Patient Attribution: CMS Knows Who Your Patients Are, but Are They Correct?

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Dr. Fiesinger is a graduate of the Baylor College of Medicine in Houston, Texas. He completed his family medicine residency at East Carolina University School of Medicine in Greenville, North Carolina. Dr. Fiesinger provides broad-spectrum family medicine to a diverse patient population in greater Houston. He sees patients from "cradle to grave" and also performs numerous outpatient procedures including joint injections and skin surgery. He is a past president of the Texas Academy of Family Physicians (AFP) and currently serves as an alternate delegate to the American Academy of Family Physician (AAFP) Congress of Delegates. Dr. Fiesinger is active in his state medical society and serves on their council on medical education. After serving on the AAFP Commission on Quality and Practice, he represented the AAFP on numerous measure development workgroups convened by the National Quality Forum, the American Medical Association Physician Consortium for Practice Improvement, and the American Board of Medical Specialties. He currently serves on the Commission on Governmental Advocacy and won the Texas AFP Political Action Committee's Political Advocacy Award in 2015. Dr. Fiesinger is especially interested in quality improvement, population health, and health policy.

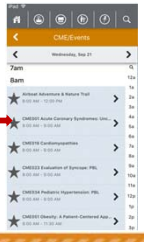
Learning Objectives

1. Identify the patients in his or her panel for which he or she will be accountable for in a value-based payment environment.
2. Analyze how the different attribution models CMS may use to will impact your existing patient panel.
3. Learn how and when to address incorrect attribution of patients.

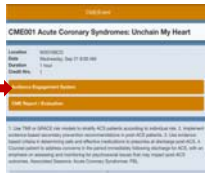
Audience Engagement System

Step 1

Step 2



Step 3



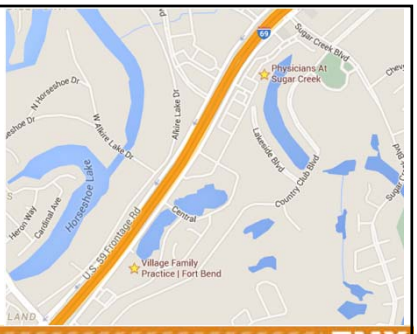
Additional Objectives

- Identify patients for whom physicians will be held accountable in a value-based payment environment
- Understand attribution models used by Centers for Medicare and Medicaid Services and other payors
- Learn how attribution models impact physicians' practices
- Learn how patient attribution will affect physician payments under the Medicare Access and CHIP Reauthorization Act of 2015

Whose patients are they anyway?

- Physician's perspective
- Patient's perspective
- Payor's perspective

A Tale of Two Clinics



A Tale of Two Clinics

- One Doctor
- Two Clinics
- Two Tax ID Numbers
- 3,817 feet

How do you identify your patients?

- Do you look forward or backwards?
  - Prospective (21%)
  - Retrospective (64%)
- How far back?
  - One year (32%)
  - More than 1 year (7%)
  - Choose another timeframe (39%)
- Which doctor gets credit?
  - Plurality of care (46%)
  - Majority of care (11%)
  - Just 1 visit (7%)
  - Some arbitrary number (7%)

How do you identify your patients?

- What do they measure?
  - Health care costs (ex. total allowed charges) (29%)
  - Visits (39%)
  - Another method (ex. Total RVU's) (29%)
- How many doctors get credit for each patient?
  - One doctor (79%)
  - Multiple doctors (14%)
- How low do you go?
  - Individual doctors (43%)
  - Physician group (7%)
  - ACO (43%)

Which method(s) do the commercial plans use?

- Aetna
  - **Majority** of total charges OR **plurality** of total charges
- BCBS
  1st : Physician who billed the **plurality** of Total RVU's
  2nd : Physician who billed **plurality** of outpatient E&M codes
  3rd : Physician who billed **plurality** of charges
- United Healthcare
  - Primary care physician who billed **majority** of charges

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Which method(s) do HMO's and Medicare Advantage plans use?

- Patient chooses Primary Care Physician from list of approved physicians
- Patient must initiate change in attribution (except when HMO / MA plan changes it)

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How does CMS attribute patients?

