cost structure for the AE systems of care in Rhode Island.

Additionally, it is important to acknowledge there are very real limits to what can be achieved in even the highest performing, integrated healthcare/community system of care under a population based payment system without significant new government investments to address basic needs like housing and food insecurity.

Without a fundamental change in the payment system, there will never be sufficient resources for Accountable Entities and Systems of Care to do what they can directly, or in partnership with others, to serve their **population** under management and improve outcomes for their members.

Because of this, we urge EOHHS to adopt language that would call for developing and implementing an **accountable, population-based payment system**, one that that will provide the resources to begin to achieve all the goals of the AE initiative. Without delivery and financing reform, achieving equitable access for all to healthcare, behavioral, and SDOH services will remain a laudable destination without a definable pathway to get there.

C. Comments on Accountable Entity PY4 Guidance Documents

Attachment H – Accountable Entities Certification Standards – Comprehensive AE (Program Year 4)

Health Equity

The PHSRI-AE welcomes the way the PY4 Certification Standards incorporate and formalize Health Equity as a priority for the AE program. We look forward to working with EOHHS, RI Medicaid, our MCO partners, community-organizations, AE members, and our front-line care providers to address health equity.

AE/HEZ Collaboration

In keeping with documents issued earlier this year, the Certification Standards also delineate a greater role for the Health Equity Zones (HEZ). We have active partnerships with two HEZ – Central Providence

and West Elmwood – and look forward to deepening our ties to these and other HEZ in areas where we have significant patient concentrations.

While there is a natural affinity between Accountable Entities and the HEZ, it is important to remember there is not complete alignment. A fundamental tenant of the HEZ initiative is that residents, and the organizations that serve residents, set the priorities for each HEZ. These priorities may not necessarily align with the priorities of the AE initiative.

To the degree that AEs and HEZ coordinate and collaborate, this work should be focused around the priorities of the AE initiative. AEs face many demands related to quality, performance outcomes, utilization, and care coordination. AE/HEZ collaboration should advance these priorities. This is the way to realize the greatest positive impact – as the work will align with our strategic plans and the initiatives we are implementing – and guard against AEs diverting limited resources away from where they would have the greatest impact.

Race, Ethnicity, and Language Data

Here and elsewhere EOHHS proposes requiring that AEs collect and report Race, Ethnicity, and Language (REL) data.

The PHSRI-AE certainly recognizes the intersection of health status and REL. However, we do not believe this is the most efficient or effective way to begin collecting this data in a way that will truly inform AE policy and practice. We urge EOHHS to reconsider the implementation of this requirement – working collaboratively with AEs, MCOs, and other key stakeholders – in order to find the most efficient, least burdensome, and most effective way to collect this data.

As a multi-TIN, multi-EHR Accountable Entity, we do not currently collect this data in a uniform way across all practices. There are varying degrees of specificity and ways of classifying some of this data. Establishing a uniform standard for collecting and coding this data would require a transition period – one which we cannot, at this time, estimate. We would be reluctant to do this unless such an effort were aligned with any potential reporting requirements that could be imposed outside of the Medicaid population. Until common standards are established and implemented, AEs should be permitted to report data in a way that reflects the variety in implementation across practices and EHRs – if this requirement is imposed and/or it remains an AE obligation.

Given this reality, we encourage EOHHS to consider whether this data collection and reporting requirement would be more efficiently implemented as part of the enrollment/re-enrollment process. In this way, data could be collected in a uniform way through a single point of entry. By centralizing, and not dispersing, this process the data collection and reporting process would be streamlined and made more efficient. This would also spare AEs and primary care providers a reporting burden when time and effort would be better deployed to patient care and care management initiatives.

Literacy

The state also proposes that AEs collect and report on the "literacy" level of AE members.

While we are well-aware of the intersection between literacy/education level and patient health, we are very troubled by this proposal.

Requiring practices to ask about, or to assess, patient literacy could seriously undermine the doctor/patient relationship. We do not see how this could be implemented within practices without significant disruption. Front-line healthcare professionals are not trained in this field and requiring them to pose questions that could make patients extremely uncomfortable will not benefit patients or patient care.

