ONECARE PAYER PROGRAM ATTRIBUTION GUIDE

Attribution is the process by which an ACO becomes accountable for the costs and quality of care for a member. Attribution is primarily based on a member's primary care relationship with a provider participating in the ACO network.

Key Definitions:

- ✓ **Opt Out** = Members cannot opt out of being attributed to an ACO; however, a member may choose not to have their claims data shared with the ACO. If a member opts out of data sharing, the ACO will still be accountable for that member's costs and quality of care. Because attributed members retain full freedom of choice of provider, a member need not seek care within the ACO network if he or she is attributed. If a member opts-out of data sharing, the ACO and the Payer may still engage in certain limited data sharing for improvement purposes (for example, the member may still be selected for quality measure reporting).

- ✓ **Allowed Amount** = amount paid by the insurer + the amount the member is responsible for paying (deductible, coinsurance, etc.)

- ✓ **Qualified Evaluation and Management (QEM) services** = Codes (HCPCS/CPT/Revenue Codes) used to determine if a member is receiving primary care services by ACO providers and should be attributed to the ACO.

- ✓ **Prospective Attribution** = The population for which the ACO is accountable is defined at the start of the performance year. This allows the ACO to begin identifying and engaging members as early as possible during the year.

- ✓ **Retrospective Attribution** = The attributed population is not finalized until the end of each performance year.

Vermont Medicaid Next Gen Pilot (VMNG):

The attribution methodology for VMNG was developed based on the Medicare Next Gen attribution methodology, and as a result the two methodologies are very similar. However, the Vermont Medicaid Next Gen methodology includes a larger list of Qualified Evaluation and Management (QEM) services than the Medicare Next Gen methodology to determine whether a member has a primary care relationship with a provider. The list of services was selected to align with the Blueprint for

Health attribution methodology, and the attribution methodology that had been used previously for the Vermont Medicaid Shared Savings Program (VMSSP).

The attribution methodology is **prospective**. Unlike VMSSP, which used a retrospective attribution methodology. Because the attribution methodology is prospective, no additional Medicaid members can be attributed during the performance year. However, members may fall off of attribution during the performance year if they lose Medicaid eligibility, if they gain additional commercial or Medicare insurance coverage, or if they pass away. The ACO will be accountable for members' costs and quality of care for the months in which members are eligible for attribution.

Only Medicaid members with primary care relationships with ACO network providers in participating communities will be prospectively attributed for 2018. The QEM services are used to determine which provider a member has historically seen for the majority of their primary care. If the provider identified is participating in the ACO network for VMNG, the member would be attributed to the ACO.

Primary care providers (including providers with specialties in **general practice, family medicine, internal medicine, pediatric medicine, geriatric medicine, and naturopathic medicine, including APPs** can attribute members to an ACO. Though the CMS Next Generation attribution methodology allows attribution to specialists, the VMNG program only allows attribution to the above primary care provider specialties in 2018.

Timeframe and Method:

To identify members for prospective attribution for the 2018 performance year, the two-year period from **July 1, 2015 to June 30, 2017** was used. Payments for QEM services in the first Attribution Year are summed and weighted by a factor of 1/3; payments for QEM services in the second Attribution Year are summed and weighted by a factor of 2/3. A member is attributed to the provider from which the member received the majority of weighted QEM service payments during the two-year attribution period.

Eligibility Requirements:

Medicaid members must have at least one month of Medicaid enrollment in either of the two Attribution Years (July 1, 2015 to June 30, 2016 and July 1,2016 to June 30, 2017) to be considered eligible for attribution. Hence, anyone born after June 30, 2017 would not be attributable for 2018 (no newborns).

A member will not be attributed to the ACO if:

- They are dually eligible for Medicare

- They have evidence of additional sources of insurance coverage (e.g. commercial)
- They receive a limited Medicaid benefits package (i.e. pharmacy-only benefits)
- They did not have any paid QEM service claims
- The DVHA member is not enrolled as a DVHA member at the start of the Performance Year

Opt-outs and Confidential Claims:

Members cannot actively choose to be attributed to an ACO; however, if a member newly established a primary care relationship with a provider participating in VMNB, they may be eligible for prospective attribution in a subsequent performance year.

