

Compare and Contrast Attribution methodologies



Speakers:

- Maria Alexander, Mount Sinai
- Henish Bhansali, Duly Health & Care, MD
- Jennifer Leazzo, Duly Health & Care, FSA

MSSP Attribution



**NAACOS Conference
September 2022**

**Maria Alexander
Senior Director, Government Channels**

Agenda

- Brief intro to Mount Sinai
- MSSP Attribution Basics
- Retrospective vs. Prospective Attribution
- Challenges with MSSP Attribution
- Attributing a specific PCP
- RHC/FQHC Attribution

Mount Sinai Health Partners: Clinically Integrated Network



~ **4,100**
faculty
physicians



~ **1,100**
committed
affiliated
physicians



Over 400
Mount Sinai
outpatient practices



55 urgent care sites
covering Manhattan,
Brooklyn, Queens,
& Long Island

Committed to a vision
of **transforming**
healthcare in
New York toward
value-based care and
population health



Dozens of
community based
organization
collaborators



8 hospitals
spanning Manhattan,
Brooklyn, Queens,
& Long Island



45 skilled nursing
facilities that collaborate
with our network



Geographic access
and coverage across
the 5 boroughs,
Long Island & beyond

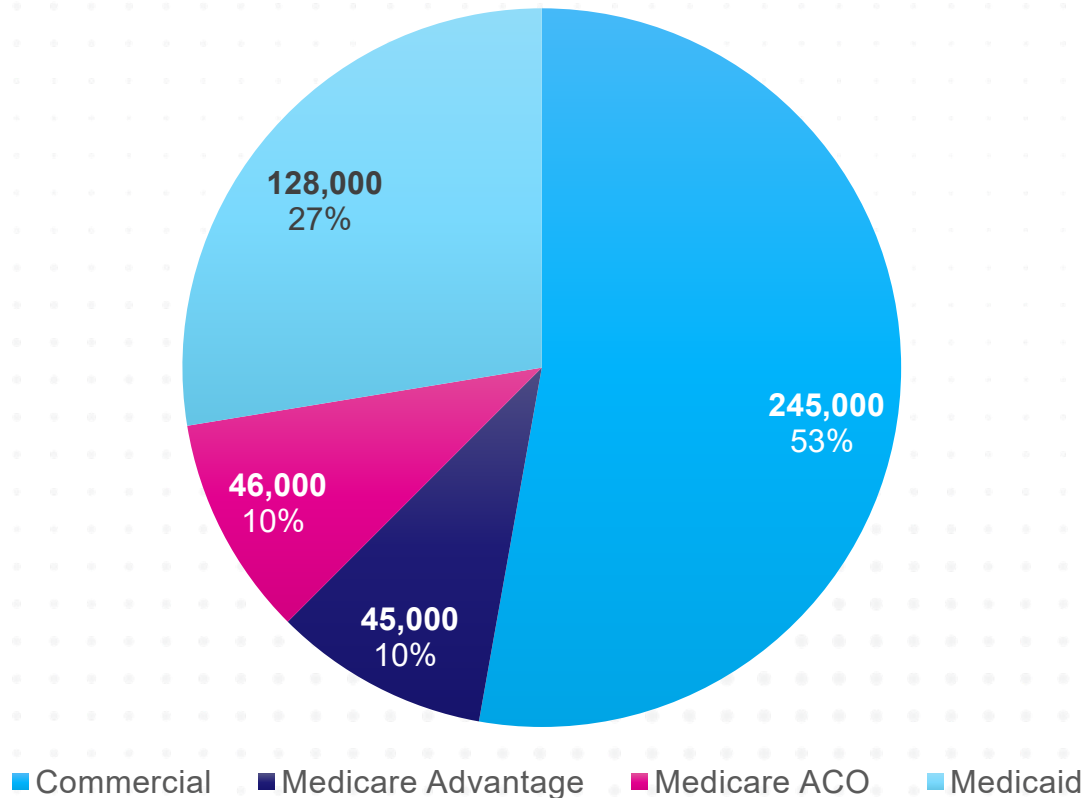


Integration with
ASCs & FQHCs
across New York City

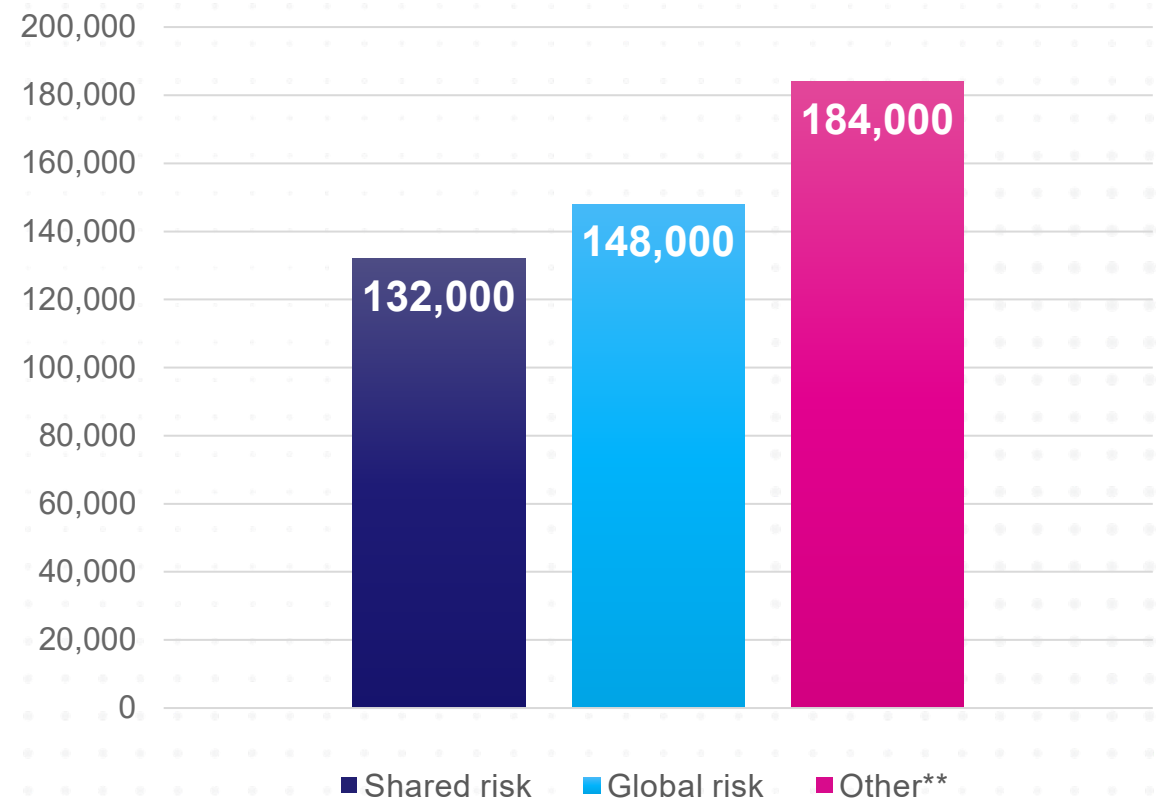
Over 460,000 Lives in Value-Based Contracts

Risk Distribution of Lives in Value-Based Contracts*

2022 Attribution by Line of Business



2022 Attribution by Risk Arrangement



MSSP Attribution - Basics

- Patients attributed via
 - PCP selection, referred to as “voluntary alignment” (less common); or
 - **Plurality of primary care services** (most common)
- Most patients are attributed based on services from primary care providers
- Patients who did not have any visits with a PCP, are attributed based on E&M services delivered by specialists
- ACOs can select prospective or retrospective attribution

Beneficiary Eligibility Criteria

- Must have at least 1 month of Part A and Part B enrollment; no months of Part A only or Part B only
- No months in Medicare Advantage
- Not assigned to any other shared savings initiative
- Lived in US or US territories in the last month of assignment window
- Had at least one primary care service with a physician who is an ACO professional

