

EOHHS Attribution Guidance for the AE Program

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This guidance includes the following elements:

Rhode Island Medicaid Accountable Entity Program **Attachment M: Accountable Entity Attribution** **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~~intention 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 with an approved IHH diagnosis and to allow Long-Term Services and Supports (LTSS) providers to assume this responsibility for members receiving certain long-term care services; 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.
 - For specialized LTSS AEs, the provider roster will consist of agencies licensed by the Rhode Island Department of Health to provide one or more of the attributable services listed in Table A in Section 4.2.
- 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.
 - For specialized LTSS AEs, this includes:
 - Monthly attribution based on service authorizations; and
 - AE validation of the attribution.

~~This~~ These attribution ~~guidance sets~~ 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. An attribution-eligible provider can only participate in one specialized LTSS AE at a time for the purposes of attribution.

A member can only be attributed to a single comprehensive AE at a time. A member can only be attributed to a single specialized LTSS AE at a time. However, 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.

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. Rhody Health Options (RHO) members shall be included in AE attribution if the RHO member is receiving Medicaid benefits only (not Medicare). RHO and Medicare-Medicaid Plan 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 to comprehensive AE's 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 ~~are prepared~~ 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 monthly roster produced by BHDDH approved methodology 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 after for one year following IHH discharge unless:
 - The member is assigned by BHDDH to a different IHH;

- 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.~~

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; ~~and~~

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. Guidance Requirements for PCP related attribution ~~is~~ 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 ~~a visit~~ 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 is a single visit to a PCP within the AE and a single visit to a non-participating provider, there is no change to the attribution.~~
 - ~~2.5.1.2. 2.5.1.1. Where there are threetwo~~ 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 ~~there are more than two~~ the AE's providers ~~and there is a tie with the AE~~ are tied for the highest number of visits, ~~the~~ attribution will remain with the AE.
~~Where there are four or more visits, and there is a tie, attribution will be based on the most recent primary care visit.~~

To be enrolled in Medicaid managed care, an individual must be Medicaid eligible. MCOs shall be required on a monthly basis 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.

4. Specialized LTSS AE Attribution

4.1. Population Eligible for Attribution to a Specialized LTSS AE

The population eligible for attribution to a specialized LTSS AE 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. An LTSS eligibility determination in the State Medicaid eligibility system is not required for attribution.

4.2. Certified Specialized LTSS AE-Identified Providers

Attribution of members to a specialized LTSS AE will be based on the defined roster of providers included within the structure of the AE. Each AE shall have a defined roster of providers. For specialized LTSS AEs, the provider roster will consist of agencies licensed by the Rhode Island Department of Health to provide one or more of the attributable services listed in Table A. Actual attribution will depend on the composition of providers in the ~~Specialized~~specialized LTSS AE.

Table A: Specialized LTSS AE Attributable Services and Billing Codes

Service Type	Attributable Services
Home and Community Based Services	<ul style="list-style-type: none"> • Home Care Services, including: <ul style="list-style-type: none"> ○ Homemaker Services <ul style="list-style-type: none"> ▪ S5130 ○ Home Health Aide/CNA/Attendant Care Services <ul style="list-style-type: none"> ▪ S5125 ▪ S9122 ▪ T1004 • Adult Day Health Services <ul style="list-style-type: none"> ○ S5100-S5109 • Assisted Living <ul style="list-style-type: none"> ○ T2031 • Supported Living Arrangements/Shared Living <ul style="list-style-type: none"> ○ S5136 ○ T2025 ○ T2028
Institutional Services	<ul style="list-style-type: none"> • Long-Stay/Custodial <u>and Skilled</u> Nursing Facility Care ○ Type of bill: 263 • Revenue codes: 0100, 0128, 0129

Services managed by BHDDH for people with intellectual and developmental disabilities are excluded as ~~the~~ attributable services.

4.3. Attribution Methodology for Specialized LTSS AEs

Attribution to a specialized LTSS AE will be based on two sequential steps each month:

- Step 1: Monthly attribution based on service authorizations; and
- Step 2: ~~AE validation~~Validation of the attribution.

Step 1: Monthly attribution based on service authorizations

When a Medicaid beneficiary in Medicaid managed care or Medicaid fee-for-service receives any of the attributable services in Table A, a service authorization or approval is entered into one or more information systems used by the MCO or the State to manage beneficiaries' services. For specialized LTSS AE attribution, this authorization and approval information will be used to link a beneficiary to a specific provider and will be used to attribute beneficiaries to a specialized LTSS AE on a monthly basis using the attribution ~~guidance~~requirements described below.