- Attribution model depends on the program
  - Value-based Payment Modifier
  - Physician Quality Reporting System
  - Electronic Health Record Incentive Program ("Meaningful use")

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Value-Based Payment Programs Use Common Structure

- **Retrospective**
- "**Look back**" 1-2 years
- **Plurality** of allowed **charges** for **outpatient** services (not ER/urgent care)
- Attribute to **1 physician** using Taxpayer ID Number (**TIN**)
- **2 step algorithm** with shared **tie breaker** approach
- **Common definitions** of outpatient primary care codes and primary care providers

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Medicare ACO Programs

- Perspective varies
  - Medicare Shared Savings Track 1 and 2 used **retrospective** approach
  - MSSP Track 3 and Next Generation ACO's used **prospective** approach
- All ACO programs used
  - Common exclusions
  - 2 year "**look back**" period
  - **Plurality** of allowed charges for **outpatient** E&M codes
  - Common definitions of outpatient primary care codes and providers

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Medicare's Two Step Method

Step 1: Is patient excluded from attribution?	•Yes → **Not attributed** •No → Go to **Step 2**
Step 2: Did patient receive primary care services from a primary care physician?	•Yes → **Attributed** to TIN that billed plurality of 1° care services •No → Go to **Step 3**
Step 3: Did patient receive primary care services from PA, APN, CNS, or non-primary care physician at same TIN?	•Yes → Go to **Step 4** •No → **Not attributed**
Step 4: Did patient receive primary services from physician at same TIN as providers in **Step 3**?	•Yes → **Attributed** to TIN whose providers billed plurality of 1° care services •No → **Not attributed**

How would these patients be attributed?

- RJ
  - Previously attributed to me via MSSP ACO
  - In 2016
    - Saw me at Village Family Practice once
    - Saw LKB at Physicians at Sugar Creek once
  - In 2015
    - Saw resident OW 4 times
  - No AWV done in 2015 or 2016
  - In 2016 admitted for stroke then discharged to SNF

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How would my patients be attributed?

- TC
  - Saw Dr. RM for years with 3 acute visits and one physical in 2015 before he sold his practice (Family Practice of Ft. Bend) to Village Family Practice
  - Has seen me 4 times in 2016 (3 acute visits, 1 physical)
  - Saw Dr. B, her ObGyn, for well woman exam in 2015 and in 2016
  - Changed PCP to me because Dr. RM plans to retire soon

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How would my patients be attributed?

- KG
  - Only goes to a doctor for acute issues
  - Sees Dr. B for annual well woman exam
  - Too busy traveling for work to schedule well woman exam this year or last year
  - Went to urgent care for UTI recently

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How would my patients be attributed?

- BW
  - Has been my patient for 7 years
  - Saw me at Physicians at Sugar Creek 5 times in 2015 (2 acute visits, 2 chronic care visits, 1 AWV)
  - Has seen me 4 times at Village Family Practice in 2916 (1 acute visit, 2 chronic care visits, 1 AWV)

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What will happen to my patients under the current Medicare rules?

RJ	TC	KG	BW
• Attributed to Physicians at Sugar Creek • was enrolled in MSSP ACO under their TIN	• Attributed to Village Family Practice of Ft Bend • Received plurality of primary care services from that TIN • Considers me her PCP but Medicare attributes her to the group practice • Make sure Medicare doesn't attribute her to "sunsetted" Legacy TIN	• Not attributed ("orphan patient") • Did not receive recognized primary care services from a Medicare-designated primary care provider	• Attributed to Physicians at Sugar Creek • Primary care charges under Physicians at Sugar Creek's TIN > charges under Village Family Practice's TIN

And then it happened …

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So how will attribution change under MACRA?

