

ATTACHMENT M - ACCOUNTABLE ENTITY- ATTRIBUTION GUIDANCE

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Attribution Overview

In the Comprehensive Accountable Entity (AE) program, AEs are responsible for the cost and quality of care for the Medicaid members who are patients of primary care providers affiliated with the AE. “Attribution” refers to the identification of those members for whom each AE is responsible. Attribution does not affect consumers’ freedom to choose or change their providers at any point.

Attribution is generally used for five purposes:

1. To inform AEs which members they are responsible for at a given time, to aid in care management and population health management;
2. To estimate the number of member months that will be attributed to each AE during a performance year in order to calculate the Incentive Fund Pool;
3. To identify the members whose health outcomes the AE is responsible for, in order to evaluate AE performance on the outcome metrics measured for the Incentive Fund Pool.
4. To identify the members whose healthcare quality the AE is responsible for, in order to evaluate AE performance on quality measures.
5. To identify the members whose cost and quality outcomes the AE was responsible for during the baseline and performance years, in order to evaluate AE performance on total cost of care (TCOC) and quality.

This document sets forth the process by which Medicaid members are attributed to AEs for each of these purposes.

Population Eligible for Attribution to a Comprehensive AE

The population eligible for attribution to an AE consists of Medicaid-only beneficiaries with full Medicaid benefits who are enrolled in managed care. Members who have dual Medicare and Medicaid coverage are not eligible for attribution to a Comprehensive AE. Members eligible and enrolled in Extended Family Planning are not eligible for attribution to a Comprehensive AE.

Primary Care Providers Whose Assigned Patients are Eligible for Attribution to a Comprehensive AE

Members are eligible for attribution to a Comprehensive AE based on their assignment for primary care to providers meeting the following definition of Primary Care Providers (PCP): An individual physician, nurse practitioner, physician assistant, team, or FQHC selected by or assigned to the member to provide and coordinate the member’s health care needs and to manage referrals for specialized services. PCPs are Medical Doctors, Doctors of Osteopathy, nurse practitioners, or physician assistants 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.

Each PCP bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with at most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs.

Methodology to Attribute Members to AEs

Step 1: Member selection or assignment by the MCO at the point of enrollment with the MCO

The managed care contract sets forth certain requirements for PCP assignment that are intended to promote PCP assignment as appropriate (per MCO-submitted and EOHHS-approved PCP assignment algorithm) for the member in the case that the member does not affirmatively select a PCP (see Attachment A).

Upon enrollment with the MCO, the member will be attributed to the AE with which their selected/assigned PCP is affiliated. This is the AE that the member will remain attributed to until Step 2, unless the member requests to change to a different PCP. When a member has requested that the MCO change their PCP to one that is not participating in the AE to which the member is currently attributed, the MCO shall update the member's AE attribution no later than on the next attribution report that incorporates quarterly reconciliation.

Step 2: Quarterly attribution reconciliation based on claims-based utilization analysis and member-requested changes to assigned PCP.

By performing the analyses of utilization outlined in “Attribution Reconciliation Logic” below, a member's attribution may change if it is demonstrated that the member uses a different PCP than the one assigned by the MCO.

Not later than thirty days after the close of each calendar quarter, MCOs shall analyze claims for eligible members 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.

Attribution Reconciliation Logic:

1. For members who have received all their qualified primary care services from a qualified provider who billed through a TIN on the roster of the AE to which the member is currently attributed, the AE attribution will be unchanged.

2. For members who have not received any primary care services during the period, AE attribution will be unchanged.
3. The MCO will identify beneficiaries who have received at least one primary care service from a PCP who did not bill through a TIN on the roster of the AE to which the member is currently attributed. For those beneficiaries, the attribution hierarchy will then be as follows:
 - 3.1 Where the member's only PCP visits for qualifying primary care services were to a PCP not participating in the AE program, the member will not be attributed to an AE.
 - 3.2 Where the member has only had one visit to a PCP for qualifying primary care services and that PCP is participating in a different AE from the AE to which the member is currently attributed, the member will be attributed to the AE where they received their primary care services.
 - 3.3 Where a member has had two or more visits for qualifying primary care services and these visits are not all to PCPs who billed through a TIN on the roster of the same AE (or include visits to PCPs who billed through TINs not on the roster of any AE), the sum of the visits provided by PCPs who billed through TINs on the roster of each AE are compared to the number of visits provided at any non-AE PCP with the highest number of visits.
 - 3.3.1 If a non-AE PCP, aggregated by TIN, has the highest number of visits, the member will not be attributed to an AE.
 - 3.3.2 If any AE has the highest number of visits, the member will be attributed to that AE.
 - 3.3.3 If two or more AEs, including the AE to which the member is currently attributed, are tied for the highest number of visits, attribution will be unchanged.
 - 3.3.4 If two or more AEs are tied for the highest number of visits and the member is not currently attributed to any of these AEs, the member will be assigned to the AE that aligns with the PCP that the member visited most recently.

Attribution to Inform AEs Which Patients They Are Accountable For

For the purposes of informing AEs which members they are accountable for, MCOs shall submit to AEs and to EOHHS electronic lists of attributed members on a monthly basis per the reporting requirements and file specifications outlined in the Managed Care Reporting Calendar.

This monthly report will be updated to reflect changes that have taken place since the previous monthly list, including new Medicaid members, persons who have lost Medicaid eligibility, persons who have requested a PCP not included in the AE, persons who have requested a PCP included in the AE, and the results of quarterly reconciliation.

MCOs shall base the list of attributed members on attribution as of the last day of the month to which the attribution list applies, i.e., incorporating any changes that took place up to the final day of that month.

