REACH Attribution

Attribution Basics

- Attribution is a foundational aspect of ACO models and identifies individual patients for whom ACOs take accountability for cost and quality of care
- Other terms, “alignment” and “assignment” may be used interchangeably
- Attribution methods in ACO REACH:
  1. Claims-based attribution through Prospective Alignment
  2. Voluntary alignment
     a. Medicare.gov Voluntary Alignment (MVA)
     b. Signed Attestation-based Voluntary Alignment (SVA)—*optional*
     c. Prospective Plus Alignment—*optional*
        - Quarterly addition of voluntarily aligned beneficiaries

Beneficiary Eligibility for Attribution

- Beneficiaries must meet all criteria to be aligned to a REACH ACO:
  - Enrolled in Medicare Parts A and B
  - Not enrolled in Medicare Advantage or any other Medicare managed care plan
  - Does not have Medicare as a secondary payer
  - Resident of the U.S. in a county that is included in the ACO Service Area
- If a beneficiary ceases to meet eligibility criteria for a given month, they will be removed for the remainder of the performance year
- Beneficiaries are ineligible for REACH attribution if already attributed to a model that takes precedence over REACH
  - Includes MSSP ACOs using prospective assignment
- For the High Needs Track, beneficiaries must meet additional High Needs eligibility criteria for attribution

Voluntary Alignment

- Voluntary alignment (VA) allows beneficiaries to designate their "primary clinician"
  - ✓ If a beneficiary selects a clinician that is a Participant Provider in the ACO, the beneficiary would be attributed to the ACO
  - × If a beneficiary selects a clinician who is not part of an ACO, the beneficiary would be excluded from the claims-based attribution methodology
- Voluntary alignment is considered "valid" for the PY if:
  - The designation was made no more than 2 years before the start of the PY, or
  - The Participant Provider designated by the beneficiary has furnished a PQEM service to the beneficiary within the 24-month period ending 1 month prior to the PY start
- Voluntary alignment supersedes claims-based assignment
- Beneficiaries must continue to meet all REACH attribution eligibility criteria to be voluntarily-aligned to an ACO

Voluntary Alignment Options

- REACH uses two methods for voluntary alignment:
  - Medicare.gov Voluntary Alignment (MVA) applies for all REACH ACOs
    - Similar to VA approach in MSSP
  - Signed Attestation-based Voluntary Alignment (SVA) applies for REACH ACOs that have selected SVA for the PY and submitted an SVA List to CMS
    - Allows ACOs to send beneficiaries a voluntary alignment form (paper or electronic) to sign and return to the ACO
    - ACO must submit SVA List to CMS by specified deadline to be included for the subsequent PY*
- Prospective Plus Alignment
  - Optional, supplements Prospective Alignment by adding new voluntary alignment designations (MVA and SVA, if selected) on a quarterly basis
  - If a beneficiary is already aligned to a REACH ACO for a PY via claims-based or voluntary alignment, they won't be removed or switched to another ACO based on new MVA/SVA designation

Claims-based Attribution

- Beneficiaries are prospectively attributed to REACH ACOs prior to each performance year through the claims-based alignment algorithm
  - Driven by utilization of primary care services
  - Determined by weighted allowable charges during the alignment period
  - Uses a 2-track alignment algorithm
- Key elements:
  - "Claims-alignable beneficiary"= had at least 1 PQEM paid by Medicare during the alignment period
  - "Primary Care Qualified Evaluation and Management (PQEM)"= primary care service (identified by list of HCPCS codes) furnished by a primary care specialist (PCP, NPP, FQHC, RHC) or selected non-primary care specialist (primary specialty designation)
  - "Alignment period"= consists of two alignment years: 1st=12-month period ending 18 months prior to the start of the PY, 2nd=12-month period ending 6 months prior to the start of the PY

2-Stage Alignment Algorithm

- Compare weighted allowable charges for all PQEM services that the beneficiary received from REACH Participant Providers to those received from providers/suppliers not in a REACH ACO
- Allowed charges for PQEM services weighted by alignment year in which they were furnished: 1st (earliest)=1/3 weight, 2nd (recent)=2/3 weight

1. PQEM Services provided by Primary Care Specialists	2. PQEM Services provided by Selected non-Primary Care Specialists
If 10% or more of allowable charges for PQEM services for a beneficiary during alignment period are furnished by PCSs, then alignment is based on PQEM services furnished by PCSs	If less than 10% of allowable charges for PQEM services for a beneficiary during the alignment period are furnished by PCSs, then alignment is based on services furnished by selected non-PCSs

- Tie-breaker rules: beneficiary will be aligned to the ACO in which a Participant Provider billed for the most recent PQEM service received by the beneficiary in the alignment period

Key Differences in REACH vs. MSSP

- As a CMS Innovation Center demonstration model, ACO REACH tests different approaches to attribution
- Fully prospective attribution with 2-year offset alignment window
  - No retrospective assignment option eliminates issues with overlap between retrospective and prospective ACOs
  - Utilizing 2 years for the attribution window vs. 1 year in MSSP creates more stable populations
  - Less adaptive to changes in beneficiaries' care patterns during the performance period
- Additional options for voluntary alignment
  - SVA option in addition to MVA creates more flexibility in how beneficiaries can complete VA
  - Prospective Plus option allows ACOs to add beneficiaries throughout the performance year, which is otherwise not an option in REACH's fully-prospective approach
  - ACOs may market to beneficiaries for purposes of VA, following approval of marketing plan by CMS
- Physician visit not required for claims-based attribution in REACH

Resources Available to NAACOS Members

- More on this topic is available to members on our website
  - Impact of Retrospective vs Prospective Attribution on your ACO
  - ACO REACH Participation Agreements
- Not a member?
  - Contact membership@naacos.com for more information on a free trial membership.

About NAACOS

489
ACO MEMBERS

9.5M
BENEFICIARY LIVES IN MEMBER ACOS

72%
OF ACOS ARE NAACOS MEMBERS

160
PARTNER ORGANIZATIONS

THOUGHT LEADERSHIP

NAACOS works to advance and promote coordinated, patient-centered, value-based care through research, publications, and other forms of thought leadership.

EDUCATION

NAACOS offers a variety of educational webinars, conferences, and other events to help value-based care entities stay up-to-date on the latest developments in the field and learn from experts and peers.

ADVOCACY

NAACOS advocates through various means, such as engaging with policymakers, participating in rulemaking, collaborating with other organizations, and communicating with the public.

Founded in 2012, the National Association of ACOs (NAACOS) is a member-led and member-owned nonprofit helping ACOs succeed in efforts to coordinate and improve the quality of care for their patient populations.