From National Insights to Local Influence: Unraveling ACO Attribution

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Collaborative Health Systems

- Elena is Vice President of Healthcare Analytics with Collaborative Health Systems (CHS) and focuses on transforming information into insight.
- She joined the CHS leadership team in 2014 and developed advanced analytics, models, and algorithms to support healthcare transformation and innovation for CHS provider partners.
- Collaborative Health Systems (CHS) is a management services organization that partners with independent primary care physicians as they move to value-based models.

Gabe

- Gabe Orthous, healthcare information technology executive offering 20+ years of progressive experience as a value-based care strategic thinker and executor with a history of scaling and driving return on investment of complex HIT solutions. Solid industry knowledge with a wealth of expertise in business Intelligence used in concert with various analytics tools to drive actionable insights.
- He is particularly accomplished in helping large healthcare systems and insurer organizations develop analytics strategies that are highly effective in raising quality levels, improving patient outcomes and reducing costs.
- Mr. Orthous is currently an adjunct professor at Georgia State University Informatics department and former adjunct at Sacred Heart University Informatics Department. He is also an active contributor as a SME for Cummings Graduate Institute for Behavioral Health Studies.

Andy Perlman

Institute for Accountable Care

- Andy is a senior data analyst with the Institute for Accountable Care (IAC). He has been with IAC for 3 years and is focuses primarily on MSSP ACO Benchmarking.
- The Institute for Accountable Care is a 503(c) that supports accountable care through research, policy analysis and custom analytic support for organizations engaged in accountable care contracts.

Role of Patient Attribution in Shared Savings Model

- Value-based delivery and payment models aim to transition from reimbursement that rewards procedures to one that rewards quality and outcomes
- **Attribution is a key element** of value-based models and used to determine panels of people for whom healthcare providers are accountable for and answers **"Whose Patient Is It Anyway"**

Attribution Overview: Populations

Assignable

Have at least 1 PC visit with a physician in the alignment window

Attribution Eligible

Assignable beneficiaries that meet eligibility requirements

Assigned

Attribution Eligible beneficiaries that had a plurality of care with an ACO

Eligibility Requirements

1. No months of MA, A-only or B-only coverage
2. Lives in US
3. Not assigned to another shared savings initiative
4. Has a PC visit with a physician that is part of the ACO*