- Merit-based Incentive Payment System (MIPS)
- Advanced Payment Model (APM)

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Attribution in Merit-based Incentive Payment System (MIPS)

- To ride the bus you must have
  - 100 Medicare patients (total)
  - $10,000 Medicare Part B allowed charges
  - At least 20 patients attributable to you for Cost portion of MIPS
  - Not participate in an Advanced Payment Model

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Attribution in MIPS

- **Retrospective**
- **Look back** two year (Calendar Year 2017 for Payment Year 2019)
- **Plurality** of Medicare Part B allowed charges for office visits, wellness visits, SNF and assisted living care, home visits

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Attribution in MIPS

- **Single** primary care provider (physician, PA, APN, CNS, and CRNA)
  - BUT proposed provider-patient relationship codes signal multiple attribution is coming
- **Individual** physician
  - BUT group reporting option determines bonus / penalty based on group performance

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Attribution in MIPS

- "MIPS eligible clinician identifier"
  - Group practices: Taxpayer ID Number (**TIN**)
  - Individual providers: Taxpayer ID Number (**TIN**) and National Provider Number (**NPI**)
- **Tie breaker** will likely be same as Value-based Payment Modifier
  - Most recent primary care E&M service

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Advanced Payment Models (APM)

- To take a limo instead of the bus
  - 20% of attribution-eligible Medicare patients OR 25% of payments from attribution-eligible Medicare patients must be attributed to you through your Advanced Payment Model (APM)
  - Determination can be made at group level (i.e. 20% of the group's patients are attributable to the APM)
  - Exact attribution model will be determined by the APM

What will happen under the MACRA?

RJ	TC	KG	BW
• Still attributed to Physicians at Sugar Creek (enrolled in MSSP ACO under their TIN) • Next step: May be eligible for "voluntary alignment" to Next Generation ACO I now participate in	• Still attributed to Village Family Practice of Ft Bend because plurality of primary care services received from that TIN • Next step: Ensure Medicare doesn't attribute her to "sunsetted" Legacy TIN	• Still not attributed ("orphan patient") • Next step: Encourage her to establish care with PCP in new practice	• Attributed to Physicians at Sugar Creek's TIN • Next step: ensure patient comes back for scheduled follow up visits • Once patient accumulates $111 in allowed charges with new practice, she will be attributed to Village Family Practice because VFP will have provided plurality of charges ($481 vs. $480)

But CMS is wrong! What can I do?

"MIPS eligible clinicians or groups may request a targeted review of the calculation of the MIPS adjustment factor under section 1848(q)(6)(A) of the Act, and, as applicable the calculation of the additional MIPS adjustment factor under section 1848(q)(6)(C) of the Act to such MIPS eligible clinician for a performance year"

Potential Reasons to Request "Targeted Review"

- MIPS eligible clinician believes
  - Measures or activities submitted to CMS have "calculation errors or data quality issues"
  - Errors were made by CMS
    - CMS examples:
      - "performance category scores were wrongly assigned to the MIPS eligible clinician"
      - clinician believes low-volume threshold exclusion should have been applied

Timeline of MIPS Appeals Process

- Must request targeted review within 60 days after close of data submission period
- CMS will decide whether targeted review is warranted
- Formal hearing not required
- Clinician must respond to requests for additional information within 10 calendar days

Areas Excluded From a Targeted Review

- Methodology used to determine the amount of the MIPS adjustment factor
- Methodology used to calculate performance scores
- Performance standards
- Performance period
- Actual calculation of the performance scores
- Measures and activities specified for a MIPS category

Questions to Ask About Patient Attribution

- Who is asking?
  - Payor
  - HMO
  - ACO
- Why do they want to know?
  - Cost
  - Quality

Questions to Ask About Patient Attribution

- **Timing**
  - Prospective
  - Retrospective
- **Measurement period**
  - How long?
  - How far back?
- **Threshold for attribution**
  - Single visit
  - Plurality
  - Majority
  - Arbitrary minimum
- **Data used**
  - Claims (allowed charges)
  - Visits
  - Enrollment (empanelment)
- **Exclusivity**
  - Single clinician
  - Multiple clinician
- **Level of attribution**
  - Individual provider
  - PCP
  - Group
  - ACO
- **Means of identifying provider**
  - TIN
  - NPI

Questions

Associated Sessions

- "Your Rx for Medicare Quality Payment" *(Wednesday @ 10:30am)*
- "APMs: Help Is On The Way" *(Wednesday/Thursday @ 10:30am)*
- "Up, Down, Sideways, and Across-Sustainable Leadership in an Ever Changing Environment" *(Thursday @ 8:00am)*
- "Medicare's Shift to Value-based Delivery and Payment Models" *(Thursday @ 8:00am/Friday@ 1:30pm)*

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