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TCOC Technical Guidance	This AE supports EOHHS' decision to include the volume of historical deliveries in defining base period expenses for total cost of care. This AE has a disproportionate volume of birthing mothers in the RI Medicaid program and have long been concerned that price increases for maternity services in RI would unfairly affect our TCOC performance. Including adjustments for this in rate setting increases our confidence that targets are equitable among AEs in the program.	EOHHS appreciates the support in the decision to include the volume of historical deliveries in defining base period expenses for total cost of care.
TCOC Technical Guidance	This MCO requests a slight change to the dates found on p.15. These dates should reflect the 15th of the month following the months as reflected on the p.15 grid. The 15th of the month aligns with the Financial Data Cost Report (FDCR) from the MCO and is consistent with previous and ongoing submissions by the MCO, as agreed to by EOHHS.	EOHHS has made the corrective edit to the grid, in order to provide clarity.
TCOC Technical Guidance	AEs and MCOs must be strategically and financially aligned if we are expected to continue to join together under value-based arrangements. The current Medicaid AE Total Cost of Care (TCOC) model is broken if it results in the level of AE-MCO misalignment that the global cap is designed to fix. Therefore, we encourage EOHHS to move towards a model where MCOs and AEs are held to the same target, such as a percent of premium model. Additionally, EOHHS has verbally indicated that MCOs and AEs may enter into alternate value-based arrangements, so long as these arrangements are presented to EOHHS for approval. Attachment J and the Total Cost of Care Technical Guidance do not clearly articulate this intent; in fact, they state that MCOs and AEs must comply with the TCOC methodology. We therefore ask that EOHHS clearly state that MCOs and AEs are encouraged to enter into alternative value-based arrangements, so long as they are a Category 3 or Category 4 APM, as defined by the Health Care Payment Learning & Action Network (Source: https://hcp-lan.org/apm-framework/).	EOHHS will consider opportunities to provide greater flexibility in AE-MCO contracting, while maintaining stability and predictability, and avoiding excessive administrative burdens on AEs in managing different contracts. EOHHS will continue to consider improvements to the TCOC methodology and welcomes feedback from MCOs and AEs on this methodology. EOHHS appreciates your comments on Value Based Payment and looks forward to your continued partnership in future work in payment reform once

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		the Managed Care procurement has concluded.
TCOC	This AE does not support EOHHS' approach to the total cost of care methodology. Per previous versions of the sustainability plan: "The specific terms of the savings and risk transfer to the AE are at the discretion of the contracting parties", but over time EOHHS has reclaimed greater and greater control over the risk transfer program. The new language in the roadmap: "The specific terms of the savings and risk transfer to the AE are at the discretion of the contracting parties, however EOHHS has set minimum standards for risk sharing and a specific Total Cost of Care methodology" appears to contradict itself so completely as to not be clear what it means. To be sure, if EOHHS prescribes a specific Total Cost of Care methodology, it cannot also leave the specific terms of the savings and risk transfer to the AE at the discretion of contracting parties. Additionally, EOHHS has modified the Total Cost of Care Methodology since reclaiming the right to specify its terms, introducing global caps on payments to AEs that transfer financial risk away from MCOs and towards AEs. AEs do not have the right to make alternative contracting arrangements within the AE program and must seek to do so outside the AE program. This AE views this as a critical flaw of the AE program, fully self-inflicted by EOHHS and continues to recommend that EOHHS reverse course on this critical policy error.	EOHHS appreciates your comments on Value Based Payment and looks forward to your continued partnership in future work in payment reform once the Managed Care procurement has concluded. EOHHS is open to discussions about how to incorporate different Value Based Payment Models into the AE program. EOHHS does not currently disallow the use of other payment models in combination with the EOHHS designed and maintained TCOC model.
TCOC	We strongly recommend the withdrawal of the Global Shared Savings/Loss Cap implemented in PY6 (p. 5). A global cap with clawback provisions runs counter to EOHHS's goals to advance and promote value-based payment arrangements. This cap, in concert with the elimination of a defined HSTP PMPM (Attachment K), does not promote AE sustainability.	The Global Shared Savings/Loss Cap will remain in place.