*Does not apply to voluntary attribution

Providers involved in Attribution

Primary Care Physicians

Set of CPT codes with PC specialty code. Stage 1

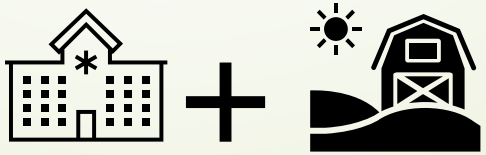
RHC & FQHC

All claims. Stage 1

Attribution

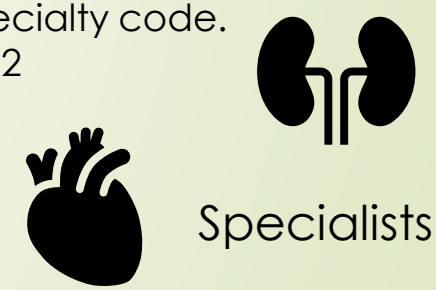
Set of CPT code. Stage 1

Set of CPT codes. Stage 1 or Stage 2 based on specialty code

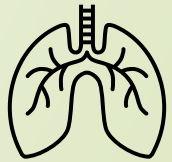


CAH Method II and ETA Hospitals

Set of CPT codes with PC specialty code. Stage 2



Specialists



APCs: PA,NP CNS

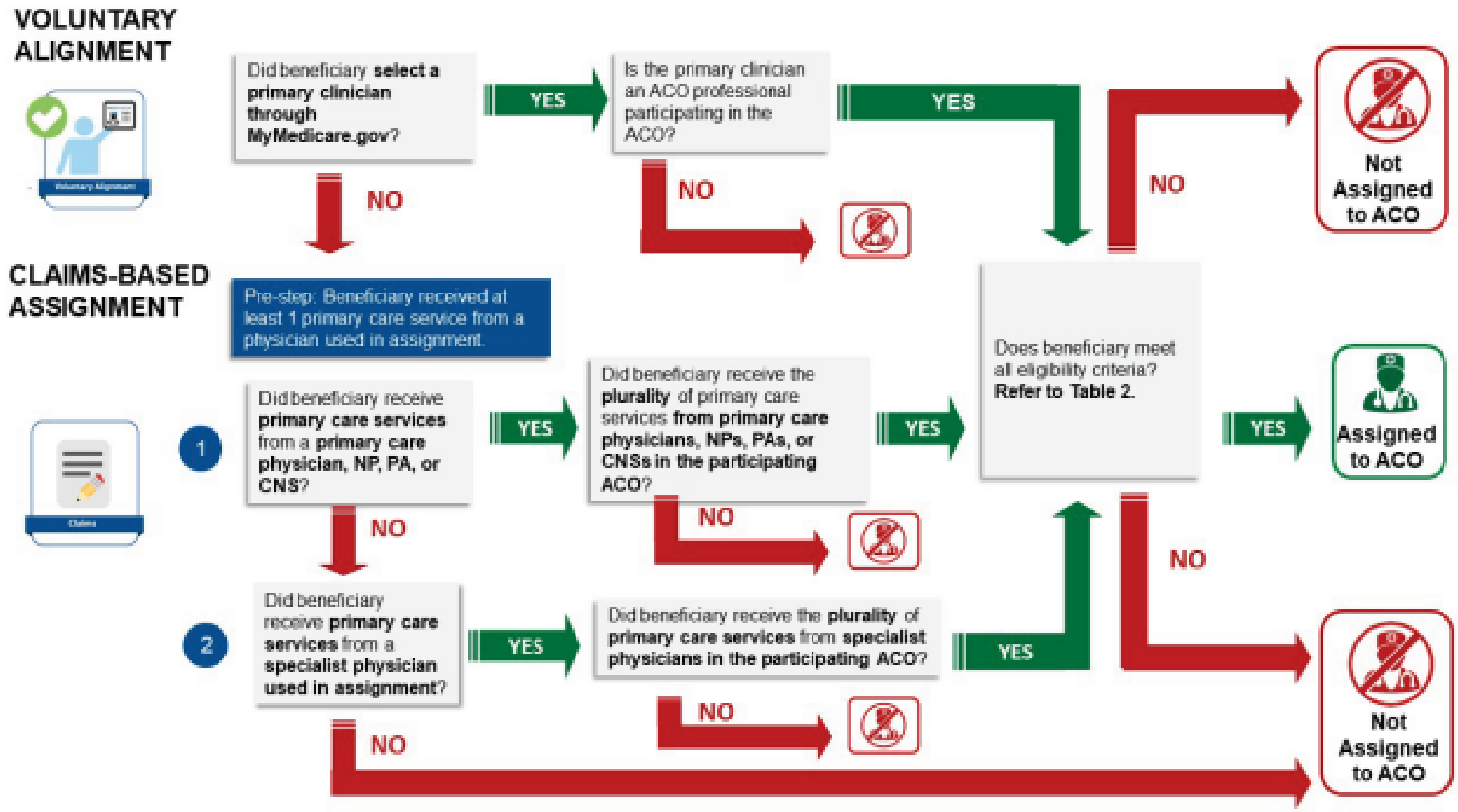
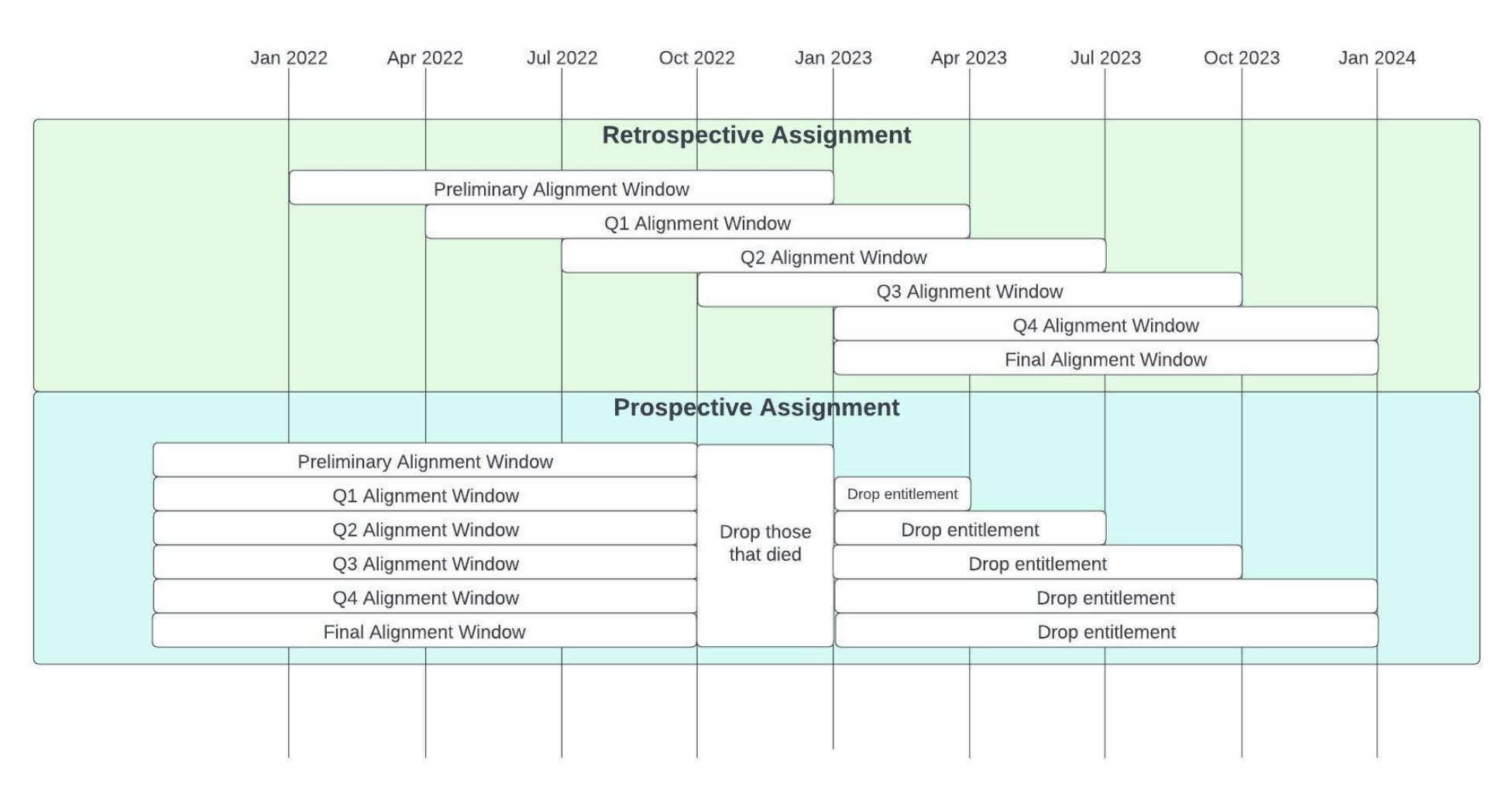


Figure 1. *Voluntary alignment and claims-based assignment process flow* APPENDIX C: DATA

Figure 1 from 'SHARED SAVINGS AND LOSSES, ASSIGNMENT AND QUALITY PERFORMANCE STANDARD METHODOLOGY' https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-2