In creating the monthly attribution lists, MCOs shall use the AE rosters that are in effect for the month in question, including any changes in those rosters that have been communicated to the MCOs by any AE.

Other Purposes of Monthly Attribution Data:

- To the extent that MCOs give AEs information about utilization patterns for attributed members, EOHHS expects that MCOs will use the monthly attribution data to generate this information.
- EOHHS performs its own analysis of claims data to confirm members whose attribution changed based on MCO analysis of member utilization have been attributed correctly.

Attribution for Setting Incentive Fund Pools:

HSTP Incentive Fund Pools for each AE are set based on estimated member months for the program year. EOHHS estimates the member months that will be attributed to each AE for each MCO contract based on the number of attributed MCO members attributed to the AE in a single month at the end of the preceding program year or the beginning of the performance year to which the Incentive Fund Pool will apply. For example, depending on the timing of data availability, EOHHS may use attribution data from April, May, June, or July 2021 to estimate member months for the performance year beginning July 1, 2021.

Attribution to Evaluate AE Performance on Outcome Metrics Measured for the Incentive Fund Pool

Outcome measure performance is evaluated on an annual, calendar year basis.

For purposes of evaluating annual outcome measure performance, each member will be attributed to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, the member will not be attributed to any AE for outcome measurement purposes. EOHHS and MCOs shall determine attribution using the AE provider rosters that are in place as of December of the performance year.

For purposes of providing quarterly performance reports to AEs, each member will be attributed to the AE to which the member is attributed in the final month of each quarter, using the AE TIN rosters that apply in the final month of each quarter. For example, for the January through March quarter, attribution will be based on attribution in March using the March AE TIN rosters.

Attribution to Evaluate AE performance on Quality Measures

Quality measure performance is evaluated on an annual, calendar year basis.

For purposes of evaluating annual quality measure performance, each member will be attributed to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, the member will not be attributed to any AE for quality measurement purposes. MCOs shall determine attribution using the AE TIN rosters that are in place as of December of the performance year.

Attribution for Total Cost of Care Analysis:

For purposes of TCOC calculations, each member should be assigned to a single AE in each baseline and performance year. That is, each member's costs during a given baseline or performance year should only be attributed to a single AE. The AE to which these costs should be attributed is based on the AE to which the member is attributed in the member's latest month of enrollment during each baseline or performance year in the MCO's Medicaid plan.

For example, consider a member enrolled with MCO #1:

- If the member is attributed to AE X from July 2020 through February 2021 and attributed to AE Y from March 2021 through June 2021, then the member's costs from July 2020 through June 2021 are attributed to AE Y.
- If this member loses Medicaid eligibility as of June 1, 2021, the member's costs from July 2020 through May 31, 2021 would be attributed to AE Y.
- If the member is attributed to AE X from July 2020 through February 2021, then is attributed to "no AE" from March 2021 through June 2021 due to switching to a PCP that does not participate in an AE, the member's costs from July 2020 through June 2021 would not be attributed to any AE.

Please see Attachment C, "Illustrative Attribution and Rate Cell Examples" for more details on the TCOC attribution methodology.

TCOC calculations for the baseline and performance years should be based on very similar provider networks in each AE in order to ensure that changes between the baseline and performance year are based on performance rather than the AE's composition. Therefore, attribution to set baseline year TCOC should be based on the TINs on the roster of each AE as of the date baseline year cost data is submitted, and when quarterly and final performance is calculated, attribution should use this same set of TINs for each AE.

Over the course of the performance year, it is possible that some TINs will change AEs or leave or enter the AE program. These changes will be reflected in the TINs used for calculating baseline data applicable in the following program year. For example, performance year costs in Program Year 3 (PY3) will be attributed using the TINs on each AE roster when the MCO submitted the baseline data used to generate PY3 TCOC targets. Then, in the spring of 2021, the TINs on AE rosters at that time (including any changes that took place between July 2020 and March or April 2021) will be used to calculate baseline data for PY4 TCOC targets, and performance year cost attribution for PY4 will use the TINs on the AE rosters from the spring of 2021.

Note that during each Performance Year, MCOs will submit data on a quarterly basis in response to the Performance Year Data Request. For these submissions, MCOs should attribute costs in the same manner described above and using the same AE rosters. Members and member costs should be attributed to the AE to which the member was attributed in the member's latest month of enrollment during the period for which data is reported. The Performance Year Data Request Template includes more detailed instructions regarding calculation of specific values in that submission.

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)

The Contractor will 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, the Contractor will 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. The 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. The Contractor will auto assign members to a NCQA recognized Patient Centered Medical Home, where possible.
- In addition to the above, EOHHS recognizes the importance of members being enrolled in a certified AE and a Patient Centered Medical Home (PCMH). EOHHS expects that, as applicable to the eligible populations, the Contractor will prioritize auto-assignment (a) first, to PCPs in a PCMH practice that is also a participating provider in a certified and contracted AE; second, to PCPs in a PCMH practice that are not in a contracted AE; third to non-PCMH PCP participating in a contracted AE; and fourth to PCPs in a non-PCMH and non- AE participating practice.

The Contractor is responsible for creating an auto-assignment algorithm and submitting this algorithm to EOHHS for review and approval within ninety (90) days of the execution of this contract. Once this logic is approved by EOHHS, the health plan should operationalize this within sixty (60) days. The 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 than quarterly or at an interval defined by EOHHS.

- The Contractor will notify PCPs of newly assigned members in a timely manner.
- If a Medicaid-only member requests a change in his or her PCP, the 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.

The Contractor will 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, the 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.

2.04.01 Changing PCPs

The Contractor will 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, the 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