The Impact of Retrospective Versus Prospective Attribution on Your ACO

In brief: Choosing an appropriate Accountable Care Organization (ACO) model requires consideration of many criteria, one of the most important being the model's attribution methodology. The Medicare Shared Savings Program (MSSP) Track 1 and Track 2 utilize retrospective attribution while MSSP Track 1+[1], Track 3, and the Next Generation ACO Model use prospective attribution. In both cases, ACOs will experience changes over time in the beneficiaries for whom they are accountable. The methods used to identify the individual beneficiaries associated with an ACO are similar for each model, although the reasons for turnover or attrition during a performance year are often very different. In general, retrospective models reward ACOs that build and maintain strong beneficiary loyalty, while prospective models are often favored by ACOs that desire predictability and by those ACOs for whom retrospective attribution would disproportionately attribute patients who are new to the ACO as a result of aging into Medicare or from receiving ACO based primary care as a result of hospital discharge. Detailed information on the components of the various Medicare ACO models and tracks is available in the NAACOS ACO Comparison Chart.

Importance of Attribution: Attribution is part of the foundation upon which value-based contracts are built, and identifying the individual patients who aggregate into a population defines the boundaries of accountability for an ACO.

Attribution Definition: While MSSP refers to the methodology as "assignment" and the Next Generation Model refers to it as "alignment," for consistency this guide uses an all-inclusive term of "attribution." In both the MSSP and Next Generation Model approaches, claims-based attribution is driven by analysis of utilization of primary care services. Primary care services are further defined as a specific set of qualified treatment codes, many of which are Evaluation and Management (E&M) codes. The Centers for Medicare & Medicaid Services (CMS) maintains up-to-date lists of these codes in the MSSP regulations and Next Generation Model Participation Agreement.

Overall Attribution Rules: CMS applies consistent structures to the attribution approaches under both the MSSP and Next Generation Model as follows:

1) Beneficiaries who receive Medicare Advantage during the performance year are excluded from attribution
2) Beneficiaries who die during the performance year remain attributed

[1] Track 1+ rules may continue to be refined, and this document is using available guidance as of June 2017 and where necessary assumes that Track 1+ attribution will mimic Track 3 approach.

3) Prospective overrides retrospective. A beneficiary prospectively attributed to an ACO will not be eligible for attribution to a different ACO, even if the beneficiary accumulates a plurality[2] of primary care services from another ACO's Participants during a Performance Year
4) Place of residence impact:
    a. MSSP: CMS excludes beneficiaries whose permanent residence is outside of the United States or U.S. territories and possessions in the last month of the attribution window.
    b. Next Generation Model: CMS excludes beneficiaries who (1) are residents of a county that was not part of the NGACO's service area in the performance year or (2) receive a majority of their primary care services outside of the geographic region of the NGACO.
5) Accurate participant lists drive attribution:
    a. Retrospective: CMS uses Tax Identification Numbers (TINs) and for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs), all possible National Provider Identifier (NPI) to CMS Certification Number (CCN) combinations.
    b. Prospective: For Next Generation Model, CMS uses TIN to NPI combinations, for Track 1+ and Track 3, CMS uses TIN submissions, and in both cases, for FQHC and RHCs, CMS uses all possible NPI to CCN combinations.

Explanation of MSSP Track 1 and Track 2 Assignment Approach

MSSP Track 1 and Track 2 use preliminary prospective assignment with retrospective reconciliation, and CMS uses a two-step process for assignment, as follows:

First step: A beneficiary is attributed to an ACO if the allowed charges for primary care services furnished to the beneficiary by primary care physicians (PCPs) who are ACO professionals and non-physician ACO professionals (i.e., physician assistant [PA], nurse practitioner [NP], and clinical nurse specialist [CNS]) in the ACO are greater than the allowed charges for primary care services furnished by PCPs and select non-physician professionals (i.e., PA, NP, and CNS) who are ACO professionals in another ACO or are not affiliated with any ACO.

Second step: (Only considers beneficiaries who have not had a primary care service rendered by any PCP, PA, NP or CNS inside or outside the ACO). The beneficiary will be attributed to an ACO if the allowed charges for primary care services furnished to the beneficiary by physicians who are ACO professionals with specialty designations in §425.402(c) are greater than the allowed charges for primary care services furnished by physicians with specialty designations as specified §425.402(c) who are ACO professionals in any other ACO or who are unaffiliated with an ACO.

Explanation of MSSP Track 1+ and Track 3 Assignment and Next Generation Model Alignment Approach:

These models have prospective beneficiary attribution, using a two-stage attribution approach.