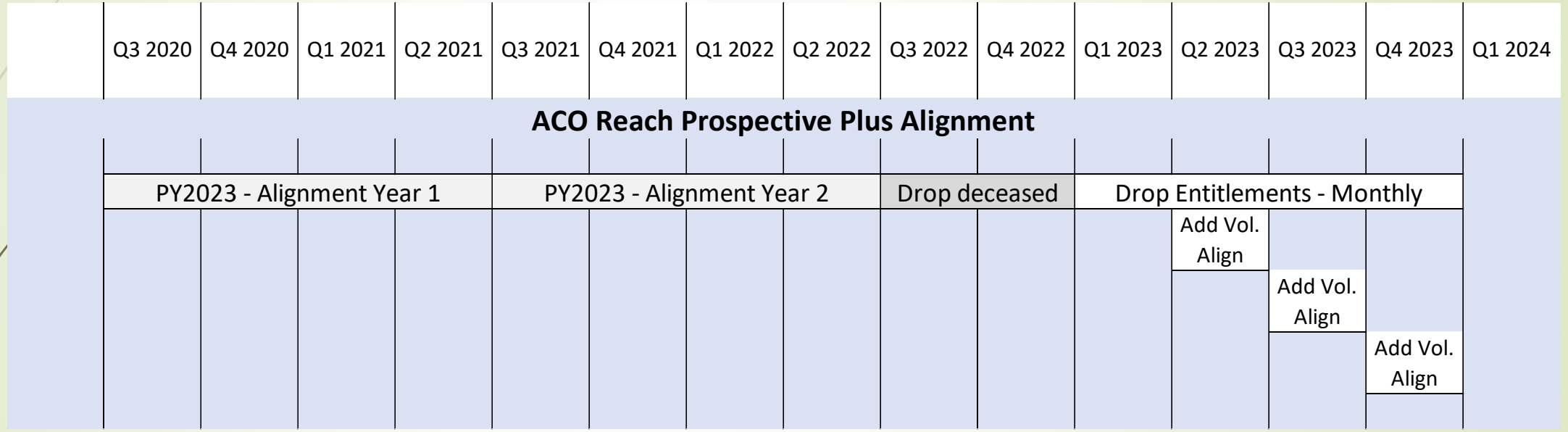
MSSP
Retrospective and Prospective Alignment



REACH Attribution Differences

- All prospective with 2-year alignment window
  - Alignment years weighted (one-third and two-thirds)
- APCs can 'trigger' alignment (i.e., No requirement to see a physician in the year)
- 2-stage but PCP has to be 10% or more of allowed charges for stage 1
- Limited to beneficiaries in the service area
- High-Needs population alignment (not covered here)