MSSP Attribution – Codes Used

“Primary Care Services”

- Generally includes E&M CPT and HCPCS codes and some care management codes
- Can be delivered in-person or via telehealth
- Full list can be found in Appendix C of Shared Savings and Losses and Assignment Methodology Specifications

PCP Specialty Codes (Step 1)

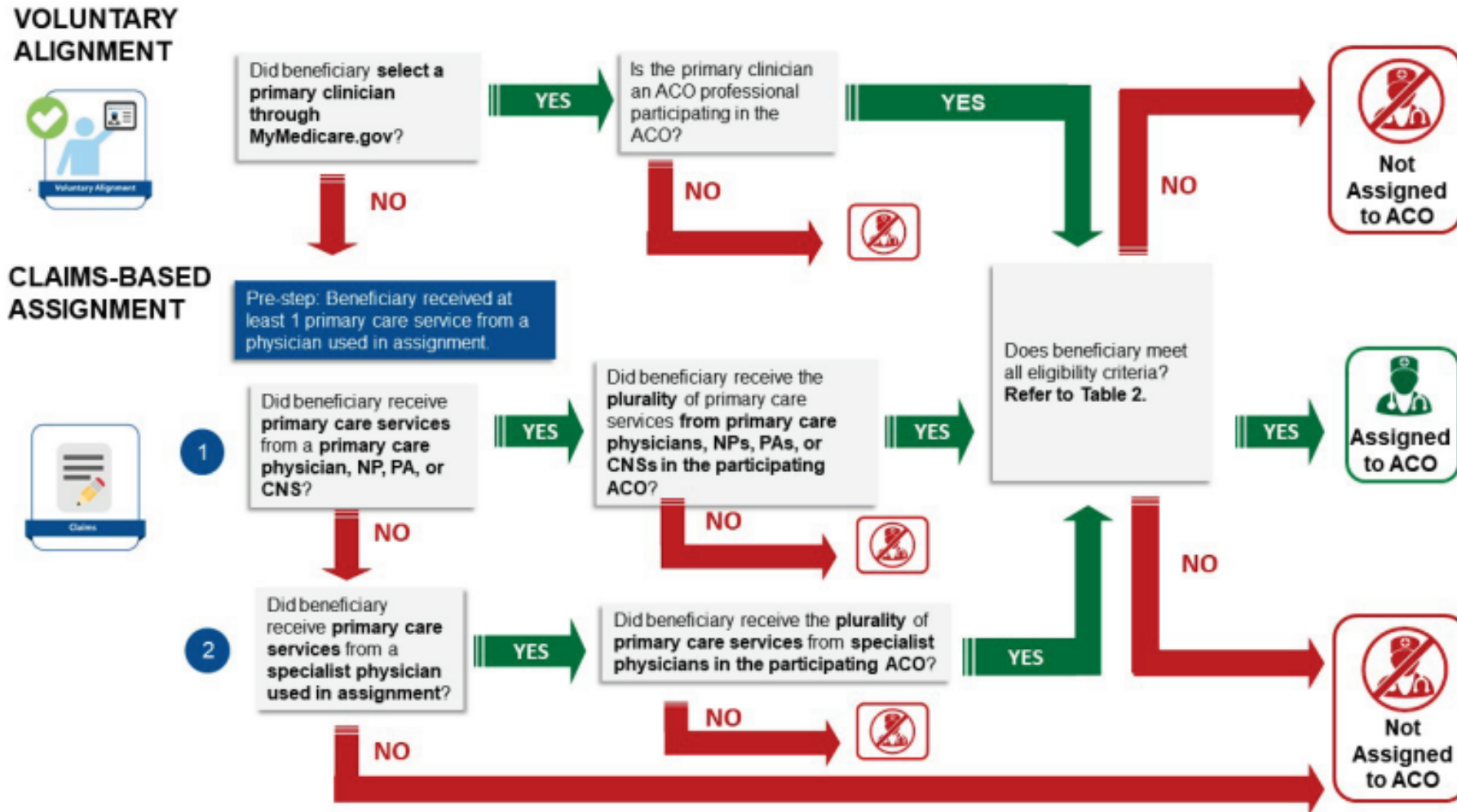
- 01 – General practice
- 08 – Family practice
- 11 – Internal Medicine
- 37 – Pediatric Medicine
- 38 – Geriatric Medicine