New members will be notified of their provider's participation in the ACO. Member may choose to opt out of data sharing at any time by notifying the ACO or DVHA.

All claims involving alcohol or substance abuse diagnosis or treatment information will only be shared with the ACO at an aggregate level.

Medicare NextGen:

The Medicare NextGen attribution methodology is **prospective**. However, there will be quarterly updates to the attribution list to remove members that have lost attribution eligibility. A member who is not attribution-eligible in one or more months of the performance year will be excluded from the population of attributed members retroactive to the start of the performance year. Hence, all members will contribute 12 months of experience to the performance year, unless the member dies (then the member months for the member would equal the number of months the member was alive during the performance year). Furthermore, if during the performance year, at least 50% of the member's QEM services are performed by providers outside the ACO's service area, the member will be excluded. The ACO's service area is defined as all counties in which providers that can attribute lives have offices and the adjacent counties.

ACOs must maintain a minimum of 10,000 members during the performance year.

Timeframe and Method:

To identify members for **prospective** attribution for the 2018 performance year, the two-year period from **July 1, 2015 to June 30, 2017** was used. Attribution of a member is determined by comparing for the 2-year look back period:

1. The weighted allowable charge for all QEM services that the member received from ACO providers

2. The weighted allowable charge for all QEM services that the member received from each provider or supplier not participating in a NextGen ACO

Allowable charges for QEM services in the first attribution year are summed and weighted by a factor of 1/3; allowable charges for QEM services in the second attribution year are summed and weighted by a factor of 2/3.

Attribution uses a two-stage algorithm:

1. **Attribution based on primary care services provided by primary care specialists.** If 10% or more of the weighted allowable charges for QEM services received by a member during the 2-year alignment period are obtained from primary care specialists, then the member attribution is based on the weighted allowable charges incurred on QEM services provided by primary care specialists.
2. **Attribution based on primary care services provided by select non-primary care specialties.** If less than 10% of the weighted allowable charges incurred on QEM services received by a member during the 2-year alignment period are provided by primary care specialists, the attribution is based on the weighted allowable charges incurred on QEM services provided by physicians and practitioners with certain non-primary specialties.
3. In the case of a tie in the dollar amount of the weighted allowed charges for QEM services, the member will be attributed to the provider or supplier from whom the member most recently obtained a QEM service.

Primary care specialties include **general practice, family medicine, internal medicine, pediatric medicine, geriatric medicine, nurse practitioners, clinical nurse specialists, and physician assistants**.

Specialists that are included in step 2 above include:

- **Cardiology**
- **Osteopathic manipulative medicine**
- **Neurology**
- **Obstetrics/gynecology**
- **Sports medicine**
- **Physical medicine and rehabilitation**
- **Psychiatry**
- **Geriatric psychiatry**
- **Pulmonology**
- **Nephrology**
- **Endocrinology**
- **Multispecialty clinic or group practice**
- **Addiction medicine**
- **Hematology**
- **Hematology/oncology**
- **Preventative medicine**
- **Medical oncology**
- **Gynecological/oncology**
- **Neuropsychiatry**

Eligibility Requirements:

Attribution is performed prior to the start of the performance year, quarterly, and again prior to financial settlement.

To be eligible for attribution, a member must:

- Be covered under Part A in January of the performance year and in every month of the performance year in which the member is alive
- Have no months of coverage under only Part A
- Have no months of coverage under only Part B
- Have no months of coverage under a Medicare Advantage or other Medicare managed care plan
- Have no months of coverage in which Medicare is the secondary payer
- Must be a resident of the United States
- Have at least one QEM service claim paid during the 2-year alignment period

Opt-outs and Confidential Claims:

Members can opt-out (or back in) of data sharing by calling 1-800-MEDICARE. All members will receive a letter from the ACO about the program. If a member opted out of data sharing in MSSP, their decision will continue into the NextGen program.

