Rhode Island Medicaid Accountable Entity Program

Attachment M: Accountable Entity Attribution Requirements – Program Year Two Requirements

Rhode Island Executive Office of Health and Human Services

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1. Attribution Overview

Attribution is the process of defining the population on which total costs are calculated for the purposes of identifying savings under a shared savings or risk contract. Effective attribution provides an incentive for providers and Accountable Entities (AEs) to invest in care management and other appropriate services to keep their attributed population well, with the intent of earning savings by lowering total costs and ensuring high quality care. Attribution does not affect consumers' freedom to choose or change their providers at any point in their care. However, AEs are expected to have continuing responsibility for the care and outcomes of their attributed members on an on-going basis, unless there is a compelling reason for that responsibility to change.

1.1. Attribution Methodology Goals

The attribution method, to be applied across all Managed Care Organizations (MCOs) and AEs, is intended to:

- Allow providers who have identified responsibility for member costs to earn savings by reducing those costs in the future;
- Allow Integrated Health Homes (IHH) to assume this responsibility for members enrolled in IHH (including Assertive Community Treatment, or ACT); and
- Be transparent and understandable to all program participants.

2. Background

Attribution is the foundation of the linkage of the member to an AE. Attribution identifies the population that the AE is accountable for in the overall AE program. This includes accountability of the AE for the health and health care for that person as represented in access, quality, and total cost of care metrics. The program intent is to recognize and strengthen an existing relationship of the member with the AE and its clinical programs. For comprehensive AEs, it is also to establish the basis for such relationship for members who do not have an established relationship with a primary care provider (PCP).

The foundations for attribution are:

- A population of Medicaid beneficiaries eligible for attribution.
- A defined provider roster of the certified AE to which members may be attributed.
    - Each certified AE will have a defined roster of providers that will qualify the AE for attributed members.
    - For comprehensive AEs, the provider roster will consist of:
        - IHH providers as licensed by the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH) if an IHH is a recognized Partner Provider or Affiliate Provider in the AE; and

        - PCPs, as described in Section 3.2, at a Partner Provider or Affiliate Provider in the AE.
- A clear methodology for attribution of eligible members to a certified AE.
    - For comprehensive AEs, this includes:
        - MCO algorithm for initial PCP assignment and attribution; and
        - Methodology for updated attribution based on utilization of identified primary care services provided by an eligible PCP.

These attribution requirements set forth the basis for:

(a) Identifying the specific AE provider roster eligible for attribution; and

(b) The basis for attribution of members to the AE.

An attribution-eligible provider can only participate in one comprehensive AE at a time for the purposes of attribution. A member can only be attributed to a single comprehensive AE at a time.

3. Comprehensive AE Attribution

3.1. Population Eligible for Attribution to a Comprehensive AE

The population eligible for attribution to a comprehensive AE consists of all Medicaid-only beneficiaries enrolled in managed care. Members who have both Medicare and Medicaid coverage are not eligible for attribution to a comprehensive AE.

3.2. Certified Comprehensive AE-Identified Providers

Attribution of members will be based on the defined roster of providers included within the structure of the AE. For IHHs, recognition by BHDDH as a qualified IHH will be the basis for attributing members to the AE.

For primary care, each AE shall have a defined roster of PCPs. A PCP is defined as the individual plan physician or team selected by or assigned to the member to provide and coordinate all of the member's health care needs and to initiate and monitor referrals for specialized services when required. PCPs are Medical Doctors or Doctors of Osteopathy in the following specialties: family and general practice, pediatrics, internal medicine, or geriatrics who have a demonstrated clinical relationship as the principal coordinator of care for children or adults and who have contracted with the MCO to undertake the responsibilities of serving as a PCP as stipulated in the MCO's primary care agreements. PCPs shall also meet the credentialing criteria established by the MCO and approved by EOHHS. In addition to physicians, the PCP may be a nurse practitioner, physician assistant, or a Federally Qualified Health Center (FQHC). Clinicians included in the provider roster shall be identified by TIN and by NPI.

AEs that include FQHCs are required to provide, through an attestation, a list of the clinicians' NPIs that provide direct patient primary care services in an FQHC. This attestation will be part of the application process for all comprehensive AEs and shall be updated minimally on a quarterly basis.

3.3.Hierarchy of Attribution for Comprehensive AEs

Members will be attributed to a comprehensive AE as follows:

Assignment Hierarchy

1st: IHH Assignment
If a member is assigned to an IHH, and that IHH is a part of a comprehensive AE, then the member is attributed to that AE. IHH assignment is based on a monthly roster produced by BHDDH and provided to the MCO. IHH assignment is based on two sequential steps.

- Step 1: Assignment to the AE based on assignment to IHH, as determined by BHDDH. Note that IHH based attribution is inclusive of persons utilizing ACT services.
- 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 until IHH discharge, unless the member is assigned by BHDDH to a different IHH.

2nd: PCP Assignment by the MCO
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; and
    - Analyses of actual patterns of utilization that demonstrate member use of a different PCP than the one assigned by the MCO.

Step 1: Assignment by the MCO at the point of entry into the MCO
A fundamental requirement of EOHHS' contract with the MCO is that, in order to ensure the member's timely ability to meaningfully access health care services, the MCO must ensure that the member has an identified PCP. The challenge for the MCO is that the MCO has very limited information about whether a new member has an established relationship with, or preference for assignment to, a specific PCP. The MCO contract sets forth certain requirements on procedures for PCP assignment that are intended to promote an appropriate PCP assignment for the member (see Attachment A). A member may change his or her PCP assignment at any time, and MCOs routinely inform members of their right to change PCPs at any time upon request.

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.