Specialty Codes Used in Attribution (Step 2)

Only if patient had no visits with PCP

- | | | |
|---|--|--------------------------|
| 06 – Cardiology | 26 – Psychiatry | 82 – Hematology |
| 12 – Osteopathic manipulative medicine | 27 – Geriatric psychiatry | 83 – Hematology/Oncology |
| 13 – Neurology | 29 – Pulmonary disease | 84 – Preventive medicine |
| 16 – OB/GYN | 39 – Nephrology | 86 – Neuropsychiatry |
| 23 – Sports Med | 46 – Endocrinology | 90 – Medical oncology |
| 25 – Physical medicine and rehabilitation | 70 – Multispecialty clinic or group practice | 98 – Gynecology/oncology |
| | 79 – Addiction medicine | |

MSSP Attribution – Process Flow



MSSP Attribution – Prospective vs. Retrospective

	Assignment Window	Pros	Cons	Other Differences
Prospective	<p>12 month period ending September 30 prior to the Performance Year</p> <p>For PY2023: CMS will use dates of service October 1, 2021 – September 30, 2022</p>	Clarity about who the ACO is accountable for at start of year	Accountable for patients who ACO may not have a care relationship with during the performance year (e.g., patients that move out of state or switch PCPs)	<p>Attribution numbers typically slightly lower</p> <p>Population typically slightly older, more expensive (also reflected in the benchmark years)</p>
Retrospective	<p>12 month period corresponding to performance year (calendar year)</p> <p>For PY2023: CMS will use dates of service January 1, 2023 – December 31, 2023</p>	More accurately reflects who the ACO actually saw during the performance year	Patient list is a “moving target” for care management and other clinical operations, gaps in care closure efforts	<p>Attribution numbers typically slightly higher</p> <p>Population typically slightly younger, less expensive (also reflected in the benchmark years)</p>

Other considerations:

- Mid-year billing TIN changes
- Financial reporting is different – rolling 12 vs YTD
- You can change selection annually but it could make it harder to compare point in time performance year over year when you change

MSSP Attribution – Challenges

- CMS assigns patients to the ACO, not to a specific PCP or practice
- MSSP requires full Taxpayer Identification Number (TIN) participation so you do not have the option to select PCPs for attribution if you have large TIN with multiple practices, specialties, etc.
- Specialist attribution
 - May have patients attributed to specialties that don't see themselves as responsible for broader preventive care
 - Advanced practitioners (NPs, PAs, CNSs) are treated as PCPs regardless of the type of practice; if these provider types do a lot of Medicare billing in your organization/practices, be aware that they may drive attribution (even if working in a specialty setting)

MSSP Attribution – Our Approach to PCP Attribution

For purposes of clinical operations and shared savings distributions, you will likely want to link each patient to a specific practice or PCP. The CMS attribution logic does not attribute to a specific individual but rather to the ACO as a whole.

To do this, we have taken the following approach:

1. Identify Part B claims as either “PCP Primary Care Service” or “Specialists Primary Care Service” based on specialty code on claim (we use the same set of E&M codes and specialty codes as CMS methodology)
2. Limit to Billing TINs on our MSSP Participant list
3. Compare allowed charges for these claims during assignment window that aligns with what CMS uses
 - a. If single PCP → attribute to that PCP
 - b. If multiple PCPs → attribute to PCP with highest allowed amounts for primary care services
 - c. If no PCP → attribute to specialist (or to specialist with highest allowed amounts for primary care services if multiple specialists)
4. If cannot identify an ACO provider through this approach, attribute to PCP from last year
5. If PCP can still not be identified, attribute to PCP in Table 1-4 of assignment file from CMS, prioritizing PCPs

MSSP Attribution – FQHC/RHC Attribution

One of the challenges we have identified with our internal PCP attribution logic is with attributing to a specific provider within an FQHC.

