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Integra Public Comment on AE Program PY3 Documentation

Executive Summary

Integra greatly appreciates the opportunity to provide comments on the draft program design for Performance Year 3 of the Accountable Entity (AE) program. We are committed to the success of the AE program, and look forward to continued collaboration with EOHHS and the Managed Care Organizations (MCOs) to advance the core objectives envisioned for the AE program.

Integra supports the overall direction EOHHS has outlined in the AE program, including the core pillars of the AE program structure. Integra applauds many of the modifications EOHHS proposed for Program Year 3. As previously shared, Integra appreciates efforts to simplify and standardize the AE program and continues to recommend that EOHHS be specific and prescriptive about the form, content, and standards for a single AE certification and Health System Transformation Project (HSTP) submission to eliminate unnecessary administrative burden.

Integra embraces the progressive movement from volume-based to value-based payment arrangement. Integra has offered feedback to EOHHS that the AE program is not mature enough to move to downside risk in PY3, which has been echoed by the MCOs and other AEs. We recommend EOHHS delay the implementation of downside risk until the PY3 proposed program structure changes have been implemented (i.e. IHH attribution, risk adjustment), the AE program has a baseline experience with the revised programmatic elements, the attribution challenges have been ameliorated, and a meaningful analytic capacity using claims and cost data has been built. This will allow Integra to project our performance with enough confidence to be able to make an informed decision about moving to downside risk.

The comments in this document do not yet include our review of the recently-released "Total Cost of Care Technical Guidance." We strongly encourage EOHHS to incorporate that document into Attachment J to ensure that all program requirements are in one place.

For each comment in this document, we have listed a "priority" which is our attempt to reflect how important we believe the issue is to the success of the Medicaid AE program.

- Comments marked as **Priority 1** are **critical**: Integra will re-evaluate our ability to continue in the AE program beyond PY2 if comments are not addressed.
- Comments marked as **Priority 2** are **important**: the indicated guidance raises significant concerns.
- Comments marked as **Priority 3** are **recommended**: Integra believes that our comments would improve the program.

Comments on Attachment H: AE Certification Standards

Executive Summary

Integra appreciates the thoughtful approach and detail outlined in Attachment H-Accountable Entities Certification Standards-Comprehensive AE. Integra fully supports the requirements outlined in the Domains for Certification, especially the focused activities needed to address the integration of behavioral health and social needs of the Medicaid populations. We appreciate the transparent public stakeholder engagement process in the development of the guidance documents.

Integra offers the following comments and request for clarification on specific sections of the draft Certification Standards. In particular, we recommend significant clarifications regarding the role of behavioral health providers described in the document. Integra is also concerned with the PY3 clinical data exchange requirements and the uncertainty about the role that IMAT will play statewide.

Detailed Comments

Page	Topic	Comment	Priority
4	Certification Period and Continued Compliance with Certification Standards	Error in second sentence: "AEs are required to comply ~~will~~ with all standards and requirements throughout the certification period."	3
6	1. Breadth and Characteristics of Participating Providers	The document does not define "Participating Provider." Are participating providers only those primary care providers that have an attributed panel?	2
7	1. Breadth and Characteristics of Participating Providers	The "Mental Health and Substance Use Disorder (Behavioral health (BH) capacity [sic]" section introduces the capitalized term "Provider Partnerships" but does not define it. What is a Provider Partnership, and how do AEs demonstrate evidence of it?	2
7	1. Breadth and Characteristics of Participating Providers	"Behavioral health capacity shall be commensurate with the size and needs of the attributed population…" Behavioral health capacity is the responsibility of the MCO, who establishes and manages the network of behavioral health providers who are available to provide services to enroll members. It is not clear what the requirement on the AE is. EOHHS should remove this section, clarify the requirement, or permit AEs to meet the requirement through executing an AE	2

