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Executive Office of Health & Human Services/Medicaid
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Cranston, RI 02920
Attn: Charles Estabrook, MPH, Accountable Entity Program Manager

IHP Accountable Entity PY5 - Public Comments
Submitted by Rebecca Plonsky, LICSW, CEO of IHP

I. ATTACHMENT L - Accountable Entity Roadmap Document
Reprocurement

EOHHS is exploring opportunities to delegate the function of delivering certain care programs (e.g., care coordination, care management, etc.) from MCOs to AEs, and to require that AEs be reimbursed for delegated functions. Through the Request for Information, EOHHS requested feedback about the potential for care management and coordination functions to be delegated from MCOs to AEs.

When will the reprocurement occur?

II. ATTACHMENT M - ACCOUNTABLE ENTITY- ATTRIBUTION GUIDANCE
Population Eligible for Attribution to a Comprehensive AE. PCPs are Medical Doctors, Doctors of Osteopathy, nurse practitioners, or physician assistants in the following specialties: family and general practice, pediatrics, internal medicine, or geriatrics

IHP recommends EOHHS consider expanding this definition to include OB/Gyns as serving adults in a primary care capacity for attribution purposes.

III. ATTACHMENT H - Accountable Entities Certification Standards – Comprehensive AE (Program Year 5)

Complex Case Management (CCM) means applying evidence-based care management services delivered to members with multiple or complex conditions to obtain access to care and services and coordination of their care. CCM is provided to highest risk members with complex conditions and to high-risk populations such as, but not limited to, individuals with HIV/AIDS, mental illness, addiction issues or those recently discharged from correctional institutions. CCM functions, at a minimum, include a comprehensive initial assessment; delineation of available benefits and resources; development of an Individualized Care Plan (ICP) and prioritized goals, and monitoring and follow-up, and should address preventative care in addition to complex condition treatment. The member/family must be involved in the development of the ICP.

IHP has serious concerns about the lack of clarity regarding the transfer of CCM services from MCOs to AEs. Please clarify the following:

1. **What would be the funding for AEs to assume CCM and are AEs guaranteed that funding post PY5? IHP would not agree with a FFS billing model and would need a pmpm or annual rate for a certain amount of Nurse Care Managers.**
2. **How will AEs take on this role when across RI there are critical workforce issues both for staff retention and recruitment to support a CCM program?**
3. **What are the reporting requirements as there would be significant EMR enhancements that would be time consuming in expensive?**
4. **What responsibilities would the MCO retain in terms of CCM?**

b. Care Continuum: EOHHS lays out a comprehensive care continuum, with general members at one end and members with multiple or complex conditions at the other. The document also lays out what is expected of AE for each category of members.
    1. Health promotion: evidence-based education, self-management tools etc. for all members.
    2. Care coordination: "deliberate organization of member care activities between two or more participants …involved in the members care." This category appears to call for activities commonly carried out by community health workers, assistance with scheduling, transportation, referrals to community services amongst others.
    3. Care management: Tailored activities and goals to meet a members situation health related needs and documented in an Individualized Care Plan. Described as occurring during time-limited episodes, such as following an acute medical event or following a new diagnosis.
    4. Complex Care Management: Care management services to highest risk members. Must include comprehensive initial assessment, delineation of benefits and resources, development of an individualized care plan with prioritized goals, monitoring and follow-up and should address preventative care as well.

    AEs must develop and use risk segmentation to classify all members into above categories. They must then implement the care programs with multidisciplinary teams with expertise. All high and rising risk members must have an Individualized Care Plan developed with the patient/family.

    Care coordination must include at minimum:
    - Process for systematically identifying members who qualify
    - Member support in navigating care
    - Coordination of communication and care between all providers within and outside the AE.
    - Rapidly identify and respond to changes in condition.

