



**EOHHS AE Stakeholder Meeting**  
**DXC 2<sup>nd</sup> Floor Conference Room**  
**September 5, 2017 2:00 pm to 3:30 pm**

**Facilitator:** Debbie Morales, Deb Faulkner, Jen Bowdoin

**Prepared by:** Maria Narishkin

**Participants:** Beth Marootian (Neighborhood Health Plan of RI), Chris Ferraro (Coastal Medical), Christopher Dooley, (Prospect Medical Holdings), Craig DeVoe (Nursing Placement), Deb Faulkner (Faulkner Consulting), Debbie Morales (EOHHS), Debra Driscoll (Ocean State Nursing), Debra Reakes (Coastal Medical), Diane Evans (Thundermist), Garry Bliss (Integra), Holly Garvey (EOHHS), Irene Qi (Hope Nursing HomeCare, LLC), Jason Brown (Tufts Health Plan), Jen Bowdoin (EOHHS), Joe Cicione (Nursing Placement), Kulwant Babra (NHP), Laurie Ellison (Cowesett Home Care), Lisa Tomasso (TPC), Maria Narishkin (EOHHS), Maria Petrillo (EOHHS), Mark Kraics (EOHHS), Mary Barry (Capitol Home Care Network), Michael Bigney (Nursing Placement), Michelle Szylin (DEA), Olivia Burke (Faulkner Consulting), Raymond Lavoie (BVCHC), Rick Boschwitz (Bayada), Shaun Cournoyer (Berkshire Place and The Friendly Home), Trish Gleason (Gleason Medical), Vinnie Ward (Home Care Services of RI)

Agenda Item	Key Discussion Points	Action Items/Follow Up
<b>Welcome &amp; Introductions</b>	Public Meeting law – no phone line available (aside from disability) Today’s focus will be on Attribution guidelines for Comprehensive and LTSS AEs	
<b>Attribution focus topic</b>	<ul style="list-style-type: none"> <li>• Accountable for a population for cost and quality               <ul style="list-style-type: none"> <li>○ We have an attribution guideline currently in place under the comprehensive AE pilot program, we can learn from it</li> <li>○ Attribution does not change patients’ freedom to choose and change providers</li> </ul> </li> <li>• Goals               <ul style="list-style-type: none"> <li>○ Recognize and strengthen relationship between provider and member</li> <li>○ Opportunity for shared savings</li> <li>○ Transparent and understandable</li> <li>○ Clear methodology for attribution</li> <li>○ Protect member choice and ensure safeguards are in place for potential risk avoidance</li> </ul> </li> <li>• Principles               <ul style="list-style-type: none"> <li>○ AE providers and members                   <ul style="list-style-type: none"> <li>▪ Can be attributed/participate in one comprehensive AE at a time</li> <li>▪ Can be attributed/participate in one LTSS AE at a time</li> </ul> </li> <li>○ A member can be in one comprehensive and one LTSS AE at the same time</li> </ul> </li> </ul>	Comments and feedback on Attribution Guidance due by September 14 <sup>th</sup>

	<ul style="list-style-type: none"> <li>• Population <ul style="list-style-type: none"> <li>○ Comprehensive <ul style="list-style-type: none"> <li>▪ Medicaid only beneficiaries enrolled in Managed Care</li> <li>▪ Dual eligible are excluded from Comprehensive AEs</li> </ul> </li> <li>○ Specialized <ul style="list-style-type: none"> <li>▪ Medicaid only and dual eligible (Medicare/Medicaid) age 21 and older</li> <li>▪ Managed care and FFS</li> </ul> </li> </ul> </li> <li>• Provider Rosters <ul style="list-style-type: none"> <li>○ Comprehensive <ul style="list-style-type: none"> <li>▪ PCP</li> <li>▪ IHH provider (recognized by BHDDH)</li> <li>▪ Identified by TIN and NPI</li> </ul> </li> <li>○ Specialized <ul style="list-style-type: none"> <li>▪ Licensed agencies in home care, adult day, assisted living and nursing facilities</li> <li>▪ BHDDH services not included</li> </ul> </li> </ul> </li> <li>• <b>QUESTIONS/CONCERNS</b> <ul style="list-style-type: none"> <li>○ Providers may choose to participate in AEs by location (strength in one part of state). This should be a business decision - send us a recommendation in writing.</li> <li>○ TCOC overlap in managed care Medicaid only members if the member is in both a comprehensive and a specialized AE. How do both AEs get shared savings? (small number). At this point, EOHHS believe the overlap would be minimal.</li> <li>○ Care planning implications and opportunity when a person is in both comprehensive and LTSS AE.</li> <li>○ If a patient is attributed to both a comprehensive and specialized AE, will the AEs be informed that the patient is part of two AEs?</li> <li>○ Can patients choose which AE they want to be in? How do we educate them on the program? - Marketing by ACOs to start to engage members but this is a slow process.</li> </ul> </li> </ul>	
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<p><b>Comprehensive AE Attribution Hierarchy</b></p>	<ol style="list-style-type: none"> <li>1. Based on IHH assignment <ol style="list-style-type: none"> <li>a. Quarterly updates <ol style="list-style-type: none"> <li>i. Member remains in that AE after IHH discharge unless member requests to change to a PCP not in that AE or member is assigned to a new IHH provider not in that AE</li> </ol> </li> </ol> </li> <li>2. Based on PCP assignment by MCO <ol style="list-style-type: none"> <li>a. Quarterly updates <ol style="list-style-type: none"> <li>i. Member remains in that AE unless member requests to change to a PCP not in that AE or retrospective utilization (claims check) shows use of a different PCP</li> </ol> </li> </ol> </li> <li>3. Back up PCP assignment with claims check</li> </ol> <p><b>QUESTIONS/CONCERNS</b></p> <ul style="list-style-type: none"> <li>• Process that MCO would implement based on claims</li> <li>• Assignment to PCP vs. Attribution to PCP. Request for EOHHS to look at PCP assignment language in contract in relation to Attribution</li> <li>• Contract amendment with the plans includes auto assignment</li> <li>• Is there a check to identify deceased patients?</li> <li>• Coordination and agreements between MCOs and AEs regarding assignment of members that AE does not own (due to churn)</li> <li>• Assignment of patient to PCP check against actual PCP</li> <li>• New patients monthly (auto assign)</li> <li>• Adjust initial list based on past use</li> <li>• How many patients are not using a PCP</li> </ul>	
<p><b>Specialized AE attribution Hierarchy</b></p>	<ol style="list-style-type: none"> <li>1. No PCP assignment</li> <li>2. Based on active authorization (there are numerous attributable services)</li> <li>3. Monthly updates <ol style="list-style-type: none"> <li>a. New members / Removed members</li> <li>b. Member who stops receiving services will stay attributed to that AE for at least 12 months unless there is a new authorization for service in another AE (90 days to update attribution)</li> </ol> </li> </ol> <p><b>QUESTIONS/CONCERNS</b></p> <ul style="list-style-type: none"> <li>• Rules in attribution methodology – please comment</li> <li>• Look at actual service hours instead of authorized hours. Recommendation for EOHHS to conduct an analysis of the total authorized hours against the actual claim utilization</li> </ul>	

<b>Next Meeting</b>	Next Meeting: Monday September 11 <sup>th</sup> , 2017 from 2:00 pm to 3:30 pm at DXC's second floor conference room. This meeting will focus on Incentive Guidance for Comprehensive and Specialized AEs Accountable Entities documents and timelines are posted online at: <a href="http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx">http://www.eohhs.ri.gov/Initiatives/AccountableEntities.aspx</a>	
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