Next Generation Model: First, CMS analyzes claims for beneficiaries who received care from a NGACO's providers to determine the percentage of each beneficiary's primary care services delivered by NGACO providers in select primary care specialties or, for purposes of the second stage of the two-stage alignment algorithm, one of the selected non-primary care specialists. Beneficiaries with such services comprising a plurality of primary care service charges are attributed to the NGACO. The second stage analysis focuses on beneficiaries with less than 10 percent of their primary care services delivered by a NGACO's PCPs and non-physician ACO

[2] Plurality – the most primary care services charges, but not necessarily a majority

professionals (i.e., PA, NP, CNS) to determine whether the NGACO's providers in select subspecialties were central to the beneficiary's care, which could result in attribution.
Track 1+ and Track 3: For these tracks, CMS conducts an evaluation similar to that for Track 1 and Track 2, which is based on where a beneficiary receives the plurality of primary care services. However, as illustrated in Figure 1, the timing of the assignment window is different, and this process results in a list of prospectively attributed beneficiaries. These beneficiaries are reflected in the data reports, quality reporting, and financial reconciliation for that ACO. The prospective list is provided to the ACO close to the start of each performance year and cannot be increased.

CMS incorporates voluntary alignment into the attribution process for MSSP and the Next Generation Model. Through voluntary alignment, beneficiaries can identify their "main doctor" and provided other criteria are met, they will be attributed to that provider's ACO, superseding any claims-based attribution. More information on voluntary alignment is in Appendix A.

CMS has stated its belief that limiting prospective attribution to ACOs in two-sided models may incentivize Track 1 ACOs to more quickly transition to a two-sided risk model. In addition to the benefit of prospective assignment, CMS also limits use of certain payment rule waivers or beneficiary enhancements such as three-day Skilled Nursing Facility (SNF), telehealth or homebound care waivers.

Pros and Cons of Retrospective Attribution:

Pros:

- **Reduces potential inequalities in care by encouraging ACOs to redesign care for all patients.** Without knowing which beneficiaries will ultimately be attributed, an ACO is more likely to implement processes to provide high quality and lower cost care to all patients equally, including those in Fee for Service (FFS). CMS cites this as a benefit for all Medicare beneficiaries.
- **Enables smaller ACOs to participate.** MSSP ACOs need to have 5,000 or more attributed beneficiaries to participate and remain in the program. Under retrospective attribution, ACOs can add beneficiaries throughout the year, which is helpful for ACOs near the 5,000-beneficiary threshold.
- **Facilitates timely additions to the ACO.** Beneficiary attribution may increase during the performance year when new beneficiaries begin to receive care from ACO participants.
- **Recognizes additional providers joining the ACO.** Providers who join the ACO during the performance year contribute to the calculation of plurality for potentially attributed beneficiaries.
- **Favors ACOs with ability to track and follow-up on beneficiaries independently of CMS reporting.** If an ACO can accurately monitor beneficiary use of primary care services during the performance year, the ACO can have very accurate predictions of which beneficiaries will ultimately be retrospectively attributed. Examples of events to track include beneficiaries eligible for Medicare Wellness Visits and those who receive primary care services from non-ACO participants. Therefore, ACOs adept at this tracking will know their final attributed beneficiaries well before CMS makes that information available to ACOs, which usually happens between May and August following the end of the performance year.
- **Enables providers to focus on building long term relationships with beneficiaries.** ACOs that implement programs to prevent attrition through appropriate preventive care and Medicare Wellness Visits can build a loyal patient base.

Cons:

- **Distracts ACOs with inaccurate information**. There is usually significant turnover or "churn" in the quarterly reports from CMS of expected attributed beneficiaries. This churn is based on beneficiaries receiving primary care from multiple providers, some of whom are outside the ACO. It is not unusual for quarterly changes to be between 10 and 20 percent with some beneficiaries cycling in and out on alternating quarters. This can be particularly challenging for ACOs where this turnover is difficult to anticipate or track, which is often the case in rural and underserved areas.
- **Diminishes patient-doctor relationships.** An ACO may discover beneficiaries attributed for reasons that conflict with long-term patient-doctor relationships or goals of the ACO. For example, a beneficiary may have been a multi-year patient of a specific non-ACO participant, but if he or she is treated by an ACO participant the one time the beneficiary receives primary care services during a performance year, the beneficiary will be attributed to that ACO. Some ACOs are surprised when these beneficiaries are discovered during final reconciliation after the performance year.
- **Penalizes ACOs with transplant programs.** Some ACOs have experienced retrospective attribution of patients who have migrated into the ACO for transplant services and as a result have received a significant amount of primary care services before and after the transplant itself. These patients often experience higher costs during the transplant period than their risk adjustment might have predicted.
- **Results in resource use that does not benefit the ACO.** Because some ACOs cannot predict which beneficiaries will be attributed, an ACO may find itself utilizing its limited resources to intervene with a larger population of patients. While all those patients may benefit from services including care management, behavioral health, medication management, or post discharge planning, the ACO may later discover that these services were provided to beneficiaries attributed to another ACO or no ACO at all. While ACOs are committed to providing highly coordinated care for all patients, this can be a strain on the ACO's resources.