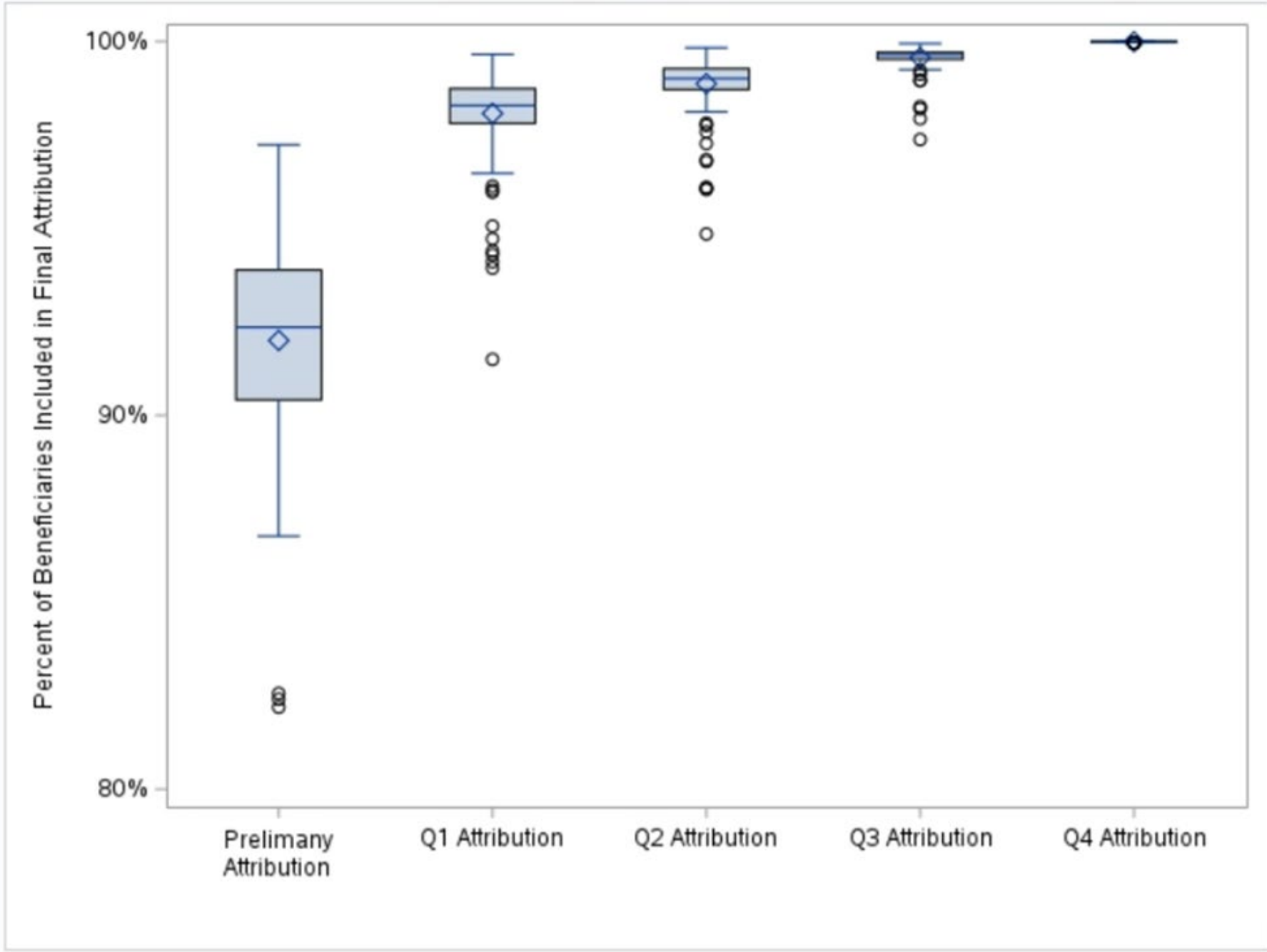
ACO Reach
Prospective Plus Alignment



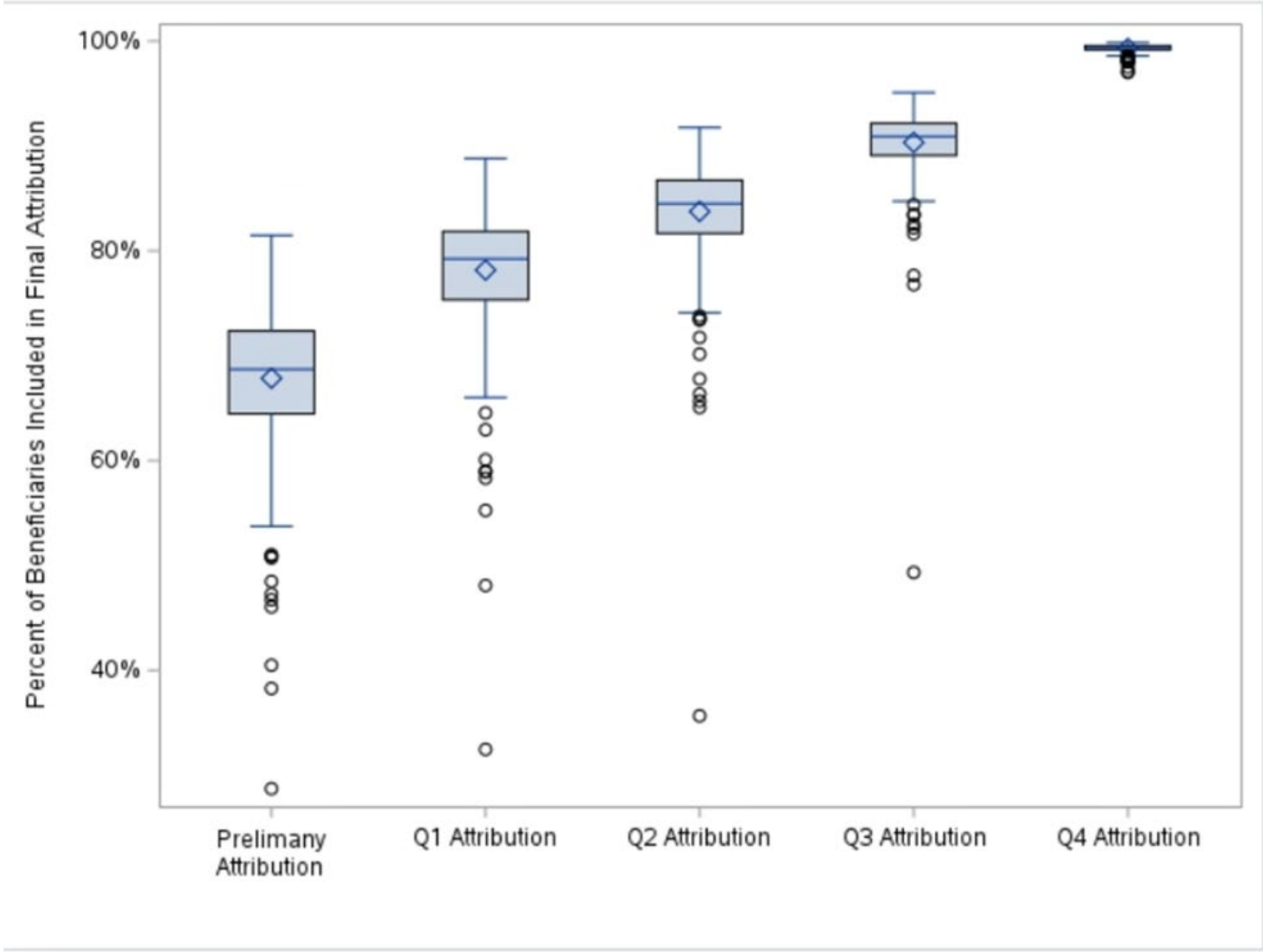
Beneficiary Retention

- An important measure to assess whether providers are delivering the results and transforming patient experience.
- A tool to maximize the impact of care management and coordination, disease management and other initiatives programs
- Increasing beneficiary retention will enable a more accurate evaluation of the clinical and quality improvement initiatives that take several months to impact patient outcomes

Distributions of Prospectively Aligned 2021 MSSP ACOs (N=150)

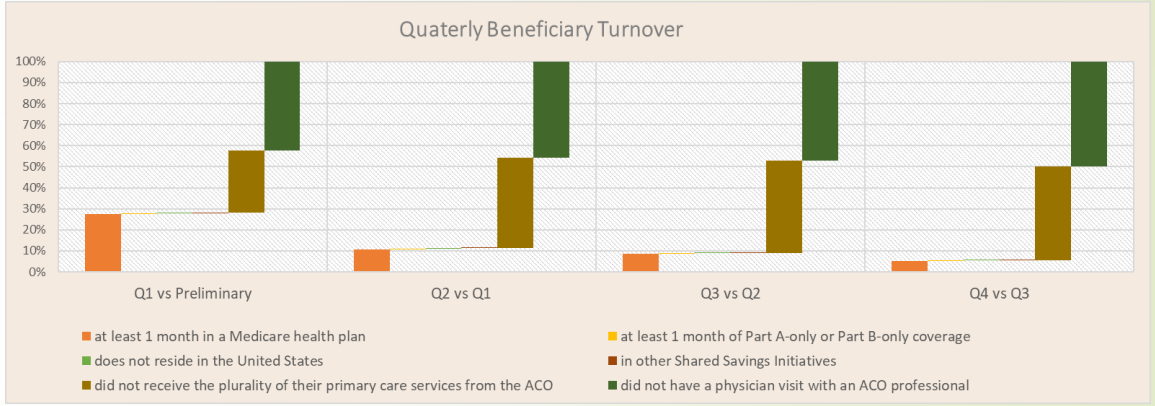


Distributions of Retrospectively Aligned 2021 MSSP ACOs (N=325)