The initial attribution to the AE will be based on any active authorization or approval, as of the first day of the month, for a service listed in Table A with any provider on the AE roster. On a monthly basis, the initial attribution will be updated to reflect new authorizations for services, changes in authorization, and changes in Medicaid eligibility. These updates will include people newly attributed to an AE, people who are removed from AE attribution, and people who move from the attribution for one AE to the attribution for another AE.

AEs are expected to have continuing responsibility for the care and outcomes of their patients on an on-going basis, unless there is a compelling reason for that responsibility to change. Once attributed to a specialized LTSS AE, a Medicaid beneficiary will continue to be attributed ~~on a monthly basis~~ to the specialized LTSS AE for at least 129 months after the beneficiary stops receiving services from a provider in ~~at~~the specialized LTSS AE, unless there is a new authorization for a different attributable service with a provider in a different specialized LTSS AE. When this occurs, the attribution will be updated to the ~~Specialized~~specialized LTSS AE that includes the provider with the new authorization after 90 days. If the new authorization begins more than 90 days after the terminated authorization ends, the attribution will be updated at the next monthly attribution update. Examples of attribution scenarios are provided for illustrative purposes in Table B.

Table B: Illustrative Examples of Specialized LTSS AE Attribution Scenarios

Scenario	Impact on Attribution	Example
<p>An authorization for an attributable service with a provider in an AE is terminated. Within three months of the authorization terminating, a new authorization for an attributable service with a provider in a different AE becomes effective.</p>	<p>The beneficiary's attribution will remain attributed to the AE that includes the provider with the terminated authorization for 90 days after the authorization is terminated. The attribution will be updated to the AE that includes the provider with the new authorization during the next monthly update that occurs 90 days after the first authorization is terminated.</p>	<p>Mary is receiving Home Care Services from a provider in AE 1. Her Home Care authorization is terminated when she has a Long-Stay/Custodial Nursing Facility admission on January 15 and a new authorization for a Long-Stay/Custodial Nursing Facility Care with a provider in AE 2 becomes effective. She remains in the facility for over 90 days. Mary's attribution is updated from AE 1 to AE 2 in the attribution update that is effective May 1.</p>
<p>An authorization for an attributable service with a provider in an AE is terminated. More than three months after the authorization terminated, a new authorization for an attributable service with a provider in a different AE becomes effective.</p>	<p>The attribution will be updated to the AE that includes the new provider during the next monthly update that occurs after the new authorization is effective.</p>	<p>Sue is receiving Adult Day Health Services from a provider in AE 3. She stops going to this Adult Day Health Services provider on March 12. She begins going to another Adult Day Health Services Provider, which is part of AE 4, on August 16. Sue remains attributed to AE 3 until August 31. Her attribution is updated from AE 3 to AE 4 in the attribution update that is effective September 1.</p>
<p>An authorization for an attributable service with a provider in an AE is terminated. There is no other active authorization for an attributable service for more than <u>129</u> months.</p>	<p>The beneficiary will remain attributed to the AE for <u>129</u> months after the authorization is terminated. The attribution will be updated to remove this person in the next monthly update that occurs <u>129</u> months after the authorization is terminated.</p>	<p>Eduardo is receiving Home Care Services from a provider in AE X. His Home Care authorization is terminated on April 20, 2018, and no other authorization for an attributable service is active for the next <u>129</u> months. Eduardo remains attributed to AE X for <u>129</u> months after April 20, 2018. He is removed from AE X's attribution in the attribution update that is effective May 1, 2019.</p>

NOTE: Table B provides examples of some specialized LTSS AE attribution scenarios for illustrative purposes only. It is not intended to address all potential attribution scenarios.