Key criteria supporting choosing Retrospective ACO model:

- High loyalty among ACO's beneficiaries
- Availability of tools to track attribution
- Acceptability of higher turnover/ change in attributed beneficiaries
- Helps smaller ACOs meet minimum attributed population of 5,000

Pros and Cons of Prospective Attribution:

Pros:

- **Allows ACOs to focus their population management resources**. The resources, initiatives and processes to actively manage care for patients and engage beneficiaries are often a driver for lowering costs and allowing an ACO to earn shared savings.
- **Gives providers stronger incentives to engage beneficiaries and their caregivers.** Engaging just attributed beneficiaries and their caregivers in care management activities is easier with prospectively attributed beneficiaries and also enhances patient satisfaction, improves outcomes, and increases the probability the beneficiary will remain part of the ACO.
- **Allows ACOs to establish stabilized financial targets**. These targets are essential for an ACO to stay on track with managing costs throughout the performance year. Because the ACO knows no new beneficiaries will be added to panels during the performance year, establishing these targets is easier.

- **Encourages transparency with attributed beneficiaries.** Prospective attribution enables patients to be fully aware of any incentives providers may have in delivering their care and allows them to incorporate this understanding into their interactions with their care providers.
- **Provides a timing benefit to an ACO**. Prospective attribution reduces the potential quality measure and financial impact from beneficiaries who initiate receiving primary care services from an ACO's participants during a performance year because those patients will not be attributed to the ACO until the subsequent performance year. In other words, if a beneficiary (who has not previously received care from the ACO's providers used in assignment) presents at a hospital for admission and is subsequently provided primary care services by the ACO's participants, that initial year's experience will not be included in the ACO's current performance year quality and financial measurement. Similar protections are provided for beneficiaries who age-in to Medicare during a performance year. Therefore, a forward thinking ACO can ensure the beneficiary receives necessary care and appropriate diagnoses for risk adjustment in preparation for being added to prospective attribution in the subsequent performance year.

Key criteria supporting choosing Prospective ACO model:

- May ease acceptance of down-side financial risk
- Provides greater predictability and stability
- Higher likelihood of new patients through hospitalizations

- **Allows focused investment in ACO infrastructure.** CMS notes that improved certainty under prospective attribution may be an important factor in an ACO's willingness to take on greater performance-based risk because the ACO is better positioned to make decisions regarding where to make investments in infrastructure to deliver enhanced services because the population is known at the beginning of the performance year.

Cons:

- **Maintains accountability even when the beneficiary receives care outside the ACO.** ACOs are held accountable for prospectively attributed beneficiaries with whom their ACO participants have had little or no contact during the performance year and therefore have virtually no ability to effectively manage their care, quality or costs.
- **Can result in disparities of care processes for attributed versus non-attributed beneficiaries**. Because some FFS Medicare beneficiaries presenting at ACO participants will not be part of the current year evaluation (the individuals not on the prospective listing), it is possible that discrimination or an appearance of disparity in application of time or resources could occur between identically insured patients based on attribution to the ACO.
- **Diminishes patient-physician relationships.** An ACO may discover beneficiaries attributed for reasons that conflict with long-term patient-doctor relationships. For example, a beneficiary may have been a multi-year patient of a specific Non-ACO participant, but if during the attribution period they happen to receive a plurality of primary care services from the ACO participants, the ACO will be attributed with the beneficiary. Some ACOs are surprised when these beneficiaries are on the prospective list, and accountability is established even though the beneficiary may never return to the ACO Participants.
- **Delays impact of changes in ACO providers.** If providers join or depart from the ACO after submission of the provider list used for attribution and/or during the performance year, those changes are not reflected in the attributed patients until the next performance year.

- **Creates more challenges meeting the larger beneficiary population required for the Next Generation Model.** NGACOs are required to have at least 10,000 (or 7,500 in the case of rural NGACOs) beneficiaries attributed to the ACO, which can be more challenging to attain with prospective attribution.

