UnitedHealthcare Community Plan of Rhode Island
475 Kilvert Street
Warwick, RI 02886

October 1, 2021

Jennifer Marsocci
Executive Office of Health and Human Services
3 West Road, Virks Building
Cranston, RI 02920
Submitted via email: jennifer.marsocci@ohhs.ri.gov

Re: Accountable Entity Roadmap PY5

Dear Ms. Marsocci,

UnitedHealthcare Community Plan of Rhode Island appreciate the opportunity offered by the Executive Office of Health and Human Services (EOHHS) to provide feedback on the revised Accountable Entity (AE) Roadmap. We support EOHHS on efforts towards ensuring program sustainability and improving health outcomes and member satisfaction.

We value the State's commitment to stakeholder engagement and look forward to continued collaboration. Should you have any questions or seek further information about the feedback provided, please do not hesitate to contact me by phone at (401) 732-7439 or email at pcooper@uhc.com.

Sincerely,

Patrice E. Cooper

Patrice E. Cooper
Chief Executive Officer
UnitedHealthcare Community Plan of Rhode Island

Rhode Island Health System Transformation Project Accountable Entity Sustainability Plan

A. Centralize key investments to achieve efficiencies that will reduce AE costs and enhance shared savings opportunities.

UnitedHealthcare Community Plan of Rhode Island appreciates the focus on efficiency and commends EOHHS for prioritizing the development of a statewide approach for assessing and addressing social determinants of health (SDOH). Through the commitment and investment in information technology infrastructure and data sharing with Unite Us, EOHHS will enable managed care organizations (MCOs), AEs, Health Equity Zones (HEZs) and community-based organizations (CBOs) to improve Rhode Islanders connection and access of local resources and supports to address social needs. The EOHHS and MCOs can use accurate, timely data collected from members, AEs and CBOs, in combination with clinical and utilization data, to identify priority areas to be addressed to improve health outcomes and reduce disparities demonstrated in our work with the Rhode to Equity projects.

B. Support achievement of shared savings through the total cost of care arrangements that AEs have with MCOs to provide some support for AE costs.

UnitedHealthcare appreciate EOHHS's continued interest in supporting system transformation and shared accountability across MCOs, AEs, and other providers. To ensure program sustainability, we encourage EOHHS and MCOs to continue working together to effectively evolve the total cost of care (TCOC) methodology over time. We recommend EOHHS consider gradually increasing the shared downside risk level and further aligning incentives and penalties across MCOs and AEs as part of that effort.

C. Obtain the authorities needed to provide reimbursement for high value services that require consistent support (e.g., Community Health Workers)

We support the proposed State Plan Amendment to reimburse for community health workers (CHWs) as a covered Medicaid service as CHWs are critical to improving care access and ensuring that our members receive the care they need, when they need it, to manage their conditions. We encourage EOHHS to deepen their commitment to CHWs and provide forums for the MCOs and AEs to share best care management practices, including best practices around staff training and performance metrics.

The COVID-19 pandemic intensified the negative impacts of SDOH faced by Medicaid beneficiaries nationwide, including food and housing insecurity. As EOHHS explores opportunities to add additional services and supports as Covered Medicaid benefits, we encourage evaluating these needs and the extent to which the state can work to address under current CMS authority, as well as with current federal aid. Improved health outcomes and individual goals cannot be attainted without fully addressing social needs. We welcome the opportunity to collaborate with EOHHS on exploring additional services.

D. Leverage contractual relationship with MCOs to increase the support of care management and social determinants of health (SDOH) activities.

Value-added benefits can be a strong tool in allowing MCOs to address critical SDOH needs of a population with benefits that otherwise would not be covered through a program. In-lieu of services can be leveraged by MCOs to offer an array of social care services that assist individuals and families with complex and acute health conditions. To encourage MCOs to develop unique value-added benefits and innovative in-lieu of services in addition to the base Medicaid benefit package, we recommend EOHHS:

- Continue to allow MCOs the flexibility to develop tailored benefits and programs. MCOs can leverage these tools to achieve program goals by providing individualized beneficiary supports and having the ability to emerging member needs, as with the pandemic.
- Maintain the current methodology of including the cost of these services in the numerator of the Medical Loss Ratio.
- Limit value-added and in-lieu of services to benefits that are currently not covered or cannot be covered by the Medicaid benefit package. This will ensure that benefit packages are designed to meet the needs of the covered populations and that MCOs are able to accurately measure utilization and bill for services provided through encounter data.
- Address the potential for "premium slide" in capitation rates that could result from effectively addressing SDOH. Having mechanisms in place to reward evidence-based investments in SDOH activities could encourage MCOs and CBOs to take meaningful steps in creating partnerships and addressing members' social needs.

E. Leverage multi-payer statewide policies to support AEs.

We encourage EOHHS and the Office of the Health Insurance Commissioner (OHIC) to work with health plans and providers to review lessons learned from existing models in the market to identify areas where meaningful alignment could occur across Medicaid, Medicare and commercial coverage. Successful VBP programs meet providers where they are and incent improvements in cost, quality and member experience. Providers are on varying paths in their journey towards accountability for outcomes and must have models tailored to their specific needs and abilities to set them up for success. In addition, tailored arrangements consider the diversity of patient populations and varying infrastructure support needs across providers. This flexibility to meet providers wherever they are and invest in their capacities to become ever more effective partners in managing care to deliver better outcomes is essential for delivery system transformation, TCOC reduction, and quality improvement. In offering services across the coverage continuum, we have found that it important to ensure that multi-payer approaches truly align incentives to create momentum for transformation, and do not unintentionally stall provider engagement or create adverse incentives that could increase costs or worsen disparities in health outcomes. We look forward to continue working with EOHHS, OHIC, AEs and other provider partners to deliver high-quality, cost-effective care to all Rhode Islanders.

F. Care Management Delegation

UHC recommends that all sites within an ACO become NCQA PCMH certified in order to delegate care management activities from the health plan to the AE. This includes any new sites that are to join the AE in the future. The health plan is held to NCQA standards, which is the gold standard in health care, and would also recommend the ACOs be held to the same standard. This will allow for our members and their patients to receive the best care and health outcomes possible. It will also allow for consistency and standardization across the health plan and AEs. Please note that if ACO sites are not PCMH certified by NCQA, this puts each health plan at a very high risk of losing NCQA Accreditation; therefore, not adhering to Medicaid contract requirements.

G. Quality and Outcome Measures

UHC appreciates EOHHS being receptive to feedback from the health plan regarding all elements of the AE program. UHC recommends that EOHHS continue to be receptive and use most recent data available to set quality and outcome measure targets. For QPY5, the health plan recommends not having a combined target for the outcome measures. It is too difficult for the health plan to support the AE not knowing what their interim rates are. If the health plan has its own benchmarks, we would be able to better support the AE. UHC also recommends all outcome measures be weighed equally. All of the outcome measures (e.g., utilization measures) are as equally as important to help improve health outcomes for our members.