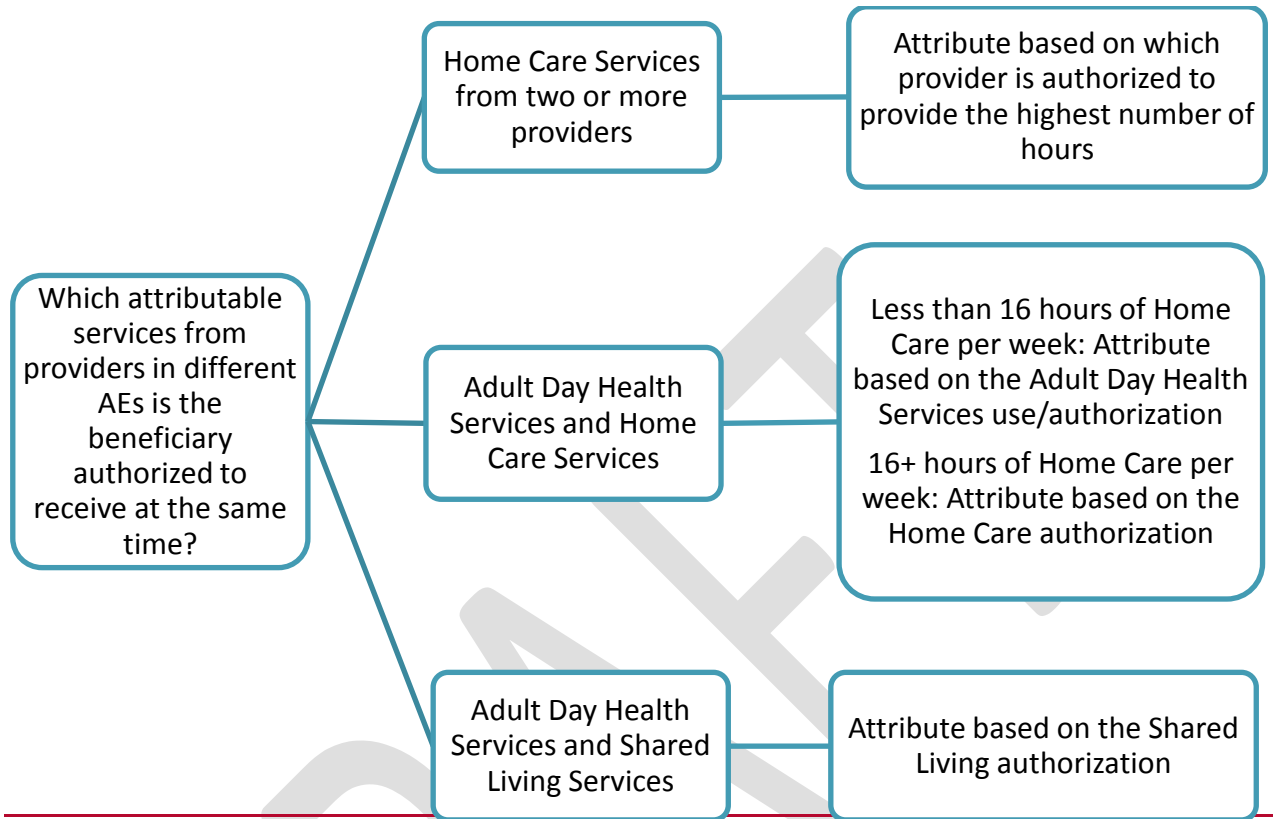
Attribution to a specialized LTSS AE will be unaffected by changes in Medicaid managed care enrollment (e.g., moved from Medicaid fee-for-service to Rhody Health Options, moved from Rhody Health Options to the Medicare-Medicaid Plan), as long as the AE is contracted with the MCO/payer the beneficiary is enrolled in.