    Care Management must include at minimum:
    - Process for systematically identifying members who qualify
    - Transitions of care approach
    - Collaboration with community and provider-based care managers
    - Coordination with SSO
    - Support and coordinate transport, DHS, RIDOH, Rite Smiles

Care Planning must include:

- ICP
- Licensed care management staff located in Rhode Island

Complex Case Management must include:

- Provision (or facilitation of access to) complex case management services. May work with contracted MCOs

The above represents a huge new lift for IHP. Not only are these new requirements, but they are poorly-defined, and it is unclear the role of the MCO vs the AE. Additionally, IHP has multiple member organizations, unlike other AEs, creating an additional coordination burden.

IHP recommends EOHHS implement these requirements gradually. In PY5, AEs could be responsible for identifying members for each category and implement health promotion and care coordination activities. In PY6, AEs could add care planning and referring members to the MCOs for complex care management.

c. 1.1.2.2. Population-specific primary care and behavioral health capacity to serve adults, including adequate internists, family practice clinicians, primary care geriatricians, and/or APRNs/PAs and adult behavioral health providers.

IHP recommends EOHHS consider expanding definition to include OB/Gyns as serving adults in a primary care capacity for attribution purposes.

IV. ATTACHMENT K – INFRASTRUCTURE INCENTIVE PROGRAM: REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND CERTIFIED ACCOUNTABLE ENTITIES

a. TCOC- For Program Year 5, the AE-Specific Incentive Pool Program Year 5: AEIP AE-Specific Incentive Pool (AEIP) Calculation PMPM Multiplier x Attributed Lives x 12 $6.49 at the start of each Program Year in accordance with EOHHS defined requirements.

IHP appreciates the additional funding to reinvest in our AE.

V. ATTACHMENT J - ACCOUNTABLE ENTITY TOTAL COST OF CARE REQUIREMENTS

C.4. - Attribution: TCOC performance period data must account for and be aligned with the list of attributed members MCOs are required to generate monthly, as described in the attribution requirements.

IHP recommends EOHHS consider assessing TCOC based on "monthly" attribution.

VI. Attachment A - Quality Framework

a. Target setting:

IHP recommends that EOHHS consider the ongoing pandemic and staffing challenges arising as a result and revise (lower) both the threshold and achievement targets for the three measures to 15% each.

b. New metrics:_EOHHS is considering dropping the childhood BMI/nutrition/activity metric and replacing it with an alternative pediatric measure.
   1. **Lead screening: IHP is concerned about how we would data capture. Please clarify how we would report out for this measure. IHP would recommend Lead screening as the replacement measure.**

VII. RHODE ISLAND ACCOUNTABLE ENTITY PROGRAM TOTAL COST OF CARE TECHNICAL GUIDANCE

a. Impact of Quality and Outcomes:

IHP is concerned that Quality scores cannot wipe out Shared Losses and would propose that the Quality influence/impact be consistent, regardless of savings/loss? Or can quality measures be tied to certain categories of care for TCOC gain/risk share purposes?

EOHHS reserves the right to include other adjustments as necessary based on program changes or emerging issues.

Though the aforementioned statement is seemingly meant to, in good faith, "protect" EOHHS with unforeseen catastrophe (e.g., COVID), concern remains for the AE and any potential fallout.

For example, the membership base may be artificially inflated during times when the State slowed on terminating eligibility. Moreover, if/when the State begins to ramp up terminating members, there is the potential that the average cost will rise to the degree that those leaving Medicaid eligibility are healthier and lower cost users. This, in turn, would impact TCOC outcomes. Additionally, to the degree the economy recovers, and people return to work, that would also affect eligibility, likely for a healthier segment of the population. Perhaps the actuarial/risk adjustments take such into account such changes during "normal" healthcare turnover, but do these models take into the dramatic influences of the pandemic and unemployment…and the influences of SDOH that undoubtedly play a major role.

Clarity of the statement is appreciated.

b. viii. Covered Services: Services included in the managed care program in the Baseline Years that are not covered under the MCO contract in the Performance Period.

IHP recommends that perhaps the inverse should be included as well…that is: Services included in the Performance Years that are not covered under the MCO contract in the Baseline Years.