EOHHS establishes a stepwise attribution algorithm hierarchy to be used in updating the attribution. Requirements for PCP related attribution are as follows:

1. Attribution to the AE will be based on PCP assignment of record within the MCO. PCP assignment of record shall be based on:
   1.1. Original assignment by the MCO
   1.2. Change of PCP assignment of record based on a member's request to change PCP
   1.3. Change of PCP assignment of record based on analysis of the member's actual primary care utilization
2. Attribution based on actual primary care utilization:
   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 visits 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.
   2.2. Attribution will be at the AE level based on aggregating utilization across all TINs that are part of the AE roster of attributable providers. Multiple visits to PCPs within an AE will be aggregated to that AE.
   2.3. For attributed members that have received all of their qualified primary care services from a qualified provider within the AE, the PCP assignment will be unchanged from the PCP assignment as recognized by the MCO.
   2.4. For beneficiaries that have not received any primary care services during the period, the attribution will continue to be based on the MCO's PCP assignment.
   2.5. The MCO will identify beneficiaries who have had at least two visits to a PCP with qualifying primary care services as described in 2.1 and received at least one primary care service from a PCP who is not a participating provider in the AE.
      2.5.1. For those beneficiaries, the attribution hierarchy will then be as follows:
         2.5.1.1. Where there are two or more visits to providers, attribution is based on a plurality of primary care visits, with attribution based on the AE providers or on the non-AE PCP providing the highest

number of visits. If the AE's providers are tied for the highest number of visits, attribution will remain with the AE.

To be enrolled in Medicaid managed care, an individual must be Medicaid eligible. MCOs shall be required monthly to provide contracted AEs with electronic lists of attributed members, inclusive of identification of additions and deletions. These lists will be updated to reflect changes including new members, persons who have lost Medicaid eligibility, persons who have requested a PCP not included in the AE, and the results of quarterly updates to PCP assignment and attribution.

Attachment A: Excerpts from EOHHS-MCO Contracts Regarding Assignment of Primary Care Providers

PCP assignment by the MCOs must comply with EOHHS contractual requirements. The following excerpts from Sections 2.05.07 and 2.05.08 of EOHHS' Medicaid Managed Care Services contracts with the MCOs describe the MCOs' contractual requirements related to PCP assignment:

2.05.07 Assignment of Primary Care Providers (PCPs)

Contractor shall have written policies and procedures for assigning each of its members who have not selected a primary care provider (PCP) at the time of enrollment to a PCP. The process must include at least the following features:

- The Contractor must allow each enrollee to choose his or her health professional to the extent possible and appropriate.

- If a Medicaid-only member does not select a PCP during enrollment, Contractor shall make an automatic assignment, taking into consideration such factors as current provider relationships, language needs (to the extent they are known), member's area of residence and the relative proximity of the PCP to the member's area of residence. Contractor then must notify the member in a timely manner by telephone or in writing of his/her PCP's name, location, and office telephone number, and how to change PCPs if desired. Contractor shall auto assign members to a NCQA recognized patient centered medical home, where possible.

  Notwithstanding the above, the EOHHS recognizes the importance of members enrolling in a Patient Centered Medical Homes (PCMHs) and building a relationship with the Primary Care Provider (PCP). EOHHS expects that the Contractor to auto-assign to providers in a PCMH practice before auto assigning to non-PCMH providers. The Contractor will provide EOHHS with quarterly reports of the number and percent of total members assigned to PCMH sites either by auto-assignment or member choice. The Contractor is responsible for creating an auto- assignment algorithm and submitting this algorithm to EOHHS for review and approval within 90 days of the execution of this contract. Once this logic is approved by EOHHS, the health plan should operationalize this within 60 days. Contractor should consider the following when creating the algorithm: a) When auto assignment is being utilized, the Contractor must regularly monitor member panel size to ensure that providers have not exceeded their panel size; b) The provider's ability to comply with EOHHS's specified access standards, as well as the provider's ability to accommodate persons with disabilities or other special health needs must be considered during the auto-assignment process; c) In the event of a full panel or access issue, the algorithm for auto assignment must allow a provider to be skipped until the situation is resolved.

Additionally, the Contractor will be required to provide registries of patients to each PCP facility where the patients are assigned, no less frequent then quarterly or at an interval defined by EOHHS.

- Contractor shall notify PCPs of newly assigned members in a timely manner.

- If a Medicaid-only member requests a change in his or her PCP, Contractor agrees to grant the request to the extent reasonable and practical and in accordance with its policies for other enrolled groups. It is EOHHS's preference that a member's reasonable request to change his or her PCP be effective the next business day.

Contractor shall make every effort to ensure a PCP is selected during the period between the notification to the Contractor by EOHHS and the effective date of the enrollee's enrollment in the Contractor's Health Plan. If a PCP has not been selected by the enrollee's effective date of enrollment, the Contractor will assign a PCP. In doing so, Contractor will review its records to determine whether the enrollee has a family member enrolled in the Contractor's Health Plan and, if so and appropriate, the family member's PCP will be assigned to the enrollee. If the enrollee does not have a family member enrolled in the Health Plan but the enrollee was previously a member of the Health Plan, the enrollee's previous PCP will be assigned by the Contractor to the enrollee, if appropriate.

2.05.08 Changing PCPs

Contractor shall have written policies and procedures for allowing members to select or be assigned to a new PCP including when a PCP is terminated from the Health Plan, or when a PCP change is ordered as part of the resolution to a formal grievance proceeding. In cases where a PCP has been terminated, Contractor must allow members to select another PCP or make a re-assignment within ten (10) calendar days of the termination effective date.

Attachment B: Qualifying Primary Care Services as Identified by CPT Codes

Evaluation/Management CPT Codes: 99201-99205, 99211-99215
Consultation CPT Codes: 99241-99245
Preventive Medicine CPT Codes: 99381-99387, 99391-99397