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Incentive Program	This AE recommends that EOHHS release a range of possible per member per month (PMPM) values for the funding of the AE program year (PY) 7 incentive pool. While we recognize that funding the pool with "leftovers" from previous years can create some uncertainty, we also believe most of the funding is known and identified, and that EOHHS could assist AEs in budgeting for upcoming years by being more transparent about likely PMPMs.	EOHHS thanks you for your recommendation. EOHHS cannot determine calculations of the PMPM until it is known whether targets have been met by the AE, as this factor decides on how much funding is allocated over to the next program year.
Incentive Program	The Plan All-Cause Readmissions and Potentially Avoidable ED Visits funding allocations (%) in the table on page 8 add up to 60%, which is the amount allocated for FQHC-based AEs remaining in shared savings only contracts. We'd ask that EOHHS clarify the metric-specific allocations for non-FQHC shared-savings AEs as well, which should amount to 65% based on EOHHS's revised weighting.	EOHHS has made the corrective edit to reflect the annual outcome measure specific weights for non-FQHC AEs, which equates to the 65% allocation.
Incentive Program	This AE recommends that EOHHS remove the requirement that 10% of incentive funds be spent on partnerships with providers of specialized services. The reduced PMPM funding for PY7 will have unintended consequences relative to these partnerships. Many partnerships may need to be eliminated or redesigned to be delivered under reduced funding. AEs should be trusted at this point to make the appropriate investments to manage cost and quality.	EOHHS thanks you for your recommendation. We are committed to improving health equity and addressing health related social needs and behavioral health. As well as enabling clinical-community linkages and improving the relationships that extend beyond traditional health care providers. In the absence of the HSTP Project Plans, it's essential that we continue to develop and build robust collaborations between AEs and partners who provide specialized services, to support behavioral health

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		care, substance abuse treatment and social determinants. Therefore, EOHHS intends to keep this requirement.
Incentive Program	We ask that EOHHS strike the requirement on page 9 that states "AEs shall be required to demonstrate that at least 10% of Program Year 7 incentive funds are allocated to partners who provide specialized services to support behavioral health care, substance abuse treatment and/or social determinants." Given how small the HSTP allocation will be, we ask that EOHHS not be prescriptive about how it is spent.	Please refer to response above.
Incentive Program	HSTP Project Plans are completely eliminated. While the federal source of incentive funding is ending – with no plans for an alternative replacement EOHHS fails to recognize and retain the benefit of this process: ○ HSTP Project Plans ensured overall coherence for the entire AE project – across all AEs, across all MCOs, and across all AE/MCO dyads. HSTP Project Plans had to align with and advance the broad goals of the AE program and priorities of EOHHS. How will EOHHS ensure this without benefit of HSTP Project Plans? ○ HSTP Project Plans ensured a common foundation for each AE with both/all MCOs. We developed ONE plan, with ONE set of measures, for BOTH MCOs. This prevented fragmentation and needless program variation, both of which would undermine AE effectiveness. EOHHS needs to protect against this occurring. Eliminating the HSTP Project Plans while creating no alternative will dilute the overall effectiveness and programmatic coherence of the AE initiative. EOHHS needs to develop an alternative.	EOHHS is committed to improving health equity and addressing health related social needs. Additional information will be provided upon the awarding of new Managed Care contracts. We thank you for your recommendation regarding the Community Care Hub and are open to evaluating the feasibility of this model.

