Comments on AE PY4 Roadmap and Sustainability Plan

Integra is strongly committed to the success of the Medicaid Accountable Entity program, and to our programmatic and financial success within it. We commend EOHHS for developing this preliminary plan, and appreciate the opportunity to offer our comment.

We recognize the constraints under which EOHHS operates: limited budget, limited federal authority, an entrenched existing payment/delivery model, and a vocal and diverse stakeholder base. We acknowledge that the plan presented in the September 10 draft reflects these constraints. However, we find that the proposals, especially those related to the long-term financial sustainability of the program, do not seem to adequately grapple with the challenges that AEs face, and do not offer sufficient concrete options to allow AEs to continue after the lapse of HSTP funding.

We strongly recommend that EOHHS offer a revised sustainability plan that includes at its center a solid commitment to a predictable administrative funding stream for Accountable Entities, in recognition of the central role that the AE program plays in EOHHS’s vision for transformation of the Rhode Island health care delivery system.

Some specific comments and recommendations follow:

General comments on the AE Roadmap

Implementation of the AE program through Managed Care. We understand the value to the state of continuing to manage the bulk of the Medicaid program through the existing managed care contracts. We would recommend, however, that EOHHS look carefully at whether the current contracting model introduces inefficiencies. We also strongly encourage EOHHS to make it possible, as specified in its March 2019 policy statement, for an Accountable Entity to contract with a single MCO and retain its full attributed membership.

In our PY3 recertification application, AEs were required to “identify concrete ways in which their MCO contracts and partnerships are being leveraged to assist the AE in achievement of the advanced standards in domains 4-8.” We encourage EOHHS to require MCOs to answer the same question: how are AE contracts being leveraged to support the achievement of the state’s goals? We believe that visibility into how MCOs answer that question will help inform our collaboration in the years to come.

Comprehensive AE TCOC methodology. Integra is supportive of the Milliman-designed TCOC methodology in use in PY3 of the program, and is grateful to operate under a single consistent risk model. We note that although there is a single state-specified model, each MCO is asked to articulate that model independently in their AE contracts. This led to a great deal of confusion, inefficiency, and delay in the execution of our PY3 AE contracts. We strongly recommend that EOHHS develop standard contract language for TCOC and other key features of the program, and require MCOs to use that standard language in their contracts with AEs.

Budget template for PY4 AE certification. In thinking about collecting data on AE budgets for evaluating sustainability, we encourage EOHHS to think about timing. If this information is being collected for PY4 certification, it will presumably take at least a year for EOHHS to analyze the budget information and propose a resourcing plan for AEs. Until that plan is in place, HSTP will remain the primary source of funding for AE operations; can EOHHS commit to level funding HSTP incentive dollars through PY5?
**Specialized AE Program.** Integra will follow with interest proposals to implement an APM model for LTSS focused specifically on preventative care and services. We look forward to opportunities to provide additional public comment on the details of a proposed Specialized APM model through the MMP program.

**Specific comments on the sustainability plan**

**By centralizing key infrastructure EOHHS expects to achieve efficiencies that will reduce costs.**

In principle, this strategy makes sense: EOHHS is offering to centralize costs for resources that otherwise an AE would have to fund on its own. In practice, however, the specific technologies proposed would not represent significant cost savings to Integra.

- The care management alerts, quality reporting system, and CurrentCare do not represent operating costs today.
- The proposed Community Referral Platform could potentially represent a reduced cost to Integra if we were able to terminate our existing referral platform contract in favor of the state’s, but that cost is quite low compared to other operating costs, and would not materially impact program sustainability.
- We are puzzled by EOHHS’s characterization of the Health Equity Challenge proposal as “centralized infrastructure,” and do not understand how it represents an efficiency or addresses sustainability.

EOHHS anticipates that shared savings from the total cost of care arrangements that AEs have with MCOs will provide some support for AEs.

Shared savings earned through reducing costs are, indeed, central to the financial sustainability of any accountable care program, and we expect to make every effort to maximize our shared savings revenue. We support the consolidation to a single TCOC model, although we do not believe it is accurate to stake a great deal of savings on the proposition that “by controlling the TCOC target development, EOHHS reduced AE costs to engage with the process, because AE staff need only spend time on one model.” Our operating costs related to “engaging with” the MCO’s TCOC models were minimal.