- FQHCs/RHCs bill as institutions, not practitioners. As a result, FQHC claims are delivered in the Part A claims files, not Part B and may not have a specific rendering provider.
- Our current approach:
 1. Use Table 1-3 to identify patients that may be attributed based on FQHC claims
 2. Use “Attending NPI” to attribute to specific provider
 3. This approach seems to under-identify patients that were likely getting most of their care from FQHCs and we working on potential changes to the methodology to better attribute.
- Some alternative/supplemental options to consider:
 - Attribute to the FQHC as a whole, rather than PCP and then ask FQHC to assign a PCP
 - Use scheduling data/EMR data from FQHC to identify PCP

Thank you!

Questions?

Maria.Alexander@mountsinai.org



Patient Attribution: *Medicare Advantage*



Henish Bhansali, MD, FACP, Dipl. ABOM

SVP and Medical Director | Medicare Advantage

Duly Health and Care

Faculty - University of Chicago Pritzker School of Medicine

MAPP Candidate - University of Chicago Harris School of Public Policy

Agenda

- Attribution methodologies - *variability*
- Tactics for success → gain *appropriate* attribution
- How to navigate *inappropriate* attribution

Attribution Methodologies

Plurality of Services

- PCP visits
- All visits
- Date ranges

Patient selection

- HMO
- PPO

Tactics for Success – *Appropriate Attribution*

Dependent on Methodology

Plurality of Services

- Patient visits → primary and specialty care
- Pitfalls when new to plan → 2 scenarios

Patient selection

- HMO – required
- PPO – during AEP/SEP

Inappropriate Attribution – *What to do?*

- Payor Attribution Methodologies
 - Example – paper form
 - Example – plurality of services
- Patient Engagement
- Payor Engagement



Pitfalls of Attribution

Jennifer Leazzo, FSA, MAAA
VP Analytics



A diversified mix of value-based care and fee for service

1,100+ Primary care and Specialty physicians providing coordination across the health and care continuum

Purpose-driven holistic health and care model with an unrivaled end to end patient experience

Multi-pronged scalable growth model

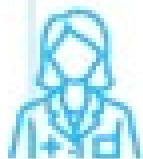


30,000 MA Global Risk Lives with significant potential to grow

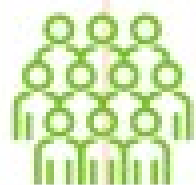
Personalized patient navigation built through an omni-channel approach

Physician-aligned model proactively managing patient health, increasing access to comprehensive care

