

Patient Attribution: Why It Matters Now More Than Ever

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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 and currently serves as an Alternate Delegate to the AAFP Congress of Delegates. He is also active in his state medical society. After serving on the AAFP Commission on Quality and Practice, Dr. Fiesinger represented the AAFP on numerous measure development workgroups convened by the National Quality Forum, the AMA Physician Consortium for Practice Improvement, and the American Board of Medical Specialties. He is a past member of the NQF's Attribution Committee and now serves on their Cost and Resource Use Committee. A member of the Commission on Governmental Advocacy, he won the Texas AAFP PAC's Political Advocacy Award in 2015. Dr. Fiesinger is especially interested in quality improvement, population health, and health policy.

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Learning Objectives

1. Identify patients for whom physicians will be held accountable in a value-based payment environment by the attribution models used by Centers for Medicare and Medicaid Services and other major payers.
2. Recognize how patient attribution will affect physician future payments under MACRA, MIPS, and Advanced APMs.
3. Develop a plan for how and when to address incorrect attribution of patients.

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Associated Sessions

- Harnessing the Power of Primary Care Access to Improve Cost of Care
- MACRA: Medicare's Shift to Value-based Delivery & Payment Models
- MACRA Medicare's Shift to Value-based Delivery & Payment Models: Ask the Expert
- What is Risk? Am I Ready for Advanced Alternative Payment Models
- Your Prescription for MIPS

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How do you identify your patients?

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

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How do you identify your patients?

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

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Whose patients are they anyway?

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

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Which method(s) do the major 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 models vary somewhat from program to program
 - Value-based Payment Modifier
 - Physician Quality Reporting System
 - Electronic Health Record Incentive Program (“Meaningful use”)
- But they tend to share common elements

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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

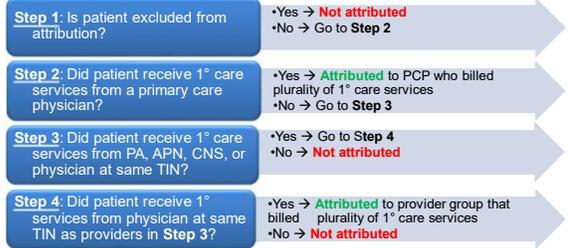
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Medicare ACO Programs

- 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 use
 - 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
- For Next Generation ACO, AWV with PCP in ACO automatically attributes patient to that ACO

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Medicare's Two Step Method



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Whose patients are they anyway?

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

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How would these patients be attributed?

- RJ
 - Previously attributed to me via MSSP ACO in which Physicians at Sugar Creek participates
 - In 2015
 - Saw resident physician OW 4 times
 - In 2016
 - Saw me at Village Family Practice once
 - Saw LKB at Physicians at Sugar Creek once
 - 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
 - 2015
 - Saw Dr. M for years with 3 acute visits and one physical before he sold his practice (Family Practice of Ft. Bend) to Village Family Practice
 - Saw ObGyn for well woman exam
 - 2016
 - Changed PCP to me because Dr. M plans to retire soon
 - Saw me 4 times (3 acute visits, 1 physical)
 - Saw ObGyn for well woman exam
 - 2017
 - Saw me for 2 acute visits

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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
 - Chose me as PCP for her Medicare Advantage plan
 - 2015
 - Saw me at Physicians at Sugar Creek 5 times (2 acute visits, 2 chronic care visits, 1 AWV)
 - 2016
 - Has seen me 4 times at Village Family Practice (1 acute visit, 2 chronic care visits, 1 AWV)
 - 2017
 - Has seen me 3 times, including 1 AWV

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How would my patients be attributed?

- CN
 - Has been going to county health clinic for years
 - On turning 65, enrolled in Medicare parts A and B and scheduled appointment in 2016 with husband's PCP

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What will happen to under current rules?