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	Language and program changes related to health-related social needs combine to seriously dilute the AE program's commitment to addressing social drivers of health (SDOH). HSTP funding is not the only tool at EOHHS's disposal to advance important reforms. EOHHS has a role to play convening stakeholders – government, payers, systems of care, providers, community-based organizations, residents and community members, etc. – to work together to build an effective system to address health-related social needs. We urge EOHHS to look at the Community Care Hub model and to consider the role it could play advancing this model in Rhode Island: https://www.partnership2asc.org/medicaidplaybook2022/ At the same time, we urge EOHHS to reconsider its decision to terminate funding the community referral platform – particularly in light of new referral and reporting requirements which the platform would support. This decision by EOHHS spins off a currently centralized investment AND increases that cost as the CRP will no longer be eligible for the federal match.	
Certification Standards	This AE supports the decision to reduce the administrative burden tied to recertification by extending the validity of each recertification to two years.	EOHHS appreciates the support for the change to a biennial recertification cadence.
Certification Standards	We support the move to bi-annual Certification.	EOHHS appreciates the support for the change to a biennial recertification cadence.
Certification Standards	We do not understand why EOHHS is eliminating language calling for AEs to have *"a critical mass of providers and community partners that are*	EOHHS reduced domain introductions in order to condense and remove

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	interdisciplinary with core expertise/direct service capacity in primary care and in behavioral health, inclusive of substance use services." [Page 6] This should be a basic expectation for all AEs.	duplicative language. This language can still be found within standard 1.1.1.
Certification Standards	The following cut represents a significant dilution of EOHHS's expectation that AEs will address health-related social needs: *The AE further needs to demonstrate defined relationships with providers of social services and community-based organizations in order to meet the needs of the member so that the member may live the most productive and meaningful life within their community*. [Page 6] The expiration of infrastructure funds and proposed termination of the CRP contract do not require this. EOHHS must maintain a commitment to, and expectation that AEs and MCOs maintain a commitment to, addressing social drivers of health. EOHHS should retain this language.	EOHHS reduced domain introductions in order to condense and remove duplicative language. EOHHS is still committed to supporting AE and MCOs in helping address health related social needs. This language can still be found throughout domain 1.
Certification Standards	EOHHS should also retain following language proposed to be cut: *Health-related social needs can play a crucial role in the health status and outcomes of Medicaid recipients. These include unstable housing/poor housing conditions, food insecurity, and exposure to safety risks and domestic violence, as well as many other factors. When unmet, health-related social needs raise stress levels and allostatic load, impact the progression of health conditions, impact the ability to procure meaningful employment, impact the ability to mitigate health risks, and impact the ability to access health care.* *A core objective of the AE initiative is to advance and enable the systematic integration of efforts to improve health-related social needs/social determinants of health and medical/BH care. [Page 8]*	EOHHS reduced domain introductions in order to condense and remove duplicative language. This language can still be found throughout domain 1 and is defined in standard 1.1.2.4. To clarify, the language pertaining to building partnerships with community-based organizations through IT infrastructure, has not been removed. Only the language pertaining to the implementation of a community resource platform has been removed.

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	Additionally, while EOHHS proposes terminating the CRP contract, we see no reason for the following proposed cut. This option should be retained: *Building partnerships with community-based organizations can also be achieved through IT infrastructure and implementation of a Community Resource Platform (CRP), as described in the HSTP Social Determinants of Health Investment Strategy. [Page 16]*	As stated in the Roadmap, upon the expiration of EOHHS' contract with Unite Us, MCOs and AEs may continue to utilize the platform through purchase of individual licenses.
Certification Standards	In light of EOHHS's decision to not renew the CRP contract, the following is now, effectively, an unfunded mandate on the AEs: *AEs must have a documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include:* ▪ *Standardized protocol for referral to social service provider* ▪ *Methods for tracking referrals, including follow-up, until referral report has been received* ▪ *Monitoring the timeliness and quality of the referral response* ▪ *Development of metrics to define a successful referral* ▪ *Development and implementation of standards and reporting of metrics and referral information to MCO* *Note: AEs may leverage the Unite Us tool procured by the state to satisfy this requirement. [Page 21]* It is ironic that EOHHS is increasing SDOH referral, reporting, and performance expectations at the very moment it is eliminating funding for the tool which makes it possible for AEs to meet these expectations. If these expectations had been coupled with the rollout of the CRP, uptake and utilization of the CRP would surely have been higher. If this had been part of a facilitated change-management process that reached across state government, involved payers, and provided incentives and support to community-based organization, uptake and utilization of the CRP would	The language included in Section 5.2.3 is not an addition but rather a clarification. As stated in prior program years, the requirement has always been that AEs will develop a standard protocol and a documented plan for social needs referrals using evidence and experience-based learning, and for tracking referrals and follow-up. This includes closed-loop referrals and providing support to maximize successful referrals.