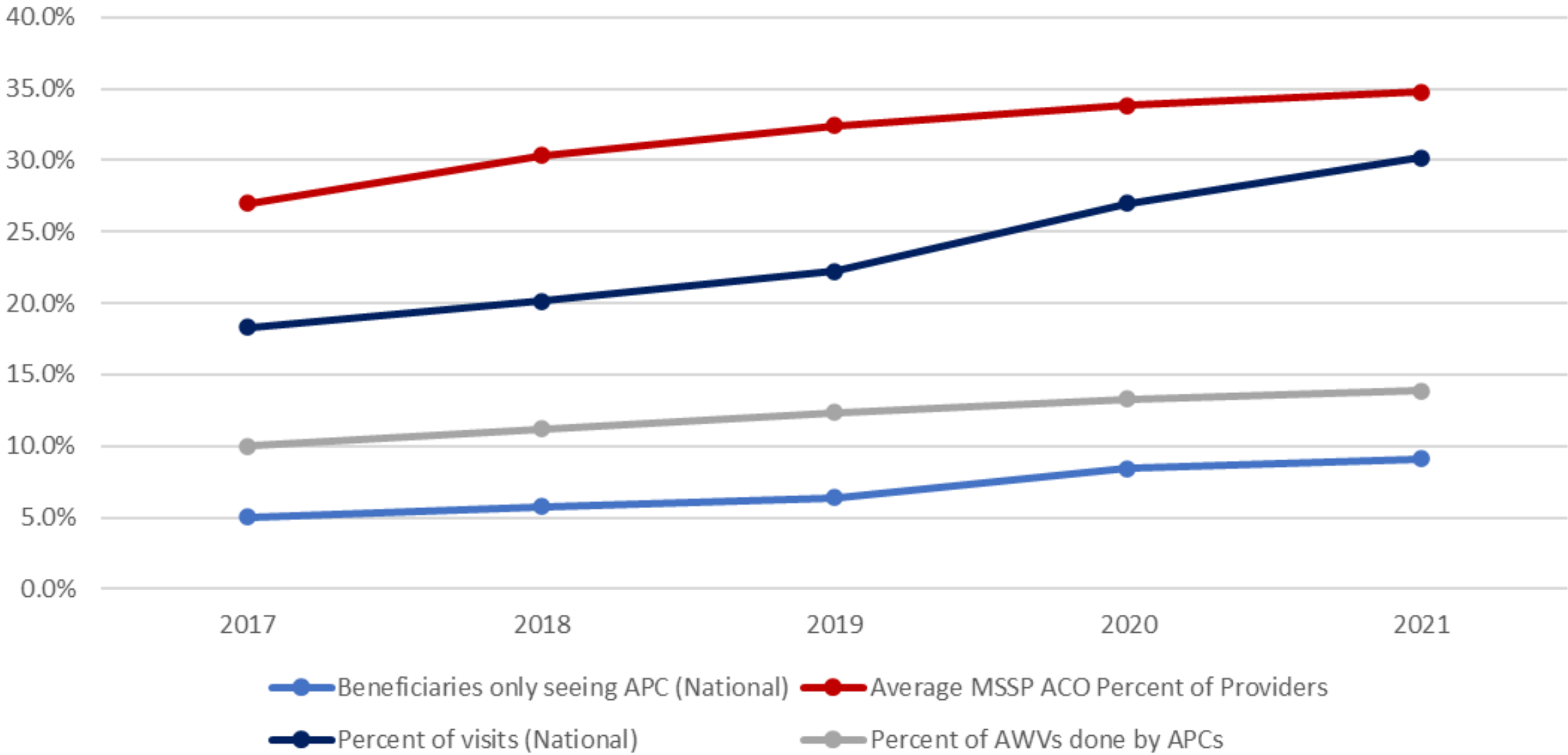
Beneficiary Turnover Analysis

- Entitlement vs primary care services
- Higher percentage of loss in assignment due to entitlement in Q1, primary driven by beneficiaries moving to Medicare Advantage at the start of the year
- Focus on beneficiaries who drop from rosters due to not having any primary care during the year or not seeing ACO providers for primary care services



Source: Collaborative Health Systems experience across 2020-2022 MSSP ACOs with retrospective attribution.

Advanced Practicing Clinician (APC) Usage



Examples of data analysis to improve retention and reduce churn

- Monitor beneficiary retention/churn by practice/ provider using quarterly rosters
- Use weekly/monthly claims to monitor year-to-date primary care services rendered by ACO participating providers
- Monitor leakage rate of primary care services to providers outside of your network
- Identify if snowbirds may impact your attribution
- Use CMS's aggregated reports if unable to set up claims-based analysis
- Consider building predictive model

Voluntary alignment

- Opportunity to grow ACO assignment
- Before setting up initiative, consider the program and if there is an option for paper alignment (i.e. ACO Reach)
- For ACO Reach may also see an impact from increase in voluntary alignment as a result of benchmark methodology - voluntary-aligned beneficiaries are based on rate book
- For FQHC the voluntary alignment is minimal