Attribution Reporting: CMS provides Assignment Summary Reports with aggregate information on the ACO's attributed beneficiaries and the primary care services they received.

Track 1 and 2: ACOs receive a report based on preliminarily prospectively attributed population for each benchmark year, a report based on the preliminarily prospectively attributed population for each quarter, and a year-end report on beneficiaries retrospectively attributed for financial reconciliation.

Track 1+, Track 3 and Next Generation Model: ACOs receive a report of prospective attribution close to the start of each performance year, reports based on prospectively attributed beneficiaries for each benchmark year, quarterly reports based on the ACO's currently attributed beneficiaries for the performance year that are updated to identify exclusions made in the year to date, and a year-end report on prospectively attributed beneficiaries for the performance year updated to identify beneficiaries no longer eligible for attribution at the end of the performance year.

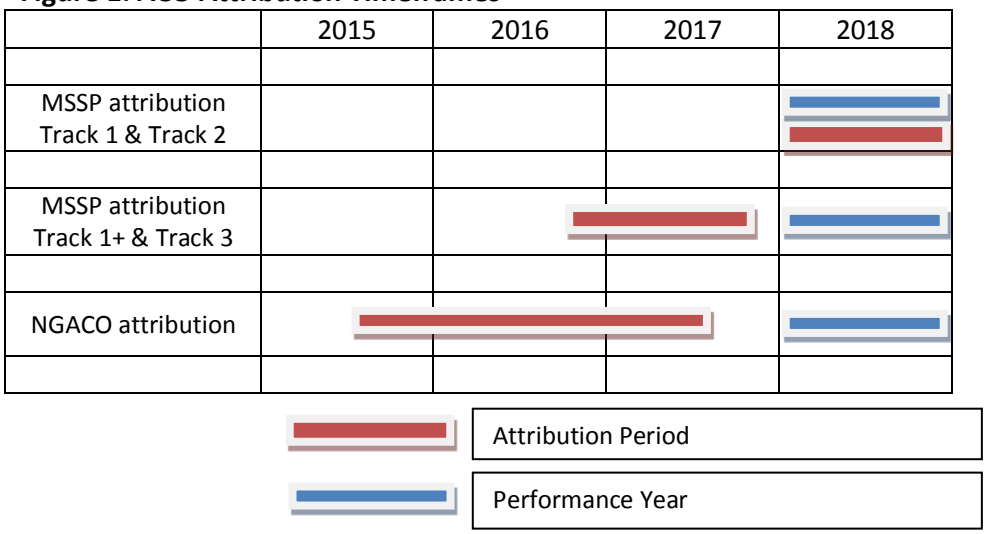
Prospects for the Future: CMS has not made any commitments to significantly change attribution methodologies, although several notable modifications have occurred as a result of feedback from NAACOS and others. One important modification was the shift of certain non-physician practitioners from Step 2 to Step 1 in the MSSP attribution process. This modification became effective in 2016. For the 2017 performance year, CMS modified the definition of primary care services used for attribution to exclude services delivered to beneficiaries in SNFs. NAACOS continues to strongly advocate for CMS to modify its policies to allow ACOs to choose retrospective or prospective assignment, regardless of track or model.

Moving forward, CMS could consider incorporating some attribution approaches found in commercial and Medicare Advantage contracts. For example, CMS could consider reconciling catastrophic expenses back to a previous ACO or provider for those that are incurred immediately following a beneficiary being attributed to a new ACO. This approach is used by some commercial payers especially where the episode is designated as preventable (e.g., certain readmissions, adverse events, hospital acquired conditions, or medical errors). Considering the significance of the assignment methodology, NAACOS continues to diligently monitor potential changes and comment to CMS about their immediate and long-term impact on ACOs.

Other Factors to Consider: ACOs contemplating which Medicare ACO track or model to select can use the characteristics highlighted above to help them prioritize the attractiveness of tracks/models with retrospective versus prospective attribution. Additional factors to consider may include:

Timing of attribution. There are differences between the MSSP and Next Generation Model prospective attribution methods, especially with the timeframe of eligibility for and calculation of attribution. The Next Generation Model uses a 24-month period ending six months before the performance year. MSSP Track 1+ and Track 3 base prospective attribution on a 12-month window usually ending three months before the performance year. Track 1 and 2 use the calendar year that aligns with the performance year.

