



July 24, 2017

The Honorable Eric J. Beane, Secretary
Executive Office of Health and Human Services
Hazard Building
74 West Road
Cranston, RI 02920

VIA E-Mail

Re: Draft OHHS Total Cost of Care (TCOC) Guidance

Dear Secretary Beane:

Thank you very much for the opportunity to provide comments on the Draft Total Cost of Care (TCOC) Guidance. We appreciate the commitment your office has made to seek the input of Accountable Entity partners.

The attached document provides detailed comments on the Guidance. Should you or others at EOHHS wish to discuss any of the issues discussed in our comments, we would be happy to meet at any time. The overall objective of our comments is to ensure the long-term viability and integrity of the Accountable Entity initiative. We share your belief this model holds the potential to realize better care, better health, and smarter spending for Medicaid beneficiaries in Rhode Island.

Again, thank you for the opportunity to review and comment on the proposed Guidance. We look forward to working with you and your staff on this initiative.

Sincerely,

A handwritten signature in black ink that reads "Garry Bliss".

Garry Bliss
AE Program Director
Integra

A handwritten signature in black ink that reads "James E. Fanale, MD".

James E. Fanale, MD
EVP, Chief Operating Officer/Chief Clinical Officer
Care New England Health System

A handwritten signature in black ink that reads "Dale Klatzker, PhD".

Dale Klatzker, PhD
Senior Vice President
Population Health Management
Care New England Health System

A handwritten signature in black ink that reads "John Minichiello".

John Minichiello
Executive Director
Integra

Cc: Deborah Florio, Domenic Delmonico, Deborah Morales, Deb Faulkner, Rick Jacobsen, Maria Narishkin



Integra's Comments on the OHHS Total Cost of Care (TCOC) Guidance

- In addition to ensuring a sustainable business model that is trusted by all parties, OHHS should also aspire to create an attractive model so that all provider systems will participate. Providing greater financial incentives for being inside the AE program does not guarantee statewide participation. Statewide participation is critical.
- Adequately protect the solvency of AEs, MCOs, the RI Medicaid Program, *and RI providers*.
- OHHS should commit to complete data sharing and transparency, both prior to commencement of the agreement, and throughout the duration of the agreement.
- Require consistent, efficient approaches by the MCOs and survey AEs regarding MCO performance annually. MCOs should be held to a consistent standard in their efforts at contracting, data sharing, risk adjustment, quality metric management, patient engagement, and timely claims payment. Please provide the list of covered services that are included in the OHHS's contract with the MCOs.
- As proposed, OHHS should include an allowance for retained savings and the historical adjustment.
- With such uncertainty in the early stages of the model, defer addressing random variation and the probability of achieving shared savings until future years.
- Consider the loss cap as a percentage of total AE revenue, and not targeted expenditures.
- Will the historical TCOC base account for outstanding claims due Rhode Island providers, but not yet paid? How will this be accounted for?
- For at least the first year, quality should be a reporting only performance measure. Providers should not be held accountable for quality outcomes until year 2. Shared savings distributions must be scaled appropriately. While the importance of including quality performance is not debatable, the impact of this performance on shared savings should be discussed.
- Experience in the AE pilot has shown great fluctuations in member enrollment from month to month. These membership swings wreak havoc when comparing base and future period trends, and will have a significant impact on changing the risk profile. These statistically significant variations need to be further analyzed and addressed so that AEs can have some comfort in taking downside risk.
- AEs should be eligible for up to 70% of the shared savings pool without assuming downside risk. When assuming downside risk, AEs should be eligible for up to 80% of the shared savings.
- How will AE TCOC budgets be impacted by federal and state Medicaid program funding cuts?
- Regarding having the TCOC methodology include infrastructure payments made to AEs (e.g. care management, utilization management), shouldn't payments for these services be deducted from plan administrative overhead?
- Include the ability for AEs to purchase reinsurance independently.