ACO FQHC attribution and retention

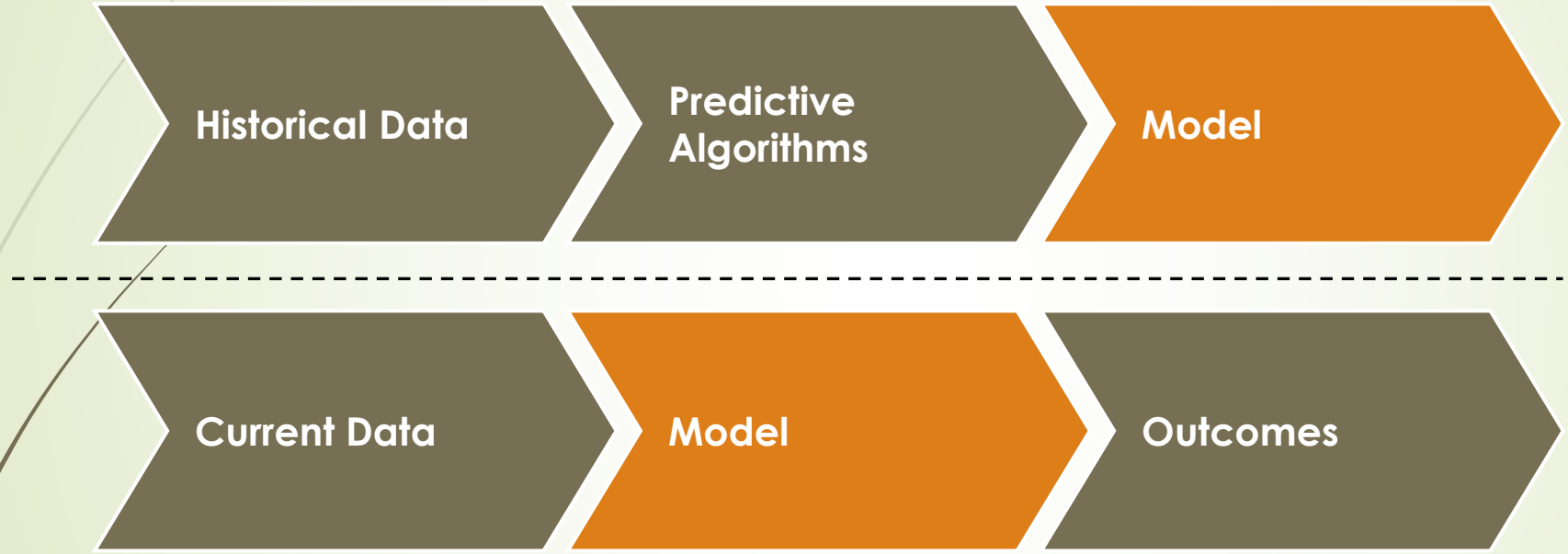
- Importance of FQHC Attribution:
  - FQHCs serve a large number of low-income and uninsured individuals, who often have complex health needs and may require extensive care coordination.
  - By attributing FQHC patients to an ACO, the ACO gains a more comprehensive view of the patient population they serve, including those with socioeconomic challenges.
  - FQHC attribution enhances the ACO's ability to identify care gaps, address health disparities, and implement targeted interventions to improve outcomes for vulnerable populations.
  - It allows ACOs to assess the impact of their initiatives on FQHC patients and evaluate the effectiveness of their care delivery models.

Strategies for FQHC Attribution and Retention in ACOs

- Collaboration and Data Sharing:
  - ACOs should establish strong partnerships and collaborations with FQHCs to facilitate data sharing and care coordination.
- Patient Engagement and Education:
  - ACOs should prioritize patient engagement initiatives tailored to the specific needs of FQHC patients.
  - Implementing culturally sensitive educational programs can improve health literacy and empower FQHC patients to actively participate in their own care.
- Care Coordination and Navigation:
  - FQHC patients often face multiple barriers to accessing healthcare, such as transportation, language barriers, and limited resources.
  - ACOs can enhance care coordination efforts by establishing care navigation programs, e
- Quality Improvement Initiatives:
  - ACOs should incorporate quality improvement initiatives that specifically target the needs of FQHC patients.
  - Analyzing data on FQHC patients' health outcomes, utilization patterns, and adherence to preventive services can identify areas for improvement deploying care coordinators, or leveraging telehealth technologies.

What is a Predictive Model?

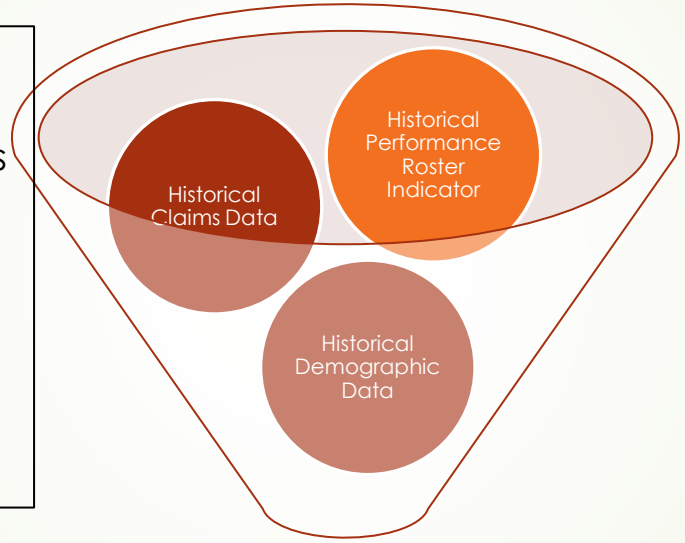
- Predictive modeling is the process of using known results to create, process, and validate a model that can be used to forecast future outcomes.



"Stickiness" Predictive Model

Step 1: Predictive Algorithms

- Calculate Explanatory & Response Variables for historical performance year population.
- Create Logistic Stepwise Regression Model: Algorithms look at which Explanatory Variables impact whether or not the Beneficiary is on the Performance Year Roster (Response Variable)