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	surely have been higher. More importantly, AE members would have benefitted from a robust system for addressing health-related social needs. If EOHHS does not reconsider this decision and now engage in a comprehensive adoption/change management process, this will have been a lost opportunity.	
Certification Standards	Page 2 states "Certification standards may be updated bi-annually." We believe this is a typo, and it should instead say "biennially", or every two years. Similarly, page 4 states "All AEs must be re-certified bi-annually. AEs that had been 'Certified with Conditions' must demonstrate the agreed-upon progress toward meeting stated conditions in order to be re-certified for the following bi-annual year;" and "Certification takes place bi-annually…" We ask that you clarify that this is biennial, or once every two years, as opposed to twice-yearly.	EOHHS has made the corrective edit to all language pertaining to "bi-annually" and has revised the language to "biennially" in order to provide clarity.
Certification Standards	We are supportive of the updates to Section 2.2.2.1 (adding "or" between "primary care providers" and "behavioral health providers" and changing "Internal Medicine primary care provider" to "Adult primary care provider"), as they add clarity to Board or Governing Committee membership requirements.	EOHHS appreciates the support for this update in order to provide clarity.
Certification Standards	EOHHS is proposing the following new requirements in italics: "AEs must have a documented plan for the tracking and reporting of referrals for social needs to MCO. The plan should include…" "Methods for tracking referrals, *including follow-up, until referral report has been received*" "*Monitoring the timeliness and quality of the referral response*" (Section 5.2.3, p. 21) These added requirements are unrealistic and overly burdensome. EOHHS should not hold tracking and monitoring for social needs referrals to higher standards than those for health care referrals. AEs are not in a	The language included in Section 5.2.3 is not an addition but rather a clarification, to ensure the standard is further defined and clear. As stated in prior program years, the requirement has always been that AEs will develop a standard protocol and a documented plan for social needs referrals using evidence and

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	position to impose standards and requirements on community-based organizations, other than those few with whom we contract directly. Imposing such requirements without commensurate investment in CBOs is inequitable and counterproductive to the goal of community-clinical partnerships. Additionally, this would require an investment in EHR modifications for this AE at a time when all HSTP funding has been eliminated. We therefore ask that EOHHS strike all proposed additions to Section 5.2.3.	experience-based learning, and for tracking referrals and follow-up. This includes closed-loop referrals and providing support to maximize successful referrals.
Certification Standards	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, AEs must be funded to perform these activities and MCOs must be held to these standards to align conceptual and AE requirements.	EOHHS thanks you for your recommendation. Additional information will be provided upon the awarding of new Managed Care contracts.
Certification Standards	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.	EOHHS thanks you for your recommendation. We will continue to seek to further align AE and MCO requirements in the future.
Certification Standards	We do not feel that PY7 is an appropriate time to add new requirements to the AE program, and we appreciate that EOHHS has kept such additions	The language included in Section 5.2.3 is not an addition but rather a

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	to a minimum. We ask that EOHHS remove the new requirements in Attachment H, Section 5.2.3.	clarification, to ensure the standard is further defined and clear. As stated in prior program years, the requirement has always been that AEs will develop a standard protocol and a documented plan for social needs referrals using evidence and experience-based learning, and for tracking referrals and follow-up. This includes closed-loop referrals and providing support to maximize successful referrals.
Attribution	We request EOHHS convene an AE/MCO workgroup to evaluate the current attribution/ assignment processes. Based on our experience, we believe there are fundamental flaws with the models used and opportunity for improvement. This process would greatly benefit from active EOHHS leadership.	EOHHS thanks you for your feedback. Although, we do not have any current plans to change the attribution methodology we will continue to reevaluate program methodologies and welcome specific feedback on perceived flaws.