Page	Topic	Comment	Priority
		agreement with a Medicaid MCO (as suggested at the bottom of page 5).	
7	1. Breadth and Characteristics of Participating Providers	"Direct service capacity within the AE shall be evidenced by the participation of Rhode Island licensed providers. MCOs, not AEs, have the responsibility to credential providers based on licensure and other factors, so it is not clear what the requirement on the AE is. EOHHS should remove this section, clarify the requirement, or permit AEs to deem the requirement as met through executing an AE agreement with a Medicaid MCO (as suggested at the bottom of page 5).	2
7	1. Breadth and Characteristics of Participating Providers	"AEs … must make available community-based treatment utilizing all federally approved Medication Assisted Therapies…" The availability of specific services and providers is the responsibility of the MCOs, who establish and maintain the behavioral health network. It is not clear what the requirement on the AE is. EOHHS should remove this section, clarify the requirement, or permit AEs to deem the requirement as met through executing an AE agreement with a Medicaid MCO (as suggested at the bottom of page 5).	2
8	1. Breadth and Characteristics of Participating Providers	"In addition, BH practitioners will adhere to guidelines that incorporate dignity and worth of the individuals served…" The AE does not necessarily include behavioral health providers as participating providers, and does not oversee the guidelines of practice for behavioral health providers. It is not clear what the requirement on the AE is. EOHHS should remove this section or clarify the requirement.	2
9	1.1.2	Is it EOHHS's intent to require AEs to explicitly include pediatric and adult behavioral health providers in its list of participating providers?	2

Page	Topic	Comment	Priority
9	1.2.1	Missing words in first sentence: "Certification that all AE participating providers have agreed to participate in the AE,"	3
12	2. Corporate Structure and Governance	"Governing Board of Directors or Governing Committee shall meet regularly, not less that quarterly." Integra appreciates this change from bi-monthly to quarterly.	3
13	2.2.2 Board of Governing Committee Membership	Integra recommends that EOHHS offer broader flexibility regarding the composition of an AE's Governing Committee and Community Advisory Committee	2
15	4.1.1.2.1 Core Data Infrastructure and Provider and Patient Portals	Achieve "State 2 Meaningful Use" requirements based on CMS EHR Incentive programs or equivalent standard subject to EOHHS approval…. Integra has concerns with this requirement for PY3 given the complexities of the IMAT certification requirements and the nexus of the HEDIS reporting requirements. Please see our comments on the "Draft Implementation Manual" included with our comments on Attachment J.	1
23	7. Member Engagement	"Social media applications and telemedicine can be used to promote adherence to treatment and for support and monitoring of physiological and functional status of older adults. Recognizing that many of these new technologies for health status monitoring and health promotion are not currently covered benefits…" Please clarify the how this aligns with the MCO contract Section 2.06.01.07 Telehealth (page 76) and Attachment A Schedule of In-Plan Benefits In Lieu of Services (page 38) Medically appropriate smart phone application.	3

Comments on Attachment J: TCOC Requirements

Executive Summary

Integra concurs with EOHHS that effective TCOC methodologies incentivizes AEs to invest in integrated care management that meet the member needs and reduces duplication of services. We appreciate the proposals to modify the TCOC guidelines to streamline and standardize the TCOC process with the goal of creating meaningful performance measures and financial incentives to reduce cost and improve access to quality healthcare for Medicaid beneficiaries.

Integra has serious concerns about the movement toward downside risk, the attribution challenges, and the misaligned responsibilities for the TCOC target benchmark setting and calculation of the actual expenditures and reporting. We are most interested in the further EOHHS guidance on the TCOC benchmarking methodology that is critical to success of the AE program. Additionally, we need to examine the impact of the Stop-Loss changes that EOHHS implemented in SFY 2018 on the TCOC calculations and performance.

Finally, we acknowledge that some of the comments below may be addressed by the recently-released detailed TCOC Technical Guidance, and we look forward to reviewing that document in detail.

