

Attribution Guidance

1. What would be defined as a “compelling reason for the responsibility of care and outcomes for a patient?”
2. What patient information will be included in the monthly attribution file?
3. LTSS attributable table seems convoluted. Is there a clearer way to demonstrate the different scenarios?
4. In the case of a tie for Home Care provider with the highest number of hours, what is the definition of “historically provided the highest number of hours?”
5. What is the attribution contestation process? Based on Medicare ACO experience this is important to define.
6. What is the rationale behind continuing to attribute a beneficiary to an AE for 12 months after services have ended? This seems excessive. An additional 30 day period to make sure no care was withheld seems sufficient.
7. Page 12, Figure 2 displays the same beneficiary explanation listed in both the “included” and “not included” buckets. “Is not authorized for any attributable services from any providers in the AE within the prior 12 months” appears in box 3 under “included” as well as box 2 under “not included”. Please clarify.
8. What is the rationale for including custodial nursing home residents in attribution? Custodial more than 100 days are attributed, but costs exceeding 6 months (as per TCOC document) are excluded. Does this mean a beneficiary is only attributed between 100 days and 6 months of a custodial stay?
9. Is there a technological mechanism in place for the state and the MCO to combine attribution rosters to create one comprehensive attributed member listing for the AE? This seems like an administrative nightmare; chances of AE receiving inaccurate, incomplete, or late information seem high.

TCOC Guidance:

1. Will the historical data used in the TCOC calculation expand? For example in 2019, will data from 2013 still be used in the calculation? It has been noted by ACOs and other participants in arrangements with CMS that using a historical base calculation (even with a trend factor) can have vast consequences for organizations as the program expands. Market changes could lead to an irrelevant TCOC.
2. Will the AEs have access to the historical base claims information for verification?
3. What is the framework for a “simulated historical base?”
4. How are low-cost outliers factored into the TCOC calculation?
5. What is the definition of a “risk profile?”
6. Are there any proposed safeguards that will be applied to ensure that beneficiary care is not being withheld?

7. Long-stay/custodial nursing facility costs in excess of six months are excluded, yet are included as an attributable event – please clarify. (Internal ques: type of bill:263; revenue codes 0100,0128, 0129)
8. Which entity applies the risk adjustment? If state and MCO are each risk adjusting their own populations, will they use the same software?
9. Which entity is responsible for creating TCOC methodology? If MCO creates the TCOC, does the state follow this same TCOC

Incentive Guidance:

1. N / A

Quality

1. For measure #4, will there be a different measure more aligned with the Medicaid population?
2. Will the AE have the ability to gain access to any historical performance, or benchmarking data?
3. Is measure #6 the raw %, or will it be risk adjusted?
4. What is defined as a “major injury?” Falls may be hard to track in beneficiaries residing in the community.
5. What tool will be utilized for measure 8? Are there proposed minimum thresholds for surveys returned? Who will administer the surveys?