All claims involving alcohol or substance abuse diagnosis or treatment information will only be shared with the ACO at an aggregate level, unless the member actively opts in to sharing this information with the ACO. The member may do this by submitting a CMS-approved substance use disorder opt in form to the ACO. The ACO would then send the opt-in form to CMS.

Blue Cross/Blue Shield QHP:

To identify members for **prospective** attribution for the 2018 performance year, the most recent 24 months of claims were used. There will be no additions to the list during the year, but attributed lives whose coverage ends during the year will be removed.

ACOs must maintain a minimum of 10,000 members during the performance year.

Timeframe and Method:

If a plan requires the member to select a primary care provider and the member does – the member is attributed to that provider.

For all other members, the QEM services rendered during the two-year lookback are counted for services performed by primary care providers (**internal medicine, general medicine, geriatric medicine, family medicine, pediatrics,**

naturopathic medicine; or NPs, PAs, or providers in FQHCs or RHCs). The member is attributed to the practice where they had the greatest number of QEMs performed by these providers. In the case of a tie, the member will be attributed to the practice with the most recent visit.

Eligibility Requirements:

Members must meet the following criteria as of the last day in the look back period:

- Employer situated in Vermont or member residing in Vermont
- BCBS is the primary insurer

Opt-outs and Confidential Claims:

Members can not opt out of data sharing in this program. All claims involving alcohol or substance abuse diagnosis or treatment information will only be shared with the ACO at an aggregate level.

QEM Services

Code	Description	Medicaid	Medicare	BCBS QHP
Office or Other Outpatient Services				
99201	New Patient, brief	X	X	X
99202	New Patient, limited	X	X	X
99203	New Patient, moderate	X	X	X
99204	New Patient, comprehensive	X	X	X
99205	New Patient, extensive	X	X	X
99211	Established Patient, brief	X	X	X
99212	Established Patient, limited	X	X	X
99213	Established Patient, moderate	X	X	X
99214	Established Patient, comprehensive	X	X	X
99215	Established Patient, extensive	X	X	X
99241	Consultation: Office and Outpatient, 15 minutes	X		X
99242	Consultation: Office and Outpatient, 30 minutes	X		X
99243	Consultation: Office and Outpatient, 40 minutes	X		X
99244	Consultation: Office and Outpatient, 60 minutes	X		X
99245	Consultation: Office and Outpatient, 80 minutes	X		X
Nursing Facility Care				
99304	Initial Nursing Facility Care, brief	X		X
99305	Initial Nursing Facility Care, moderate	X		X
99306	Initial Nursing Facility Care, comprehensive	X		X
99307	Subsequent Nursing Facility Care, brief	X		X
99308	Subsequent Nursing Facility Care, limited	X		X
99309	Subsequent Nursing Facility Care, comprehensive	X		X
99310	Subsequent Nursing Facility Care, extensive	X		X
99315	Nursing Facility Discharge Services, brief	X		
99316	Nursing Facility Discharge Services, comprehensive	X		
99318	Other Nursing Facility Services	X		

Code	Description	Medicaid	Medicare	BCBS QHP
Domiciliary, Rest Home, or Custodial Care Services				
99324	New Patient, brief	X	X	X
99325	New Patient, limited	X	X	X
99326	New Patient, moderate	X	X	X
99327	New Patient, comprehensive	X	X	X
99328	New Patient, extensive	X	X	X
99334	Established Patient, brief	X	X	X
99335	Established Patient, moderate	X	X	X
99336	Established Patient, comprehensive	X	X	X
99337	Established Patient, extensive	X	X	X
Domiciliary, Rest Home, or Home Care Plan Oversight Services				
99339	Brief	X	X	
99340	Comprehensive	X	X	
Home Services				
99341	New Patient, brief	X	X	X
99342	New Patient, limited	X	X	X
99343	New Patient, moderate	X	X	X
99344	New Patient, comprehensive	X	X	X
99345	New Patient, extensive	X	X	X
99347	Established Patient, brief	X	X	X
99348	Established Patient, moderate	X	X	X
99349	Established Patient, comprehensive	X	X	X
99350	Established Patient, extensive	X	X	X
Preventative Care / Wellness Visits				
G0402	Welcome to Medicare visit		X	
G0438	Annual wellness visit	X	X	
G0439	Annual wellness visit	X	X	
99381	Preventive Medicine Visits - Initial, age younger than 1 year	X		X
99382	Preventive Medicine Visits – Initial, age 1 through 4 years	X		X
99383	Preventive Medicine Visits – Initial, age 5 through 11 years	X		X