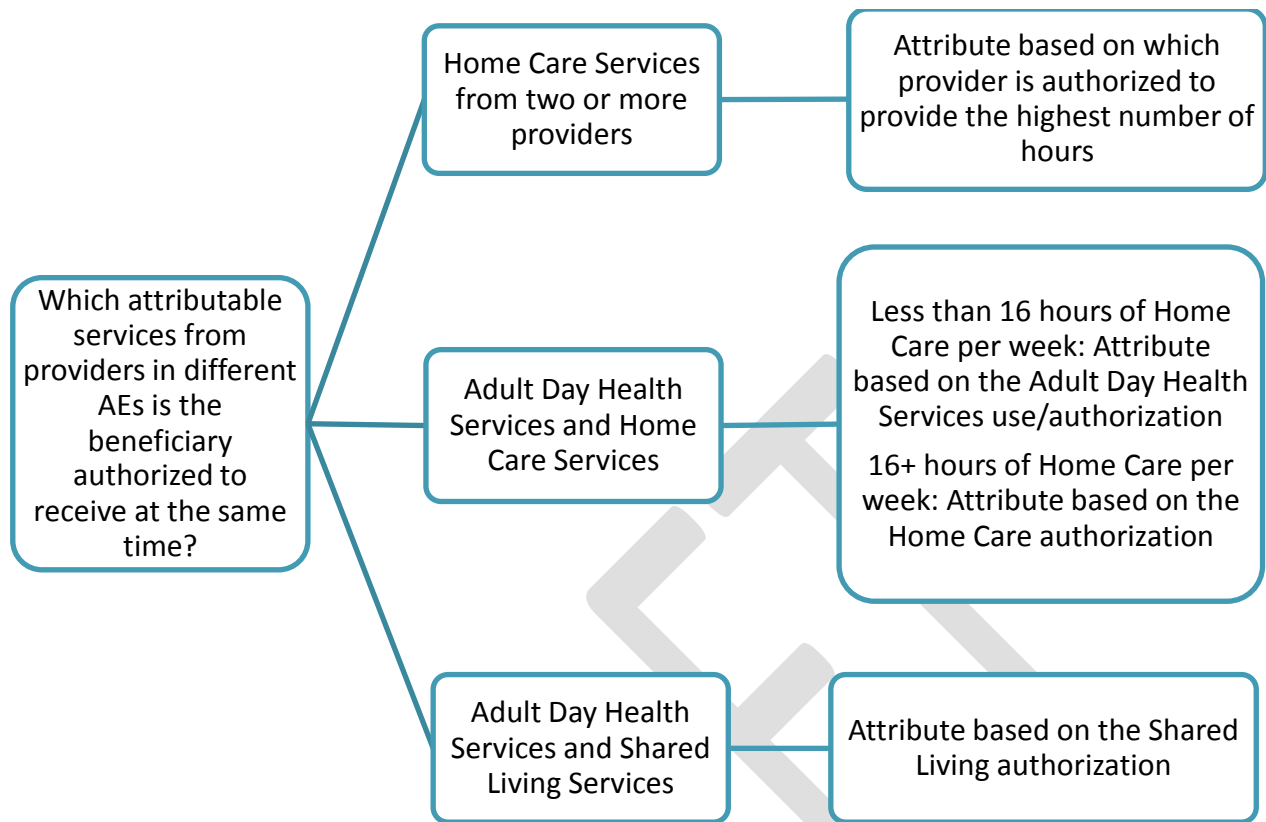
If a beneficiary has active authorizations for services from providers in different AEs at the same time, the hierarchy for attribution will be as follows:

1. If a beneficiary is authorized to receive Home Care Services from more than one agency, attribution will be to the AE that includes the provider authorized for the highest number of service hours. If there is a tie for the provider with the highest number of hours, attribution will be based on the provider that historically has provided the highest number of hours.
2. If ~~an adult~~ beneficiary is authorized to receive Adult Day Health Services and Home Care Services, attribution will be to the AE that includes the Adult Day Health provider if the beneficiary is receiving fewer than sixteen (16) hours per week of Home Care Services from a single provider. Otherwise, attribution will be based on the AE that includes the provider with the highest number of Home Care Services.
3. If an adult beneficiary is authorized to receive Adult Day Health Services and Shared Living Services, attribution will be to the AE that includes the Shared Living provider.

Figure 1 summarizes the attribution rules when beneficiaries receive specialized LTSS AE attributable services from two or more providers in different AEs at the same time.

Figure 1: Attributing Beneficiaries Who Simultaneously Receive Attributable Services from Providers in Different AEs ~~Simultaneously~~





NOTE: Figure 1 addresses only those scenarios in which beneficiaries receive attributable services from multiple providers simultaneously. As a result, it does not reference all types of attributable services.

These guidelines apply to both the initial attribution and the monthly updates. Due to Medicaid rules related to service use, beneficiaries should not ~~be receiving~~ receive Home Care Services while receiving Shared Living, Assisted Living, or Nursing Facility services, ~~or receiving Adult Day Health Services while receiving Assisted Living or Nursing Facility services.~~ Beneficiaries should also not ~~be receiving~~ receive Shared Living, Assisted Living, and Nursing Facility services simultaneously. As a result, the attribution hierarchy does not address those situations. In the event that a beneficiary is identified to have overlapping authorizations for these services, the MCO and/or EOHHS will validate the authorization information and ensure appropriate assignment. Where other discrepancies in the attribution are identified, the MCO and/or EOHHS may also validate and adjust the assignment as needed on a case-by-case basis.