Detailed Comments

Page	Topic	Comment	Priority
2	C.1. Minimum membership/population size	Has EOHHS conducted modeling to demonstrate that an MCO/AE contract with only 2,000 lives is robust enough to meaningfully impact total cost of care?	3
3	C.4. Downside risk	Integra has shared our concerns about moving too quickly to downside risk in the Medicaid AE program. To reiterate, our concerns include: • We do not have sufficient data or experience to project our performance under a downside risk model, and therefore cannot analyze and assess our likelihood of success in the program. It would be irresponsible to commit and expose our primary care network to an unknown level of financial risk. • The guidance released so far by EOHHS does not include sufficient detail to evaluate our potential exposure under the program. For example, EOHHS has not defined how it will calculate "Provider Revenue." EOHHS must postpone mandatory downside risk until at least PY4 while AEs and MCOs	1

Page	Topic	Comment	Priority
		work together to improve data, systems, and processes.	
3	C.5. Attribution	We have concerns about the proposal to assign all costs for a member during the performance year to the AE to which the member is attributed in the final quarterly update. Thus far in the program, we have not seen evidence that attribution is being properly updated to account for actual primary care utilization, and this proposal has the potential to allocate costs to the wrong AE. Even if attribution works as designed, it will inevitably result in AEs being held accountable for costs that were incurred while a member was attributed to a different AE. Take these two hypothetical situations: • A member is attributed to AE "A" while seeing primary care physicians from both AE "A" and AE "B." During this time, the member has many unnecessary ED visits that AE "B" is unaware of, because the member's utilization data is not provided to it by the MCO. Then, halfway through the year, the member's attribution switches when the preponderance of PCP visits switch to AE "B." Now, AE "B" is suddenly accountable for health care costs incurred while the patient was attributed to another entity. • A member has no primary care visits at all, but uses the ED frequently while attributed to AE "A." Finally, towards the end of the performance year, the member is seen for an E&M visit at a PCP affiliated with AE "B." AE "B" is suddenly accountable for a full year of costs for a patient they have only seen for one month. Either of these situations is quite possible, and neither is remotely fair. We recommend that EOHHS develop an approach where costs are assigned to an AE based on the member's monthly attribution (that is, the AE would be accountable for costs for services provided	2

Page	Topic	Comment	Priority
		during member-months when the member was attributed to the AE). Additionally, we would expect claims data sent to us by the MCOs to align to the attribution methodology (that is, we expect to receive claims data covering the entire population, and only the population, for which we are accountable). Retroactively changing attribution at the end of the year will add considerable complexity to the claims data feed.	
3	D.1. Establishing TCOC targets	The details of the TCOC benchmarking methodology are critical to success of the AE program, and Integra appreciates the opportunity to review the recently-released technical guidance on this topic. We are particularly concerned about risk adjustment, since the AEs have not had the opportunity to review the methodology and the impact of the new Medicaid Rx-based risk adjustment methodology implemented in SFY20. One specific concern is that we would like to understand how EOHHS will ensure that the risk adjustment applied to each AE's benchmark is specific to the AE/MCO's population, not the MCO's population as a whole.	2
4	D.2.a. Responsibility for calculating actual expenditures/performance	Integra is very concerned about the proposal that EOHHS will calculate and establish the prospective TCOC benchmark, but have the MCO calculate and report actual expenditures. • How will EOHHS ensure that the same categories of medical expenditure are included/excluded in the benchmark and actual calculation? • How will EOHHS ensure that risk adjustment is applied to the benchmark and actual performance in the same way? • How will EOHHS adjust for any negotiated changes in the underlying rates paid to providers by each	1

Page	Topic	Comment	Priority
		individual MCO?	
4	D.3.a. Small sample size adjustment	Integra appreciates the rigor involved in developing a statistical test to ensure that any TCOC reductions are based on the performance of the AE rather than chance. However, we are concerned that his adjustment adds unnecessary complexity to an already complex program. We also note that under the proposed set of adjustments, even the largest AE in the state would have to achieve a TCOC reduction of 4% to avoid being penalized. We recommend that the state remove this adjustment. *(Integra is currently reviewing the updated technical guidance on this topic.)*	2
5	D.3.b. Quality score	AEs should have the opportunity to have any shared loss payments reduced for achieving high quality, in exactly the same way that shared savings payments are reduced for low quality achievement. This would ensure than even high-cost systems retain an financial incentive to improve quality.	2
6	D.5.a. Downside risk	EOHHS has not clearly defined "Provider Revenue." In order to evaluate the impact of this proposal, and the maximum risk exposure for Integra, the state must clearly define how this value will be calculated.	1
6	D.5.a. Downside risk	The definitions in the risk table are unclear. EOHHS should clarify how the risk exposure cap is intended to work, by expressly stating that the shared losses pool is equal to the *lesser* of 1 percent of TCOC or 3 percent of Provider Revenue, and that any potential shared loss payment by the AE would be limited to the shared losses cap times the risk sharing rate. *(This appears to be addressed in the updated TCOC technical guidance, and we look forward to that material being incorporated into Attachment J.)*	1

