Provider-led Arkansas Shared Savings Entity (PASSE)

Proposed Attribution Model

Background Paper

Arkansas Department of Human Services

June 27, 2017

Purpose

The purpose of this background paper is to describe how the Arkansas Department of Human Services (DHS) intends to use an attribution methodology to enroll eligible individuals into a new risk-based model of organized care created by Act 775 of 2017. Under this unique organized care model, providers will enter into new partnerships with experienced organizations that perform the administrative functions required by federal Medicaid managed care regulations. Together, groups of providers and their business partners will form a new business organization called a Provider-led Arkansas Shared Savings Entity (PASSE).

Introduction

This new organized care model will provide an integrated system of coordinated care. The importance of coordinated care is described in a 2016 paper, *Attribution Methods and Implications for Measuring Performance in Health Care*, commissioned by the National Quality Forum (NQF). "The resulting system-failures from poorly coordinated care are perceived to be responsible for many of the spending and quality problems in the United States."[1]

There are different methods of attribution used by different programs across the country. Researchers for NQF found 171 unique attribution models. NQF does not recommend a specific attribution model as there is insufficient evidence to do so. Attribution, also known as assignment, is not new to Arkansas Medicaid. DHS already uses attribution to assign individuals to Patient Centered Medical Homes (PCMH). Attribution is simply a matter of matching an individual to his/her group of providers. In this case, the individual will then follow those providers into the PASSE which the providers have joined.

As emphasized in NQF's Final Report*, Attribution Principles and Approaches*, "[k]ey criteria to consider when selecting an attribution model are actionability, accuracy, fairness, and transparency. "[2] NQF also states, "[i]n a fair, meaningful attribution model, an accountable unit must be able to influence the outcomes for which it is being held accountable either directly or through collaboration with others."[3]

Background

Currently, Arkansas Medicaid spends approximately $2 billion annually on the entire array of Medicaid services on about 150,000 individuals who have at least one claim for behavioral health (BH) or developmental disabilities /intellectual disability (DD/ID) services. This model will be targeted to about 30,000 individuals with higher levels of need for behavioral health, substance use disorder, and developmental disability/intellectual disability services, in addition to their medical care. Arkansas Medicaid spends about $1 billion annually on care for the targeted individuals.

---

[1] Ryan, A, Linden, A, Maurer, K, Werner, R,, Nallamothu, B. *Attribution Methods and Implications for Measuring Performance in Health Care*. Version 7/15/16. National Quality Forum. Washington, DC 2016.
[2] National Quality Forum. *Attribution Principles and Approaches Final Report December 2016,* Washington, DC. p. 10.
[3]Ibid. p. 25.

Each PASSE will become responsible for integrating specialized services for individuals who have a need for intensive levels of treatment or care due to mental illness, substance abuse, or intellectual and developmental disabilities with their physical health care. The Arkansas Department of Insurance (AID) will license and regulate the PASSEs as a risk-based provider organization under the state insurance laws. A PASSE must complete a Medicaid provider agreement and if approved, will be accountable to both AID and the Department of Human Services (DHS). A PASSE must operate on a statewide basis. A PASSE must meet the requirements of federal Medicaid managed care regulations.

Beginning September 1, 2017, individuals in need of BH or DD/ID services will undergo an Independent Assessment (IA). Individuals will be stratified into three levels of need—Tier I (lowest), Tier II (intermediate), and Tier III (highest). Individuals meeting the level of care needs in Tier II and Tier III will be mandated to enroll in a PASSE under Section 1915(b) authority. Beginning October 1, 2017, the PASSE will assume responsibility of care coordination for each of their members. Beginning January 1, 2019, each PASSE will assume full risk for the cost of benefits and administration. In the federal payment model taxonomy, the PASSE will be in Category 4, a population-based payment model. Individuals with BH or DD service needs who meet the Tier I level of care may voluntarily enroll in a PASSE beginning January 1, 2019.