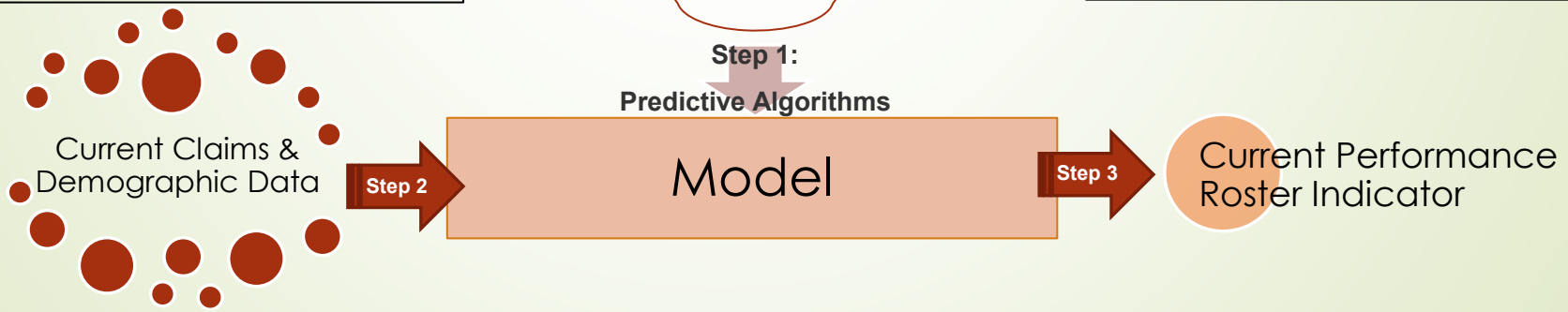


Step 2: Calculate Explanatory Variables for current year population

- Run through Model

Step 3: Current Performance Roster Indicator (Response Variable) generated

- "Stickiness Score" output



Appendix

Appendix A:
Definition of Primary Care Codes Used in MSSP Assignment

Category	HCPCS Code	HCPCS Code Description
Administration of HRA	96160	Admin of patient-focused health risk assessment
	96161	Admin of caregiver-focused health risk assessment
Office or Other Outpatient Visit for New Patient	99201	New Patient, brief
	99202	New Patient, limited
	99203	New Patient, moderate
	99204	New Patient, comprehensive
	99205	New Patient, extensive
Office or Other Outpatient Visit for Established Patient	99211	Established Patient, brief
	99212	Established Patient, limited
	99213	Established Patient, moderate
	99214	Established Patient, comprehensive
	99215	Established Patient, extensive
Professional Services Provided in a Non-Skilled Nursing Facility	99304	Initial Nursing Facility Care
	99305	Initial Nursing Facility Care
	99306	Initial Nursing Facility Care
	99307	Subsequent Nursing Facility Care
	99308	Subsequent Nursing Facility Care
	99309	Subsequent Nursing Facility Care
	99310	Subsequent Nursing Facility Care
	99315	Nursing Facility Discharge Services
	99316	Nursing Facility Discharge Services
	99318	Other Nursing Facility Care
Domiciliary, Rest Home, or Custodial Care Services	99324	New Patient, brief
	99325	New Patient, limited
	99326	New Patient, moderate
	99327	New Patient, comprehensive
	99328	New Patient, extensive
	99334	Established Patient, brief
	99335	Established Patient, moderate
	99336	Established Patient, comprehensive
	99337	Established Patient, extensive
Dom, Rest Home, or Home Care Plan Oversight Services	99339	Brief
	99340	Comprehensive
Home Services	99341	New Patient, brief
	99342	New Patient, limited
	99343	New Patient, moderate
	99344	New Patient, comprehensive
	99345	New Patient, extensive
	99347	Established Patient, brief
	99348	Established Patient, moderate
	99349	Established Patient, comprehensive
	99350	Established Patient, extensive
Telephone Visits – Online Digital or Audio Only	99421	Online digital, Established Patient, 5–10 mins
	99422	Online digital, Established Patient, 10–20 mins
	99423	Online digital, Established Patient, 21+ mins
	99424	Principal Care Management (PCM)
	99425	Principal Care Management (PCM)
	99426	Principal Care Management (PCM)
	99427	Principal Care Management (PCM)
	99437	Principal Care Management (PCM)
Cognitive Assessment / Care Plan Services	99483	Cognitive assessment and care plan services
Behavioral Health Integration (BHI) Services	99484	Monthly services using BHI models
	99492	Initial psychiatric collab care mgmt.., first 70 mins
	99493	Subseq psychiatric collab care mgmt., first 60 mins
	99494	Initial or subseq psychiatric collab care mgmt., add '30 mins
	G2214	Psychiatric collaborative care management
Chronic Care Management (CCM) Services	99439	Non-complex chronic care mgmt. services, add 30 min
	99487	Extended care coord for complex patients (first 60 mins)
	99489	Additional care coord for complex patients (30 mins)
	99490	Comprehensive care plan establish/impl/revision/monitoring
	99491	Chronic care monitoring service, moderate
	G2058	Non-Complex Chronic Care Management Service
	G2064	Comprehensive care management, physician
	G2065	Comprehensive care management, clinical staff
	G0506	Add work for the billing provider in face-to-face or CCM plan
Other	G3002	Chronic pain mgmt. 30 mins
Wellness Visits	G0402	Welcome to Medicare visit
	G0438	Annual wellness visit
	G0439	Annual wellness visit
Transitional Care Management Services	99495	Communication (14 days of discharge)
	99496	Communication (7 days of discharge)
Depression and alcohol misuse	G0442	Annual alcohol misuse screening
	G0443	Annual alcohol misuse counseling
	G0444	Annual depression screening
Prof Services in ETA Hosp	G0463	Professional Services Provided in ETA Hospitals
Prolonged Care for Outpatient Visit	99354	Prolonged visit, first hour
	99355	Prolonged visit, additional 30 mins
	G2212	Prolonged visit, additional 15 mins
Prolonged Care	G0317	Prolong nursing fac eval 15m
	G0318	Prolong home eval add 15m
Advance Care Planning	99497	ACP first 30 mins (subject to excl if overlapping inp stay)
	99498	ACP add 30 mins (subject to excl if overlapping inp stay)
Virtual check-ins	G2010	Remote evaluation, Established Patient
	G2012	Brief comm technology-based serv , 5-10 mins of med disc
	G2252	Brief comm technology-based serv , 11-20 mins of med disc

Source: https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-2

Appendix B:
Definition of Providers Used in MSSP Assignment

Table 1. Applies to Non-FQHC/RHC claims*, defines a primary care physician, Assignment Step 1, specialists, Assignment Step 2.
***All FQHC/RHC providers are treated as primary care physicians.**