Page	Topic	Comment	Priority
7	D.5.b. FQHCs	By exempting FQHCs from the requirement to take on downside risk, EOHHS has signaled that downside risk is not, in fact, an absolute necessity for PY3 of the program. This two-tiered system creates a material inequality between FQHC-led and non-FQHC-led AEs, which is not adequately accounted for by simply reducing the maximum gain share for FQHCs by 10 percentage points. In addition, we note that Massachusetts has been operating an ACO program in which its FQHCs have successfully taken on downside risk. We strongly encourage EOHHS to research how this was achieved in Massachusetts, and delay the imposition of mandatory downside risk in RI until it can be applied equitably. In PY3, EOHHS should permit any AE to participate in an upside-only agreement on the same terms as the FQHCs.	1
8	E. TCOC Reporting Requirements	EOHHS should explicitly require MCOs to regularly provide detailed TCOC reports to AEs on at least a quarterly basis. Our experience has shown that without a clear state mandate spelling out responsibilities of the MCO, AEs do not have sufficient leverage to compel cooperation or collaboration by the MCOs through our contracts.	2
16	c. Process for Review	If OHIC does not qualify an AE based on its application, does that mean the AE will be ineligible to participate in the AE program for PY3?	3
17	d. Pre-qualification Application Materials 2.a	Will an AE have all of the information listed in the table on page 17 by the application due date?	2

Additional Comments on the Draft Implementation Manual

Integra appreciates the comprehensive work that EOHHS has done to ensure that the Draft Implementation Manual included meaningful stakeholder feedback, as evidenced by the multiple revised versions over a six month period. We commend EOHHS for many of the improvements made to the specifications and reporting requirements, especially the removal of the patient engagement measure until a shared definition is established.

Integra supports EOHHS efforts to promote the capabilities of the AEs to transmit clinical data to the MCOs, and appreciate the inclusion of alternative methods to submit clinical data to the MCOs. We encourage EOHHS to move quickly to remove any uncertainty about the data submission through IMAT to the MCOs meeting the NCQA/HEDIS supplemental data certification standards.

Page	Topic	Comment	Priority
13	Electronic Clinical Data Exchange	"Should an AE be unable to electronically exchange clinical data for practices representing 90% or more… Integra appreciates EOHHS providing additional options to submit data to the MCOs. Given the complexities of EHR documentation and standard formats such as CCD files, Integra requests that PY2020 be considered a pilot year for quality measurement based on clinical data. This will give AEs time to modify documentation and/or CCD formats with EHR vendors in order to effectively capture all data elements needed for a complete and fair quality measurement. Integra requests that PY2020 final quality measurement be based on electronic clinical data as well as manual documentation for members that remain noncompliant based on electronic clinical data measurement, regardless if the AE meets the 90% clinical data exchange threshold.	2

Comments on Attachment K: Incentive Program Requirements

Executive Summary

We appreciate the detailed guidelines for the Incentive Program and the goal to ensure the funds are used to advance the AE program success and address identified gaps and needs of our attributed Medicaid members.

Integra offers feedback grounded in the desire simplify the program in order to achieve success in PY3 and beyond. Our most significant concerns involve the potential for statewide IT investments, the large weighting given to a set of untested outcome measures, and the impact on AE cash flow.