We would welcome the opportunity to work with EOHHS, the MCOs, our academic partners, and others to find ways to garner truly actionable information on patient literacy, health literacy, and education levels in ways that do not undermine the doctor/patient relationship or subject patients to a series of questions that prompt a negative experience while seeking needed healthcare.

For now, we encourage EOHHS to eliminate this proposed requirement.

SDOH Data Reporting

We believe the proposed requirement for AEs to report SDOH data in EHRs to the state's Quality Reporting System (QRS) is premature, particularly given the prospect of the state adopting an SDOH platform for the AE program.

This platform, rather than EHRs, might be the better source of this data given the fact such platforms are specifically built to collect, store, and report SDOH information. This is not a core function/role of EHRs and pursuing this path may not be the most efficient or effective route to collecting this data from AEs.

This is a premature decision that will limit the future flexibility of EOHHS, AEs, and MCOs that does not need to be – and should not be – made at this time. Instead, this decision should be postponed until after the state makes a decision about an SDOH platform. Postponing the decision does not limit future options for EOHHS. On the contrary, imposing this requirement now does limit and constrain EOHHS and the AEs prematurely.

Given this, we encourage the state to delay this decision to avoid imposing a requirement that may later be revised.

We have similar concerns about the proposal to require the collection of Z-Codes for health-related social needs. We believe any decision regarding this should be made *after* any decision is made regarding an SDOH platform. This would preserve the maximum flexibility for the state to ultimately adopt the most effective way for coding and collecting this information.

Z-Codes may in fact comprise the best possible structure for standardizing SDOH data. Yet, to the extent they currently exist, Z-Codes are an incomplete and extremely high-level series of protocols that address only certain social needs, and only in the most general possible terms. A prudent approach would avoid EOHHS boxing itself in and, instead, work with AEs and SDOH platform vendor(s) on the best way to standardize and capture important data – via Z-Codes or otherwise.

Attachment J – Accountable Entity Total Cost of Care Requirements

QPY4 (2021) Quality Targets

We have two concerns about the proposed method for setting QPY4 targets.

First, the state proposes using QPY2 performance data. We understand the logic behind not using QPY3 data given the impact of the COVID pandemic, however this seems to assume that 2021 will not be dominated by the pandemic as has the current year.

At this point in time, we see no reason for making that assumption. The most optimistic forecasts for a vaccine do not foresee one being available until about halfway through next year. Additionally, there is no indication how widely any vaccine will be available.

We applaud EOHHS for its responsiveness and flexibility over the past year relative to the COVID pandemic, and we have confidence that EOHHS will be similarly responsive and flexible in 2021 as the COVID pandemic plays out. However, it would be helpful if EOHHS were to formally acknowledge in this document that plans may need to be revised depending on the future pandemic-related developments.

Second, we are troubled by the short time between when the state will share proposed targets, mid-December, and when the state will finalize them, December 31, 2020. This is a very short time for AEs to analyze and comment on the proposed targets.

We urge EOHHS to provide more time for AEs to engage in a collaborative process of setting QPY4 targets.

Pre-Qualification of Accountable Entities Bearing Financial Risk

In *Attachment B: Pre-Qualification of Accountable Entities Bearing Financial Risk*, the state adds a new requirement for evidence that “secured liquid assets and reinsurance to cover maximum potential losses” are “secured in a controlled or custodial account.”

We believe this requirement is overly prescriptive and encourage EOHHS to remove this new, additional requirement.

Total Cost of Care Technical Guidance

In Section 5, *Calculated Shared Savings/(Loss) Pool*, subsection a, *Minimum Savings Rate*, we recommend EOHHS remove the minimum shared savings provision and allow AEs to share in first dollar savings.

In section 5, *Calculate Shared Savings/(Loss) Pool*, subsection c, *Risk Exposure Cap*, we recommend EOHHS remove the requirement for the AE and MCO to obtain an independent actuarial analysis for pursuing a downside risk contract agreement.

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.

Attachment K – Infrastructure Incentive Program: Requirements for Managed Care Organizations and Certified Accountable Entities

Infrastructure Incentive PM/PM

We understand that funding realities require EOHHS to decrease the Infrastructure Incentive PM/PM, however we believe that a cut of nearly 20% is excessively steep.