SPECIALTY CODE	DESCRIPTION	PRIMARY CARE PHYSICIAN (STEP 1)	SPECIALIST (STEP 2)
01	**General practice**	**Yes**	**No**
06	Cardiology	No	Yes
08	**Family practice**	**Yes**	**No**
11	**Internal medicine**	**Yes**	**No**
12	Osteopathic manipulative medicine	No	Yes
13	Neurology	No	Yes
16	Obstetrics/gynecology	No	Yes
23	Sports medicine	No	Yes
25	Physical medicine and rehabilitation	No	Yes
26	Psychiatry	No	Yes
27	Geriatric psychiatry	No	Yes
29	Pulmonary disease	No	Yes
37	**Pediatric medicine**	**Yes**	**No**
38	**Geriatric medicine**	**Yes**	**No**
39	Nephrology	No	Yes
46	Endocrinology	No	Yes
70	Multispecialty clinic or group practice	No	Yes
79	Addiction medicine	No	Yes
82	Hematology	No	Yes
83	Hematology/oncology	No	Yes
84	Preventive medicine	No	Yes
86	Neuropsychiatry	No	Yes
90	Medical oncology	No	Yes
98	Gynecologist/oncologist	No	Yes

Table 2. Specialty codes for non-physician practitioners included in the definition of an ACO professional used in Assignment Step 1

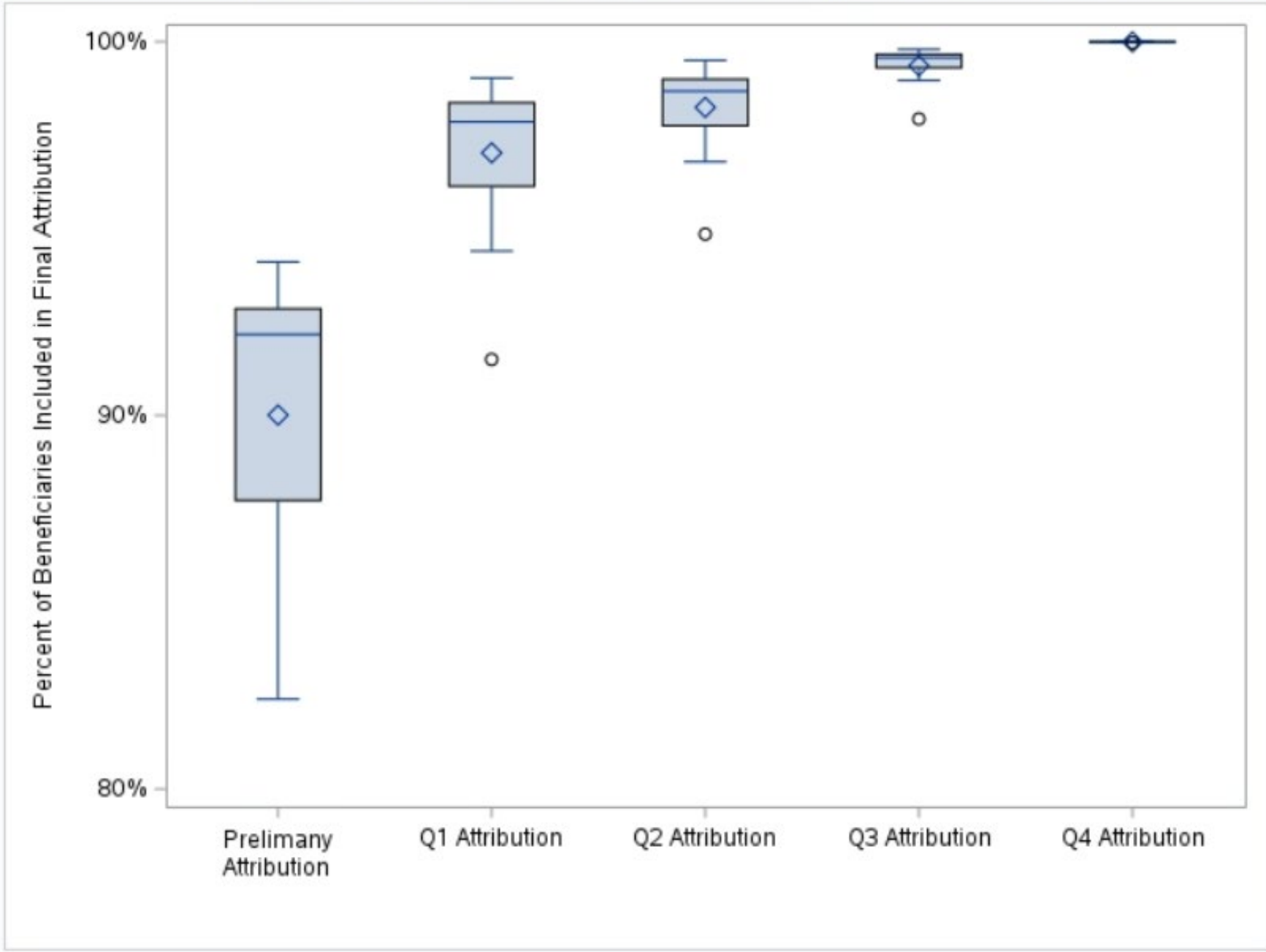
SPECIALTY CODE	DESCRIPTION
50	Nurse practitioner
89	Clinical nurse specialist
97	Physician assistant

Table 3. The bill types for selecting carrier (physician/supplier Part B), Method II CAH, FQHC, RHC, and ETA institutional claims

SPECIALTY CODE	
Method II CAH Claims	Type of bill 85X with the presence of one or more of the following revenue center codes: 096x, 097x, and/or 098x
RHC Claims	71x bill types
FQHC Claims	77x bill types
ETA Claims	13x bill types (from ETA hospitals)

Source: https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-2

Distributions of Prospectively Aligned 2021 MSSP ACOs: High FQHC/RHC Involvement (N=11)



Distributions of Retrospectively Aligned 2021 MSSP ACOs: High FQHC/RHC Involvement (N=37)