Detailed Comments

Page	Topic	Comment	Priority
4	II.2. AEIP	EOHHS should clearly specify the date on which the member snapshot is taken.	2
4	II.2. AEIP	In addition to reducing an AE's AEIP funding in the event of a material reduction in membership, EOHHS should commit to increasing funding if membership increases by a similar amount.	1
5	IV. HSTP Project Based Metrics Eligible for Award of AEPI Funds	Several typographical errors in the first paragraph	3
6	IV. HSTP Project Based Metrics Eligible for Award of AEPI Funds	The footnote after the table references certain statewide IT investments that EOHHS might make. Integra strongly encourages EOHHS to clearly lay out the investments that are likely to be made in the area of electronic clinical quality data exchange, in order for us to prioritize our IT investments. For example, the state has in some contexts encouraged the use of the IMAT system, and has suggested that a connection from CurrentCare to IMAT might support CDE activities. The uncertainty around the availability of these solutions makes it difficult to initiate any needed investments in a timely fashion.	1
6	V. AEIP requirements	EOHHS should permit non-FQHC AEs to meet the first "Fixed Percentage" milestone through the "readiness assessment and development plan" deliverable.	1
6	V. AEIP requirements	Can EOHHS clarify whether the "performance milestones" in the APM contract requirement	2

Page	Topic	Comment	Priority
		refer to the HSTP variable milestones described later in the table?	
7	V. AEIP requirements	Duplication of "Execution of an EOHHS qualified APM contract with the MCO, including performance milestones agreed upon by both parties (5%" *[sic]*	3
7	V. AEIP requirements	EOHHS should provide clearer requirements and specifications for the "agreement with Social Service Organization, BH, and/or SUD Provider." In the first two years of the program, we have found there to be considerable uncertainty around the interpretation of what kinds of organizations would quality, and what such an agreement should consist of. For example, we believe that the agreement cannot include the use of HSTP funds to pay for the provision of services that are already Medicaid covered benefits—is this correct? If so, can EOHHS provide examples of the kinds of services that should be provided through such an agreement?	3
7	V. AEIP requirements	By making 45 percent of the AEIP funding contingent on the results of annual reporting on outcome metrics, EOHHS has essentially postponed a plurality of the HSTP funding to beyond the PY3 performance year. MCOs will not be able to report, and EOHHS will not be able to assess, AE performance against these measures until many months after the end of PY3, in order to account for claims run-out and other timing factors. This is likely to create a cash flow challenge for AEs who may be relying on HSTP funds to fund day-to-day operations, while waiting for other source of revenue, including any shared savings payments that may be earned, which will also be delayed until well after the end of the performance year. In addition, it is unreasonable to attach 45 percent of the HSTP funding to these outcome metrics. These metrics are untried, and have not yet gone through a pay-for-reporting year. An increase in the funding tied to outcome metrics from 15 percent in PY2 to 45 percent in PY3 is	1

Page	Topic	Comment	Priority
		also too large a jump. EOHHS should make the following changes to this provision: 1. Reduce the share of HSTP funding tied to outcome metrics to 25%, *or* 2. Offer AEs an opportunity to earn partial payment of these funds through meeting interim outcome metric targets at least once during the performance year.	
7	V. AEIP requirements	The AE program includes a very large set of performance measures to which payment is attached. These include: • MCO-specific TCOC targets • 12+ clinical quality measures • Three or more "outcome measures" Adding an additional set of at least six additional pay-for-performance measures and targets will add an overwhelming and unnecessary burden to AEs, and will greatly increase the difficulty of meeting any/all of them. There are only so many initiatives that an AE can successfully implement and complete, and if the initiatives are all aimed at the same overall goals (reducing total cost of care, reducing unnecessary utilization of high-cost services, and improving quality outcomes), then any additional measures will be, at best, redundant. We recommend that EOHHS replace this requirement with a set of project-based milestones, similar to those that are used in PY1 and PY2. This will reduce the amount of "measure creep" in the program, and will also create opportunities for AEs to earn payments during the course of the performance year so as to have a reliable source of operating revenue.	2
8	VI. AEIP funding requirements	"AEs submit quarterly reports to the MCO using a standard reporting form to document progress in meeting identified performance metrics and targets." EOHHS should establish and disseminate this reporting form to ensure that it is in fact standard across all participating MCOs.	2