We also support the new risk adjustment approach and the market adjustment factor. We encourage EOHHS to consider increasing the adjustment for “efficient” AEs as rapidly as possible, and to monitor the risk adjustment methodology to make sure it adequately accounts for the acuity of the population.

We offer the following cautions: earning meaningful shared savings in the early years of an accountable care program—especially a Medicaid program—is very difficult. Under even our most optimistic projections for PY3, PY4, and PY5, it is difficult to assert with confidence that we will be able to generate enough shared savings to fully cover our operating costs. We are concerned that EOHHS does not appreciate the difficulty in generating sufficient return on investment through cost-reduction programs for this population. In the absence of an alternative source of operating funding, we will not be able to continue to operate all of our programs.

We also note that while shared savings, and the incentive to reduce cost, are an important part of EOHHS’s management of and funding for managed care organizations, MCOs are not expected to operate their programs solely based on shared savings revenue. On the contrary, MCOs receive a predictable and generous administrative payment, in acknowledgement of the expense needed to successfully manage this complex population.

EOHHS has stated publicly many times that the AE program is central to Rhode Island’s Medicaid strategy. In that case, **EOHHS should commit a predictable administrative funding stream to AEs**, to ensure that variations in cost performance do not force an AE to drop out of the program because it is not financially sustainable. **We propose that EOHHS require each MCO to provide their contracted AEs with a monthly administrative payment equal to at least one percent (1%) of the month’s aggregate medical capitation for that AE’s attributed members.**
EOHHS will work with AEs to obtain the authorities needed to provide reimbursement for high value services.

Offering Medicaid reimbursement for AE services could be a meaningful way to reduce AE operating costs. We have some concerns that moving programs like community health worker services into the health care claims payment space could have the effect of “medicalizing” a set of effective interventions that are currently more rooted in social work and the community, and we encourage EOHHS to work with AEs to ensure that the intent and function of existing programs are not distorted by new reimbursement models. CHW relationships are built on trust, and that dynamic may not be well-served by incentivizing volume through traditional time-based billing.

At the same time, we hope that EOHHS will broaden the potential set of reimbursed services beyond community health workers, and consider whether nurse care managers, social workers, and consulting pharmacists could potentially be reimbursed for care management efforts on behalf of Medicaid enrollees.

We also note that any newly reimbursable service raises questions of the timeline for federal approval and the availability of funding to provide the state match.

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

Integra notes with some concern that none of the items in this section include an explicit commitment of funding for AEs.

While we agree that a substantial amount of AE activities are related to care management and coordination, and while we believe that an AE has the potential to be more effective at care management than an MCO, we are not interested in taking on full delegation of an MCO’s care management responsibilities, with all of the legal, regulatory, and compliance requirements that come with them. **We strongly encourage EOHHS to reconsider the proposal to require that care management be fully delegated to AEs** and note that, if this does become a requirement for continued participation as an AE, Integra would likely consider exiting the program. We look forward to clarification of EOHHS’s intentions in this area.

We would like further clarification on the proposal to allow MCOs to include SDOH investments in the MLR numerator. Specifically, is this signaling EOHHS’s intent to move responsibility for addressing SDOH away from AEs and to the MCOs? Or is it intended to create flexibility for MCOs to fund AE initiatives that address SDOH? If the latter, we encourage EOHHS to say so explicitly.

We strongly support finding ways for MCOs and AEs to collaborate on member engagement. We urge EOHHS to encourage MCOs to support meaningfully integrated member communications, such as co-branded marketing materials and member ID cards.

EOHHS will leverage multi-payer, statewide policies to support AEs.

Integra generally supports the proposal to require Medicaid MCOs to contribute funding towards PCMH. A more robust investment in PCMH could be a source of funding for an expansion of existing PCMH programs to include the Medicaid population. We imagine that the current PMPM contribution level would not be sufficient to meet the needs of the Medicaid population, and encourage EOHHS and OHIC to develop a Medicaid PCMH investment requirement that is higher than the current PMPM. However, we do not believe that PCMH investment alone would be sufficient to sustain HSTP-funded AE population health programs at their current level.