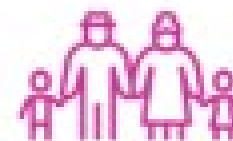
Diversified payor mix



900+
Physicians



6,000+
Team Members



1
million+
Total Patients



50+
Specialties



150+
Locations



90
Patient Trust
Score



227,000+
Telehealth
Visits

ACO Reach

- Only Prospective
- Smaller minimums
- Potential Market alignment

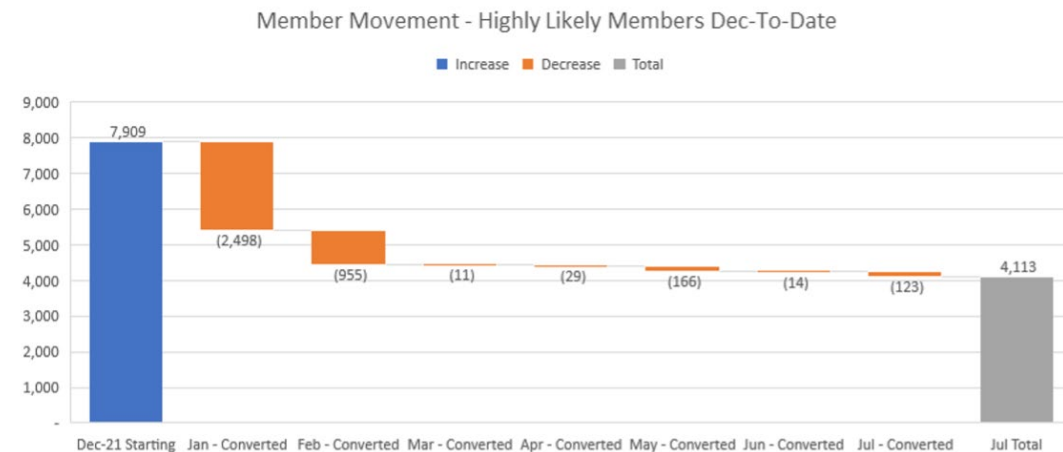
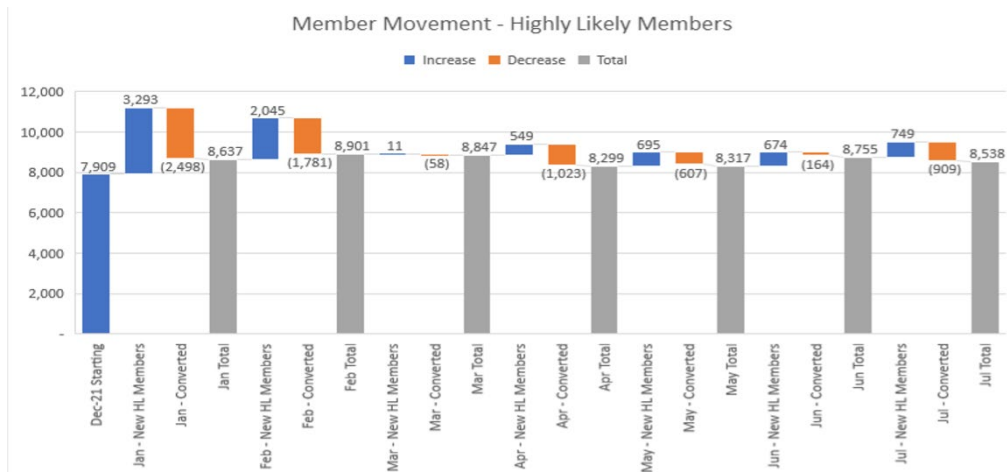
Beneficiary Alignment				
	MSSP Basic Level E	MSSP Enhanced	REACH – Professional	REACH – Global
Minimum number of beneficiaries	5,000	5,000	<ul style="list-style-type: none"> • Standard ACOs: 5,000; at least 3,000 “alignable” beneficiaries in at least one base year (CY2017, 2018, or 2019) • New Entrant ACOs: 2,000 in PY2023; 3,000 in PY2024; 5,000 in PY2025-2026; max. 3,000 “alignable” beneficiaries in any base year • High Needs Population ACOs: 500 in PY2023; 750 in PY2024; 1,200 in PY2025; 1,400 in PY2026 	
Beneficiary assignment	<ul style="list-style-type: none"> • Prospective or preliminary prospective with retrospective reconciliation; elected annually • Claims-based and voluntary • Voluntary alignment takes precedence over claims-based 		<ul style="list-style-type: none"> • Prospective • Claims-based and voluntary alignment • Ability to market voluntary alignment • Voluntary alignment will take precedence over claims-based • Voluntary alignment completed through MyMedicare.gov takes precedence over paper-based voluntary alignment • Option to add voluntarily aligned beneficiaries quarterly 	

Pitfalls of attribution in PPO offerings

- #1: Patient choice
 - Which PCP field do you believe?
 - Plan does not share data until member is prospectively attributed; or data shared for retrospective members that are ultimately not in risk settlement
 - Variance of attribution methodologies
- ➔ Difficulty validating members are attributed to the ACO and PCP they should be