Enrollment in a PASSE Through Attribution

Individuals will be enrolled in a PASSE by DHS through an attribution methodology based on the individual's relationship with providers who joined that PASSE's network of providers. Given the medical complexity of these individuals, they most likely receive care from multiple providers. The NQF found that visits and spending are the two most common approaches to determine the qualifying events for attribution. NQF also "… recognized that claims-based approaches have the benefit of reflecting the care that was actually provided."[4]

Based on an individual's IA and relationships with providers, DHS will attribute that individual into a PASSE. For existing Medicaid clients, DHS will examine claims history to determine specialty service providers, primary care providers, pharmacists, and other providers used by the individual. Then, the individual will be attributed to a PASSE according to a methodology that will be weighted toward the individual's DD and BH specialty providers.

However, as noted by NQF, "… providers are not inherently equal in their roles in patient care even when they have similar levels of contact with patients."[5] "The issue of care dispersion creates additional challenges when selecting an appropriate method to attribute patients to providers."[6] Therefore, attribution must consider the ability of a provider to influence other providers in the total cost of care.

[4] National Quality Forum, *Attribution Principles and Approaches Final Report December 2016,* Washington, DC, p. 19.
[5] Ibid. p. 54.
[6] Ibid.

Attribution Methodology

It is critical to bear in mind that the individuals to be attributed to a PASSE have complex needs. The attribution in general values the relationship between the patient and the provider AND recognizes the ability of the provider to influence the total cost of care. DHS will use a methodology that is:

- Prospective—the individual will be enrolled into a PASSE prior to the beginning of services.
- Plurality-based—using paid claims to identify all providers connected to the individual in the previous 12 month period.
- Not risk-based—all enrollees will already have been identified as individuals who have high needs and are high utilizers of services and are determined to meet a Tier II or Tier III level of care through the Independent Assessment (IA) system.

An individual will be attributed to a PASSE based on their "relationship score." **The "relationship score" is the product of the visit points and the specialty points plus the cost points** (RS=VPxSP+CP)

1. Visit Points

Using available databases, DHS will determine if there is an established relationship between the individual and providers based on whether an individual received at least one service from a provider in any month in the previous 12 month period. Each provider that rendered a service to an individual in a month will be recognized for that month. There are no additional points for multiple visits within the same month. A visit must include direct contact with the individual to deliver a reimbursable service in that month and must not be incidental. For example, a mere referral will not be recognized as a visit. Receiving a payment for case management merely because an individual is in a provider's panel will not be recognized as a visit. A service must have been performed to be recognized. Visit points will be assigned as follows:

12 months	100 points
9-11 months	75 points
6-8 months	50 points
Less than 6 months	0 points

2. Specialty Points

Weights will be assigned among provider classes to reflect the importance of specialty providers for this population. Providers will be grouped into Provider Classes by specialty. Provider Classes will be assigned the following point values:

Provider class 5 (5 points)

- Certified Behavioral Health Provider including independent psychiatrists and psychologists
- Intermediate Care Facilities/DD/ID
- Supportive Living Provider
- Developmental Day Treatment Clinic Services (DDTCS) and successor programs
- Child Health Management Services (CHMS) and successor programs

Provider class 4 (4 points)

- Physician—PCP
- Pharmacy
- Federally Qualified Health Center (FQHC)
- Person-Centered Medical Home (PCMH)

Provider class 3 (3 points)

- Physician—non-PCP
- Nurse
- Nurse Practitioner
- Outpatient Clinic
- Inpatient Hospital Services including psychiatric stays for adults

Provider class 2 (2 points)

- Speech therapist
- Physical therapist
- Occupational therapist
- Case manager who is not otherwise a provider of direct services

Provider class 1 (1 point)

- DME
- Personal care
- Home health

3. Cost Points

The cost of care is also an important consideration in determining the relationship between the individual and the provider. Points will be added to the relationship score according to the percentage of total cost a provider rendered:

Less than 5% of total cost:	0 points
6-10% of total cost:	10 points
11-20% of total cost:	20 points
21-30% of total cost:	30 points
31-100% of total cost:	40 points

Majority/Plurality Rule

If a single provider accounts for at least fifty percent (50%) of both visits and spending for an individual, the individual will be attributed to that provider; and therefore assigned as a member into the PASSE that the provider has joined. If the majority rule provider belongs to more than one PASSE, there will be a proportional assignment made among those PASSEs. That is, if the majority provider belongs to two PASSEs, the first member will be assigned into PASSE A; the second into PASSE B. If the majority provider belongs to three PASSEs, the first would be assigned into PASSE A; the second member into PASSE B; and the third member into PASSE C.

When there is no majority provider, the member will be attributed to the PASSE with the highest relationship score that is greater than 35% of the total possible score.

Tie-breaker

In the case in which there is no majority/plurality provider, but there is a tie between PASSEs that represent at least 35% of the total possible relationship score, DHS will review an additional 12 months of data to determine whether there is a majority provider or break the tie using the highest relationship score after considering the additional 12 months of claims data.

Proportional assignment

If a majority/plurality provider relationship does not exist or a tie-breaker is needed, members will be proportionally assigned on a rotating basis. That is, if there are three PASSES, the first member would be assigned to PASSE A, the next to PASSE B, the next to PASSE C, the next to PASSE A, etc.

If no provider represents 35% or more of the total possible score, DHS will find that no relationship exists between the individual and any provider. In such cases, DHS will make proportional assignments among the PASSEs that exist at the time. That is, if there are three PASSES, the first member will be attributed to PASSE A, the second to PASSE B, the third member l to PASSE C and the fourth to PASSE A, etc.

DHS may modify the proportional assignment rule in the future if necessary to ensure competition and thereby protect the interest of the taxpayers.

Claims Data

DHS will use all available Medicaid claims data that is fully adjudicated and refreshed on a quarterly basis. For example, for attribution of individuals identified by the IA system as Tier II and Tier III, DHS will use claims data from the following time periods:

Attribution Period	Claims Data
October-December 2017	12 months of claims by date of service ending April 30, 2017
January-March 2018	12 months of claims by date of service ending June 30, 2017
April-June 2018	12 months of claims by date of service ending October 31, 2017

Exclusions from Attribution Methodology

- Payment for Medicare covered services for individuals who are eligible for Medicare and Medicaid ("dual eligible")
- Services covered by private insurance and private payment
- Cost of Transplants
- Emergency Department visits—may reflect lack of community access to services and therefore may not reflect patient choice
- Psychiatric Residential Treatment Facilities (PRTF)—may reflect lack of community access to services and therefore may not reflect patient choice

Disenrollment and Annual Selection

The member may voluntarily disenroll from their attributed PASSE and choose another PASSE within ninety (90) days of attribution. The member will not be permitted to change PASSE's more than once in a twelve (12) month period, unless there is good cause.

Typically, a member will be attributed into a PASSE only once. After the initial attribution, the member will have 90 days to switch to another PASSE and will stay enrolled in that PASSE until the anniversary of attribution. On his or her anniversary, if the member remains in Tier II or Tier III status, he or she will be allowed to choose to remain in the PASSE or enroll into another PASSE.

Tier I Status

Beginning on January 1, 2019, individuals identified as Tier 1 may join a PASSE on a voluntary basis. Thus, there is no need for attribution. Tier I individuals will have 90 days to choose another PASSE or opt out, but after 90 days, will remain in the PASSE until the anniversary of first choosing a PASSE.

If a Tier I individual who voluntarily joined a PASSE enters a Tier II or Tier III status, that individual will remain in that PASSE for 90 days and then may switch to another PASSE. On his/her anniversary, if the individual remains in Tier II or Tier III status, the person will again have a choice of PASSEs.