Page	Topic	Comment	Priority
8	VI. AEIP funding requirements	Can EOHHS please clarify how MCOs will operationalize the requirements around completion of the variable project-based measures? The requirement says that these metrics "require a process by which an AE that fails to meet a performance metric in a timely manner (thereby forfeiting the associated [HSTP] payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric." What does "related metric" mean in this context? How will the relatedness of a metric be determined for the purposes of allowing an AE to achieve a milestone payment after the original proposed date? Does this provision mean that the one year "grace period" does not apply to the "last" milestone for any given project, which would not have any subsequent "related" milestones? EOHHS should permit AEs to meet *any* variable milestone within one year of the original proposed completion date.	2
8	VI. AEIP funding requirements	As we've shared in the past, we have significant concerns with the requirement that AEs spend at least 10% of their incentive funding on partnerships with CBOs to address SDOH. We want to reiterate that we share the goal of addressing SDOH, and that we agree that partnerships with CBOs are the best way to achieve this. However, the minimum expenditure requirement is problematic for several reasons: • Given the size of Integra's membership, 10 percent of our HSTP funding is a significant amount of money. We have concerns that although we can establish contracts with CBOs under which we spend nearly $0.5M, we may not be able to get that much *value* out of the contracts. In other words, it's not clear that our potential CBO partners can provide services which meaningfully impact the health outcomes and TME for	2

Page	Topic	Comment	Priority
		our members such that those services are worth $500,000.[1] • This requirement is an outlier, and is inconsistent with the overall HSTP structure. The HSTP program is organized around establishing milestones at which AEs earn payments. In other words, the entire plan and structure are about determining how and when funds flow *to an AE from the MCO*. With the exception of this requirement, there is no explicit expectation that an MCO must monitor how an AE *spends* its HSTP funds. The 10 percent expenditure requirement implies a robust system for an AE to be accountable to the MCO for how funds flow *out of* the AE. However, no such process is described in state guidance, and no process is defined in our contractual arrangements with the MCOs. Despite repeated conversations, neither of our MCO partners has been able to articulate how they will operationalize this requirement, which creates considerable uncertainty. • If the state's goal is to ensure that HSTP funding flows to CBOs to increase capacity and ensure sustainability for those organizations, it's highly inefficient to try to achieve that goal through six different AEs, who may all choose to contract with the same organizations, or overlapping organizations. There is no process in place to ensure this funding is allocated equitably or efficiently. Rather than delegate the responsibility to support community-based providers in Rhode Island to AEs, the state should instead implement a mechanism to develop that capacity directly.	
9	VII. Allowable and Disallowable Use of AEIP	"EOHHS does require each Medicaid AE and MCO to attest that earned HSTP incentive funds will not be used for specific expenditures as outlined	3

[1] The minimum expenditure requirement is, ironically, a requirement to focus on *volume* rather than *value*.

Page	Topic	Comment	Priority
	Funds	below." What form will this attestation take? We recommend that EOHHS include a specific attestation as a standard attachment to the MCO/AE contract, which AEs can use to create a model attestation for any subcontractors paid with HSTP funds.	
10	VII. Allowable and Disallowable Use of AEIP Funds	"To provide goods or services not allocable to approved Participation Plans and Budgets" Can EOHHS clarify what "approved Participation Plan" and "Budget" mean in this context?	3
10	VII. Allowable and Disallowable Use of AEIP Funds	Can EOHHS clarify the intent and scope of these prohibitions? AEs may wish to use HSTP funds to pay for items to address the social determinants of health for their members, or may wish to offer certain incentives to members for achieving health goals. Some of these kinds of activities appear to fall within the disallowed categories. Do these disallowed categories apply to any use of the HSTP funds, including on behalf of a member? Is there a process for an AE to get prospective approval from EOHHS to use HSTP funds for a member incentive or non-medical benefit?	2

Comments on Attachment M: Attribution

Executive Summary

Integra fully supports the elimination of the IHH attribution priority in the proposed hierarchy of attribution guidance and the requirement for the MCO to provide monthly detailed attribution reports to the AEs.