~~Figure 2 illustrates which beneficiaries should be included and excluded from a specialized LTSS AEs attribution.~~

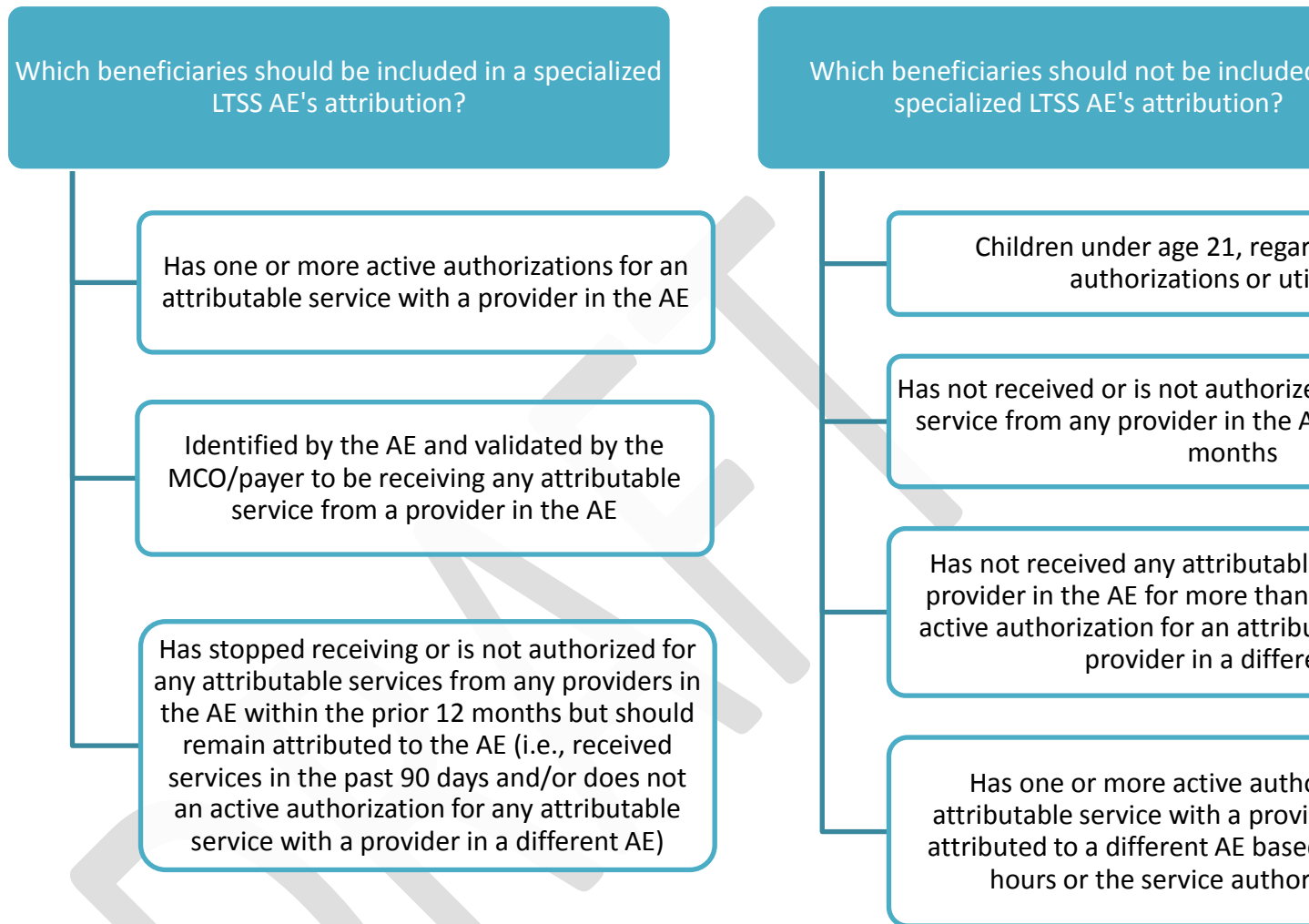
Step 2: ~~AE validation~~Validation of the attribution

No more than 5 calendar days after the first day of each month, each AE will receive a list of all Medicaid beneficiaries attributed to the AE from each MCO/payer. The AE will have 5 business days to identify and report any person actively receiving any of the attributable services in Table A who is not included in the attribution list. The MCO (for managed care enrolled

members) and the State or its designee (for Medicaid fee-for-service beneficiaries) will validate the AE-reported information and update the attribution list as appropriate. Where other discrepancies in the attribution list are identified, the MCO/payer may also validate and adjust the assignment as needed on a case-by-case basis.

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Figure 2: Summary of Inclusion and Exclusion Criteria for Specialized LTSS AE Attribution



To be attributed to a specialized LTSS AE, an individual must be Medicaid eligible. He or she may be receiving services through either managed care or fee-for-service. The MCO/payer shall be required on a monthly basis 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, and persons whose attribution has changed pursuant to these guidelines.

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 than 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

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