While we have realized some shared savings, the AE program is still in an early, developmental phase. At this point, AEs require continued investment that exceeds the gains AEs could realistically expect to achieve in shared savings. On top of this, AEs – like the healthcare system as a whole – are wrestling with the enduring impact of once-in-a-lifetime pandemic.

<u>REL Reporting</u>
Please see our comments above regarding the proposed requirement for AEs to collect Race, Ethnicity, and Language data. We do not believe imposing this requirement on AEs and primary care practices is the best path forward.

Should the state retain this requirement, we would like clarification of the REL reporting requirement. In this section AEs are required to report on the percentage of AE members with a PCP visit in the last two years for whom AEs have collected REL data. It would appear this is a retrospective requirement – with AEs expected to report data they were not, at that prior point in time, required to collect and not expected to report.

<u>Material Change in Population</u>
As we have in previous years, we urge the state to include a provision for a "material increase" in AE population to match the language accounting for a "material reduction."

We continue to believe that, just as it is reasonable to make an adjustment should an AE experience a significant decrease in population, AEs should be protected from a potential spike in attribution.

Language like this is even more important in the current economic climate where Medicaid enrollment is rising, and likely will continue to increase, due to the COVID pandemic.

Attachment M – Accountable Entity – Attribution Guidance (PY4)

<u>PCP Participation on Multiple AEs</u>
We urge the state to remove the new provision that would allow PCPs to participate in more than AE through different TINs.

We do not believe this will serve the AE program well as it will needlessly complicate administration and, in particular, quality initiatives. This will present a significant implementation challenge for AEs, and one for which there is no model or precedent as there are no other payer attribution programs in Rhode Island that allow for multiple provider affiliations.

<u>Attribution for Total Cost of Care Analysis</u>
We 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 little to no opportunity to manage newly attributed patients.
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 data. We encourage EOHHS to engage AEs and MCOs in ways to address these issues.

Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual

Outcome Scoring

We encourage the state to consider allowing AEs to earn "partial credit" on outcomes performance. As it is now, the state proposes that AEs will earn either "no credit or full credit."

We believe, in recognition of the developmental nature of the AE program, that AEs should be recognized for progress improving outcome performance.

Note: We believe there is a typo in the section describing the weighting of measures. The text on page 20 (non-redline version) states that "35% of the AE Incentive Pool allocation and 35% of the MCO Incentive Management Pool allocation will be determined by Outcome measure performance." The table, however, indicates that 45% will be allocated.

ED Use for Individuals Experiencing Mental Illness

The outcome measure that presents some of the greatest implementation challenges, *ED Utilization for Individuals Experiencing Mental Illness*, has the greatest weighting.

One significant implementation challenge is the fact that the daily ED reports AEs rely on do not identify ED visitors who meet the "experiencing mental illness" criteria. This requires AEs to review daily ED reports to identify qualifying patients. This is made slightly easier for our AE members with NHP-RI insurance as NHP-RI provides a quarterly report flagging such patients. We will be identifying AE members with UHC insurance who meet these criteria by analyzing claim data.

We have approached RIQI and begun conversations about the benefit to AEs if their reports could be modified to include a flag for patients "experiencing mental illness." We urge the state to actively support this request as this would be a significant benefit for AEs.

We would like a clarification regarding the new language for this measure referencing a 36-month lookback. How will this be implemented in instances when a patient's current MCO does not have utilization data for this period? Will AEs still be measured for patients for whom their current MCO cannot provide this data?

Note: If EOHHS *will be* evaluating AEs for patients who might not be identified as "experiencing mental illness" based on MCO data – by using three year data available to EOHHS – this could be corrected for through the RIQI ED reports if those reports drew on three years of data.

Finally, the documents state there are two ways to calculate performance for this measure. It is not clear how the decision regarding which method will be used will be made.

D. Concluding Comments

We thank EOHHS for the opportunity to provide comments on the proposed PY4 Guidance Documents.

We remain confident that together we can achieve the ambitious goals set for the AE program. Our comments above are offered in the belief they will help us move in the right direction.

We are ready at any time to offer supplemental comments or information.