September 14, 2017

To: Deborah Morales
(Via Email)

From: Garry Bliss, Program Director
Integra Medicaid AE

Re: EOHHS Attribution Guidance for the AE Program

CC: James E. Fanale, MD, EVP, Chief Operating Officer CNE & Chief Clinical Officer, Integra
John Minichiello, Executive Director, Integra
Deb O'Brien, President, The Providence Center

Thank you very much for the opportunity to comment on the proposed Attribution Guidance for the Accountable Entity Program. Prior to comments which reference specific sections of the document, we offer some general comments.

As always, if you have any questions, or would like to discuss any of the issues raised in this memo, we would be more than happy to meet with you at your convenience or provide additional detail via email or phone.

We continue to appreciate the state's collaborative and inclusive process for refining the original AE Pilot and look forward to working with EOHHS in the months and years ahead.

General Comments

One of the state's goals throughout the AE process has been to ensure oversight and regulation remained efficient and streamlined. We urge EOHHS to ensure collaboration among its partner agencies to avoid contradictory or overlapping rules and regulations.

This is particularly important in behavioral health where the state is seeking greater integration of behavioral and primary care, and where effective care for the SMI/SPMI population is necessary if this initiative is going to meet goals for improved quality of care, well-being, and financial performance.

Therefore, rules, regulations, and monitoring of the different providers that make Comprehensive and Specialized AEs must align with the overall goals of the AE initiative. Steps taken by one regulatory entity could have a ripple effect across an AE that would undermine the viability of that AE of this initiative. New rules regarding staffing expectations, hours of service, could have significant financial impact on AEs and on their ability to remain viable and meet the state's goals.

Additionally, one of the greatest strengths of Rhode Island's AE model has been the recognition of the unique needs – and unique opportunities for improvement in care, quality, and spending – of the SMI/SPMI population. The state is currently proposing that dual eligible SMI/SPMI individuals be removed from the AE model. While this does represent a small population, overall, and the financing of duals presents challenges, we urge the state to consider modifying the proposal so this decision could

be revisited in whole or in part. We would like to explore with EOHHS ways this subset could continue to benefit from the AE model.

Section 2 Background

"An attribution-eligible provider can only participate in one comprehensive AE at a time. An attribution-eligible provider can only participate in one specialized LTSS AE at a time."

This seems to be unnecessarily restrictive and could undermine the ability to form robust Specialized LTSS AEs. In order to provide the full suite of LTSS AE services, and to provide them over a broad geography, it may be necessary for one LTSS AE to partner with an attribution-eligible provider that is part of the network created by another LTSS AE. So long as the attribution remained with the foundation LTSS AE, this arrangement could function with that provider serving clients attributed to more than one LTSS AE, including, potentially, an LTSS AE of which it was core member. We urge EOHHS to reconsider this restriction.

"…a member who meets the requirements for attribution to both a comprehensive AE and a specialized LTSS AE at the same time will be attributed to both AEs."

This provision is understandable and to be expected, however, it will require that the final rules and regulations be very clear about which services and costs for which each AE, the Specialized the Comprehensive, are responsible. A lack of clarity and blurring of responsibility would undermine the effectiveness of both AE models.

Section 3.3 Hierarchy of Attribution for Comprehensive AEs

Step 2: Quarterly Updates to that assignment

- *A member attributed to an AE based on assignment to an IHH shall continue to be attributed to that AE after IHH discharge unless:*
  - *The member requests that the MCO change his or her PCP to one that is not participating in the AE; or*
  - *The member is assigned by BHDDH to a different IHH.*

This proposal could be quite burdensome on IHH providers, particularly in those instances where this would require the IHH to maintain responsibility for clients who have *actively chosen* to separate themselves from that organization's service.

Clearly, under these circumstances it would difficult, if not impossible, for the IHH which patient has, effectively, "terminated" to maintain productive engagement with the client. However, under this scenario and the guidelines detailed above, that IHH would remain responsible for the healthcare utilization of a patient who has affirmatively severed their ties with that organization.

We urge EOHHS consider the practical implications of this rule and seek a more reasonable solution in such circumstances. Perhaps the following language could provide clarity to this issue:

> When a member is discharged from an IHH, attribution of the member to an AE shall be based on the PCP or the assignment to a different IHH by BHDDH

PCP assignment by the MCO will be based on two sequential steps:

- *Step 1: PCP assignment by the MCO at the point of entry by the member into the MCO*

- *Step 2: Quarterly updates to that assignment based on:*
    - *Member requests to the MCO to change his or her PCP*
    - *Analyses of actual patterns of utilization that demonstrate member use of a different PCP than the one assigned by the MCO*

Based on our experience during the Pilot phase, we believe that the AE should be consulted prior to patient reassignment based on an MCO utilization review. There can be temporary reasons for changes in patient care utilization, including – but not limited to – patient engagement with specialists that, without insight from the AE, could result in an inappropriate patient reassignment. We urge EOHHS to include a review role for AEs in this process.

Step 2: Quarterly updates to PCP assignment and attribution based on:

- *Member requests that the MCO change the PCP to one that is not participating in the AE*
- *Analyses of actual patterns of utilization that demonstrate member use of a different PCP than the one assigned by the MCO*

Despite best efforts by MCOs at initial PCP assignment and the ready accommodation of member requests for a change in the assigned PCP, there will be some differences between the assigned PCP of record and the actual pattern of primary care utilization by the member. MCOs will update attribution on a quarterly basis based on retrospective analysis of actual patterns of primary care use.

We believe the bulleted list should be amended to include a third item: "Member requests that the MCO change the PCP to one that is participating in the AE." We believe this suggestion is reasonable and fair and in keeping with the priority on ensuring patient choice.

Additionally, in line with our comment on the previous provision regarding PCP reassignment, we believe the final sentence in the above excerpt should be amended to read "*based on retrospective analysis of actual patterns of primary care use, in consultation with the AE.*" Again, the AE perspective is essential to ensure against a misreading or misunderstanding of patient utilization patterns.

2.1 Not later than thirty days after the close of each calendar quarter, claims for eligible members shall be analyzed to identify the presence of a visit to a PCP with qualifying primary care services as identified by CPT codes and/or FQHC encounter codes for the preceding twelve-month period (see Attachment B for qualifying CPT codes). The provider specialty must be a PCP eligible for attribution.

We urge EOHHS to consider allowing flexibility for instances when a visit to an in-AE specialist was the more appropriate appointment for a patient.

Section 4.1.Population Eligible for Attribution to a Specialized LTSS AE

The population eligible for attribution consists of all adult (age 21 and older) Medicaid-only and Medicare-Medicaid beneficiaries enrolled in managed care, including the Medicare-Medicaid Plan, or receiving Medicaid benefits through Medicaid fee-for-service. Children under age 21 are not currently eligible for attribution to a specialized LTSS AE.

We understand the exclusion of minors from the Specialized LTSS AE, but are concerned about those patients between 18 and 21 who would, effectively, fall into a care gap. We urge EOHHS to consider this risk and to either clarify this section or revise as most appropriate.

4.3. Attribution Methodology for Specialized LTSS AEs, Table B: Specialized LTSS AE Attribution Scenarios

These scenarios appear to envision many instances where patients will remain the responsibility of a Specialized AE long after they have switched to a service provider under a different Specialized AE. This could prove burdensome and undermine the overall integrity and sustainability of this initiative.

We urge EOHHS to explore ways to shorten the “carry over” of responsibility when a patient has transferred to another provider. The current proposal appears to create instances when the term of responsibility would be excessive.