Integra outlines recommended areas for improvement in the attribution process consideration. Integra believes the recommendations outlined below will further strengthen the member's relationship with the PCP and Integra's ability to improve healthcare outcomes for our attributed population.

Detailed Comments

Page	Topic	Comment	Priority
3	3.3 Hierarchy of Attribution for Comprehensive AEs	Integra appreciates the removal of the IHH attribution priority.	3
4	3.3 Hierarchy of Attribution for Comprehensive AEs 1.2 Change of PCP assignment of record by member request	Integra recommends that EOHHS permit AEs to recommend attribution changes to their partner MCOs. MCOs would then have the responsibility to validate the change request by examining primary care utilization, and/or proactively reaching out to members.	3
4	3.3 Hierarchy of Attribution for Comprehensive AEs 1.3 Change of PCP assignment based on utilization analysis	Integra would like to emphasize how important this regular claims-based attribution analysis is, and to note that it does not appear to be broadly occurring currently. We recommend that EOHHS require MCOs to provide detailed quarterly reporting on attribution analyses to EOHHS and AEs.	2
4	3.3 Hierarchy of Attribution for Comprehensive AEs 2.3	Integra would like to further discuss the implications of an analysis of claims that reveals that a member is attributed to the "wrong" PCP within the "correct" AE. We would also like to discuss the possibility of permitting an AE to make a PCP change for a member (that is, without the member's proactive request) when the change is to a new PCP within the same AE. This would give AEs the ability to more closely manage and support member-PCP engagement.	3
4	3.3 Hierarchy of Attribution	Is it possible that this step is missing part of the algorithm? We recommend it be re-written as	3

Page	Topic	Comment	Priority
	for Comprehensive AEs 2.5.1.1	follows: 2.5.1.1 If the member has had only one visit to a PCP for qualifying health primary care services, and the PCP is not a participating provider in the AE to which they are currently attributed, the member will be re-attributed to the PCP with the qualifying claim.	
4	3.3 Hierarchy of Attribution for Comprehensive AEs 2.5.1.2ff.	We suggest EOHHS consider a minimum threshold of PCP visits before changing attribution based on utilization, and perhaps also a maximum number of changes of attribution that can occur within a given performance year. For clarity, we recommend this section be re-written as follows: 2.5.1.2 If there are two or more visits to a PCP for qualifying primary care services, the MCO will sum the visits provided by AE-affiliated PCPs (aggregated by AE) and visits provided by non-AE-affiliated PCPs. 2.5.1.2.1 If the plurality of visits are to non-AE PCPs *or to an AE with which the MCO does not have an MCO/AE agreement in place*, the member will be unattributed from their current AE, and not attributed to an AE. 2.5.1.2.2 If the plurality of visits are to an AE other than the AE to which the member is currently attributed, then the member will be attributed to the AE with the most visits, and unattributed from their current AE. The MCO will assign the member to a PCP in the new AE according to its usual PCP assignment policies. 2.5.1.2.3 If two or more AEs have the same number of visits and there is no clear plurality, then,	2

Page	Topic	Comment	Priority
		2.5.1.2.3.1 If one of the "tied" AEs is the member's current AE, the member remains attributed to that AE. 2.5.1.2.3.2 Otherwise, the MCO will attribute the member to one of the tied AEs based on which AE has the most *recent* claims for the member.	
5	2.5 "MCO monthly requirement to provide AEs and EOHHS with electronic list…"	Integra greatly appreciates the new requirement for MCOs to provide monthly detailed attribution reports to AEs.	3
5	2.5 "Calculation of the final TCOC performance…"	Assigning medical costs to an AE on only a full-year basis is potentially problematic, since it will inevitably result in AEs being held accountable for costs that were incurred while a member was attributed to a different AE. We recommend that EOHHS develop an approach where costs are assigned to an AE based on the member's monthly attribution (that is, the AE would be accountable for costs for services provided during member-months when the member was attributed to the AE). Additionally, we would expect claims data sent to us by the MCOs to align to the attribution methodology (that is, we expect to receive claims data covering the entire population, and only the population, for which we are accountable). Retroactively changing attribution at the end of the year will add considerable complexity to the claims data feed.	2