RJ	TC	KG	BW	CN
<ul style="list-style-type: none"> • Attributed to Physicians at Sugar Creek • was enrolled in MSSPACO under their TIN 	<ul style="list-style-type: none"> • Attributed to Dr. M, because he billed plurality of Medicare part B allowable charges in 2015 and in first half of 2016 	<ul style="list-style-type: none"> • Not attributed ("orphan patient") • Did not receive recognized primary care services from a Medicare-designated primary care provider 	<ul style="list-style-type: none"> • Attributed to Physicians at Sugar Creek • Has to change PCP from TF with Physicians at Sugar Creek to TF at Village Family Practice 	<ul style="list-style-type: none"> • Not attributed to anyone because new Medicare beneficiary this calendar year

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And then it happened ...



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So how will attribution change under MACRA?

- Merit-based Incentive Payment System (MIPS)
- Advanced Alternate Payment Model (AAPM)

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Attribution in Merit-based Incentive Payment System (MIPS)

- To participate as a physician, you must:
 - Not have started billing Medicare during current performance year (not eligible until second performance period)
 - Have ≥ 100 Medicare patients attributed to you
 - Have $\geq \$30,000$ Medicare Part B allowed charges
 - Not be a Qualified Participant in an Advanced Alternate 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, 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 are coming
- **Individual** physician
 - BUT for physicians who use group reporting option, positive / negative payment adjustment based on group performance

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Attribution in MIPS

- "MIPS eligible clinician identifier"
 - Provider groups:
 - Patients attributed first to provider's NPI
 - Patients then assigned to group practice of which provider is a member, based on group Taxpayer ID Number (TIN)
 - Individual providers: Patients attributed based on National Provider Number (NPI)
- **Tie breaker** will be same as Value-based Payment Modifier
 - Patient attributed to whomever billed most recent primary care E&M service

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Advanced Alternate Payment Models (AAPM)

- You may be a Qualifying Participant if you participate in:
 - Medicare Shared Savings Program (MSSP) Track 2 and Track 3
 - Comprehensive Primary Care Plus (CPC+) initiative
 - Next Generation Accountable Care Organization
 - Vermont Medicare Accountable Care Organization initiative (part of Vermont All-Payer ACO Model)

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Advanced Alternate Payment Models (AAPM)

- AAPM Entity must do one of these for its eligible clinicians to be qualifying participants (QPs):
 - 25% of Medicare Part B payments received through AAPM
 - See 20% of its Medicare patients through AAPM
 - QPs will receive an annual 5% lump-sum bonus in payment years 2019-2024.
 - QPs excluded from MIPS reporting requirements.
 - QPs receive 0.75% increase to their Medicare physician fee schedule beginning in 2026.
- If AAPM Entity does not meet payment threshold or patient threshold
 - Can participate in MIPS instead
 - Will be scored using APM scoring standard

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What will happen to under MACRA?

RJ	TC	KG	BW	CN
<ul style="list-style-type: none"> • Would remain attributed to former practice • Under Next Generation ACO rules could voluntarily assign himself to new Medicare ACO 	<ul style="list-style-type: none"> • Would remain attributed to prior PCP until new PCP submitted enough claims to have plurality of Medicare part B charges 	<ul style="list-style-type: none"> • Still not attributed until she sees a PCP for an acute or wellness visit 	<ul style="list-style-type: none"> • Still attributed to PCP as long as she selects same PCP and remains enrolled in Medicare Advantage plan 	<ul style="list-style-type: none"> • Attributed to new PCP once she completes initial visit and Medicare receives claim with new PCP's NPI and TIN

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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”

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Because I Said So: 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
 - Examples from CMS:
 - “performance category scores were wrongly assigned to the MIPS eligible clinician”
 - clinician believes low-volume threshold exclusion should have been applied

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Timeline of MIPS Appeals Process

- Physician 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

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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

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Questions to Ask About Patient Attribution

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

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Then ask for details

- **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

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Questions



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