What do we track

- Attribution change month to month
- Patient coverage changes month to month
 - Who has moved into and out of a risk plan
 - Where do attribution by payor not match coverage payor in EMR
 - Requires patient mastering
- Likelihood of being attributed based on billing data and retro review



Working with the Healthplans

- List members we are attributed but can see in their data they are not seeing our doctors
- List members we are seeing but not attributed and ask plan to review attribution
- Request attribution source info from payor, selection v claims attribution, to improve patient outreach success



Attribution Appendix



Category	Plan A	Plan B	Plan C
Freq of Attribution run	Run 1/1 then monthly only on non assigned members	Monthly for unassigned members	Monthly on members eligible to be reassigned
Claims Data Used/Available	Only receive claim data for months of service the member is attributed; plan will use up to 24 month of data on member for attribution	Only receive claim data for months of service the member is attributed; plan will use up to 24 month of data on member for attribution	Only receive claim data for months of service the member is attributed; plan will use up to 24 month of data on member for attribution
When or why can a patient change	Attribution is run annually in January. Attributed members remains fixed for the year unless the member selects a different PCP	Once a customer has been attributed by Plan to a PCP, then the attribution is not changed, even if a claim is submitted subsequently by a different PCP, however Plan may change the PCP to whom a Customer is attributed at the request of a PCP or customer, or if the customer moves and their primary address is no longer in the same state as their attributed PCP.	<ul style="list-style-type: none"> Patients whose PCP has changed in the past six months are not evaluated through the attribution model until the seventh month. Patients must have three or more visits to cause a change in PCPs. Patients can call us anytime to change PCPs.
Voluntary Alignment Trump Claims Attribution	Yes	Yes	Yes
Lookback Period	12PCP > 24PCP > 12Spec > 24Spec	Prioritize providers with (2) Std Vst in 24 mo or (1) Comp Vst in 15 mo; otherwise most recent established visit in last 15 mos	6, 12, 24 mos
Win if:	Plurality Visits	Most recent visit date	Plurality Visits
Tie breaker	Most recent visit date	Most recent visit date	Most recent visit date b) total claim dollars
PCP/Spec	PCP/Spec as 2nd step	PCP Only	PCP/Spec
Mid levels?	Midlevel providers that support a Family Medicine, Internal Medicine or Geriatric MD PCP can earn attribution	Midlevel providers that support a Family Medicine, Internal Medicine or Geriatric MD PCP can earn attribution	
What Specialties	Endocrinology; Hem/Onc; Trhumatology; Pulmonary; Cardiology; Nephrology; OB/GYN; Gastro; Rheumatology		
Notes	<ul style="list-style-type: none"> Attribution runs prospectively, with September attribution running in early August for example. Claim-based attribution runs annually for January. Once assigned, a claim attributed member remains fixed for the year unless they select a PCP. Member PCP selection ALWAYS trumps claim. For unattributed and new members, claim based attribution runs monthly until a member becomes attributed. Their attribution remains fixed for the remainder of the year UNLESS the member selects a different PCP. 	<p>Rendering Based PCP Logic</p> <ul style="list-style-type: none"> A customer will be attributed to an ACO PCP if that customer has had: 1) 2 Standard Visits in the last 24 months with PCPs and the most recent Standard Visit was to an ACO PCP or 2) Comprehensive Visit in the last 15 months and the most recent Comprehensive Visit was to the ACO PCP. If a customer has had: 1) 2 Standard Visits during the last 24 months to ACO PCPs and 2) 1 Comprehensive Visit during the last 15 months to a PCP who is not an ACO PCP, then the customer will be attributed to the PCP who had the most recent visit. If a customer has had: 1) 2 Standard Visits during the last 24 months to a PCP who is not an ACO PCP and 2) 1 Comprehensive Visit during the last 15 months to an ACO PCP, then the customer will be attributed to the PCP who had the most recent visit. If a customer has not had 2 Standard Visits during the last 24 months or 1 Comprehensive Visit during the last 15 months, the ACO customer will be attributed to the PCP who they have had the most recent Established Patient Visit with during the last 15 months. <p>Attribution to a ACO PCP</p> <ul style="list-style-type: none"> If the Customer made a PCP selection, Plan will attribute that customer to the selected PCP if that PCP practices in the state of Customers primary address. If the customer did not make a PCP selection, customers are attributed to ACO if the PCP: 1) practicing in the state of customer's primary address, 2) is identified on the ACO PCP roster at the time attribution is determined, and 3) is attributed to the ACO PCP in accordance with the Rendering Based PCP logic. Plan will review most currently available Medicare Advantage and commercial paid claims data in its database to determine attribution using the Rendering Based PCP Logic. Plan will review previous payers paid claims data using the Rendering Based PCP logic if that data is provided to Plan by a previous payer to determine attribution. 	<ul style="list-style-type: none"> Claims for evaluation/management (E/M) visits, wellness visits, physical assessments and some OB-GYN visits are reviewed. (See back page for applicable codes.) Visits are evaluated within the most recent six months, then the remainder of a year, then 13-24 months. In the event of a tie, total visits, most recent visit date and total claim dollars are used. Patients must have three or more visits to cause a change in PCPs. Patients who currently do not have a PCP will be attributed with one visit. Patients can call us anytime to change PCPs. <p>Please note:</p> <ul style="list-style-type: none"> Patients without an attributable visit in the past 24 months are not removed from a physician's panel. Patients whose PCP has changed in the past six months are not evaluated through the attribution model until the seventh month.
Other		Once attributed the only way for member to change attribution is for member or PCP to proactively change with the plan.	//27