Code	Description	Medicaid	Medicare	BCBS QHP
99384	Preventive Medicine Visits – Initial, age 12 through 17 years	X		X
99385	Preventive Medicine Visits – Initial, age 18 through 39 years	X		X
99386	Preventive Medicine Visits – Initial, age 40 through 64 years	X		X
99387	Preventive Medicine Visits – Initial, age 65 years and older	X		X
99391	Preventive Medicine Visits – Periodic, age younger than 1 year	X		X
99392	Preventive Medicine Visits – Periodic, age 1 through 4 years	X		X
99393	Preventive Medicine Visits – Periodic, age 5 through 11 years	X		X
99394	Preventive Medicine Visits – Periodic, age 12 through 17 years	X		X
99395	Preventive Medicine Visits – Periodic, age 18 through 39 years	X		X
99396	Preventive Medicine Visits – Periodic, age 40 through 64 years	X		X
99397	Preventive Medicine Visits – Periodic, age 65 years and older	X		X
99401	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 15	X		X
99402	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 30	X		X
99403	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 45	X		X
99404	Counseling Services: Risk Factor and Behavioral Change Mod, approx. 60	X		X
99406	Counseling Services: Smoking and Tobacco Cessation, 3 to 10 minutes	X		X
99407	Counseling Services: Smoking and Tobacco Cessation, greater than 10	X		X
99408	Counseling Services: Alcohol and/or substance abuse, 3 to 10 minutes	X		X
99409	Counseling Services: Alcohol and/or substance abuse, greater than 10	X		X
99411	Counseling Services: Preventive medicine in group setting, 30 minutes	X		X
99412	Counseling Services: Preventive medicine in group setting, 60 minutes	X		X
99420	Health Risk Assessment – Admin and interpretation of health risk assessment	X		X
99429	Health Risk Assessment – Unlisted preventive medicine service	X		X
Child and Maternal Health				
99460	Evaluation and Management Svcs. for Age 28 Days or less, initial hosp. or	X		X
99461	Evaluation and Management Svcs. for Age 28 Days or less, initial care	X		X
99462	Evaluation and Management Svcs. for Age 28 Days or less, subsequent hosp.	X		X
99463	Evaluation and Management Svcs. for Age 28 Days or less, admitted and	X		X
99464	Attendance at delivery and initial stabilization of newborn			X
99465	Delivery/birthing room resuscitation			X

Code	Description	Medicaid	Medicare	BCBS QHP
Transitional Care Management Services				
99495	Communication (14 days of discharge)		X	
99496	Communication (7 days of discharge)		X	
Chronic Care Management Services				
99490	Comprehensive care plan establishment/implementations/revision/monitoring		X	
Prolonged Services - Prolonged Physician Services with Direct (Face-to-Face) Patient Contact				
99354	Prolonged Services Direct Contact, first hour	X		X
99355	Prolonged Services Direct Contact, each additional 30 minutes	X		X
Prolonged Services - Prolonged Physician Services without Direct (Face-to-Face) Patient Contact				
99358	Prolonged Services Indirect Contact, first hour	X		X
99359	Prolonged Services Indirect Contact, each additional 30 minutes	X		X
FQHC/RHC Encounter				
T1015	Clinic visit/ encounter, all-inclusive	X		
0521	Revenue Code = Clinic visit by member to RHC/FQHC			X
0522	Revenue Code = Home visit by RHC/FQHC practitioner			X
0525	Revenue Code = Nursing home visit by RHC/FQHC practitioner			X