CODES	DESCRIPTION	MSSP	Plan A	Plan B	Plan C	Plan B	
99160-99161	HRA-Telehealth	X					Comprehensive
99201-99205	Office E&M New Patient	X	X		X		Established
99211-99215	Office E&M Estab Patient	X	X	X	X		
99241-99245	Office Consult			X	X		
99271-99275	Confirmatory Consults				X		
99304-99306	Nursing Facility	X			X		
99307-99310	Subsequent Nursing Facility	X			X		
99315-99316	SNF D/C	X			X		
99318	Other Nursing Fac Services	X		X	X		
99324-99328	Domicillary/Custodial care	X			X		
99331-99333	Rest Home Visit			X	X		
99334-99337	Domicillary/Custodial care	X		X	X		
99339-99340	Home Care Overnight	X			X		
99341-99345	Home, New	X	X		X		
99347-99350	Home, Estab	X	X	X	X		
99354-99355	Prolonged Home	X	X				
99358-99359			X				
99374-99380	Care Plan Oversight Services				X		
99381-99387, 99391-99397	Preventative Visits E&M		X	X	X		
99401-99404	Preventative Counseling		X	X			
99401-99404, 99406-99409, 99411-99412	Preventative Counseling			X	X		
99432	Newborn not in Hosp				X		
99441-99444	Telephonic Care Management				X		
99484	Integration care mgmt	X					
99487-99490	Chronic Care Mgmt	X	X		X		
99492-99494	BH Integration	X					
99495-99496	TCM	X	X		X		
99497-99498	Advanced Care Planning	X	X		X		
G0101-2	Screening Tests			X			
G0179-G0182	Care Plan Oversight				X		
G0246	F/u E&M of Diabetic w/ Neurop			X			
G0344-G0402	Preventive Physical Exam		X		X		
G0402	Wellness	X	X	X			
G0438-G0439	Annual Wellness Visit		X	X			
G0442-G0443	Alcohol Misuse Scrn/plan	X					
G0444	Depression Screening	X					
G0463	Hospital Outpatient Clinic Visit	X			X		
G0466-G0470, G0511-G0512	FQHC Visits				X		
G0506	CCM	X					
G0508-G0509		X	X				
G0513-G0514	Prolonged Care Services		X		X		
G0738-G0739		X					
S0610			X				
S0612	Annual Gynecological Exam		X	X			
S0613			X				