Figure 1: ACO Attribution Timeframes



Providers used in attribution. The Next Generation Model uses a historical snapshot of providers submitted in June before the performance year. For MSSP Track 1+ and Track 3, attribution is based on the providers listed by the ACO for prospective attribution, the lists are due August 31, 2017 with deletions possible only through October 20, 2017. MSSP Track 1 and Track 2 attribution is based on providers in the ACO participant TINs who furnish care to beneficiaries during the performance year. As previously noted, these two tracks are the only ones that allow additions of new providers during the performance year. In both MSSP and the Next Generation Model, primary care physicians are the central focus for attribution but certain specialty physicians and non-physician practitioners also play a role.

Prospective attribution attrition is front loaded. The exclusion of a majority of the initially attributed beneficiaries who will be excluded occurs during the first quarter due to Medicare Advantage enrollment. These exclusions are usually communicated by CMS by late April or May of the performance year. While similar Medicare Advantage related attrition occurs to retrospectively attributed ACOs because beneficiaries are added and excluded at a significant pace throughout the performance year, attrition is more evenly distributed for retrospectively attributed ACOs.

Commercial ACO Contract Attribution Methodologies

During research for this resource, ACOs reported many variations on the retrospective and prospective attribution models used by commercial payers. Many commercial, Medicare Advantage and managed care Medicaid contracts enforce prospective attribution by naming a specific primary care provider or practice for each covered person. Some contracts use default or assignment of a primary care provider when the covered person doesn't or can't designate one. This approach helps establish a specific provider or practice as the initial building block for attribution. While no ACO touted their contracts as perfect, most ACOs reported that they value improved stability and predictability to help them achieve improved quality, cost, and patient as well as physician satisfaction.

Some contracts use retrospective attribution based on covered person behavior within the network associated with the contract. According to ACO feedback for this resource, the least popular method was based on using the most recent primary care visit to associate a covered person with an ACO. ACOs also reported that frequency or volume of primary care was commonly used to drive retrospective attribution. In general, these retrospective attribution approaches may not be as popular

as prospective with the provider community but are convenient for payers because of the "end of period" accuracy.

Commercial and Medicare Advantage contracts are often the product of negotiation and therefore reflect the variety of leverage providers and payers bring to the table. As ACOs enter into or revise contracts with commercial payers, it is important to negotiate an attribution methodology that is beneficial to the ACO.

References:

https://innovation.cms.gov/Files/x/nextgenacorfa.pdf

https://innovation.cms.gov/initiatives/Next-Generation-ACOModel/

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V5.pdf

Shared Savings Program's November 2011 Final Rule (76 FR 67802), as amended by the June 2015 Final Rule (80 FR 32692), June 2016 Final Rule (81 FR 37950), and codified at 42 CFR part 425.

Appendix A: Voluntary Alignment

CMS utilizes voluntary alignment with the Next Generation Model, and beginning with the 2018 performance year, with the MSSP. The purpose of voluntary alignment is to encourage ACOs to work on establishing or confirming care relationships between ACO providers and beneficiaries. This allows ACOs to focus efforts and resources on segments of their beneficiary population that may not be aligned based on claims data, but would benefit from a relationship with the ACO. It's important to note that voluntary beneficiary alignment does not obligate a beneficiary to receive care from a particular ACO, and the beneficiary still retains freedom to receive services from the Medicare provider of their choice.

Next Generation Model Voluntary Alignment

The Next Generation Model voluntary alignment is available only for years subsequent to the first performance year. Voluntary alignment is accomplished by the NGACO sending a CMS drafted letter to beneficiaries and receiving back forms signed by beneficiaries showing their voluntary alignment election. An NGACO must then submit a listing of those individuals to CMS and should be prepared to provide the beneficiary election forms in case of an audit. NGACOs that choose to implement voluntary alignment must adhere to the specific requirements outlined in the Participation Agreement (PA) and Appendix C of the PA. If a NGACO wishes to conduct targeted outreach to beneficiaries who are neither currently aligned to their NGACO, nor were aligned to their NGACO in the previous performance year, the NGACO must submit a "Proposed Voluntary Alignment Targeted Outreach List" to CMS, typically in the spring. CMS will verify that the beneficiaries on the "Proposed Voluntary Alignment Targeted Outreach List" satisfy the targeted outreach eligibility criteria.

A beneficiary who does not qualify for targeted outreach without prior approval from CMS will be approved for targeted outreach if the beneficiary has at least one paid claim for a Qualified Evaluation and Management (QEM) service, as defined in Appendix B of the Participation Agreement (PA), furnished on or after January 1, 2014, by a provider or supplier billing under the TIN of a Next Generation participant that is included on the ACO's Next Generation Participant List for the performance year during which the ACO has selected to participate in voluntary alignment; the current performance year. Returning the Beneficiary Voluntary Alignment form to the NGACO provides evidence that a beneficiary confirms their expectation that the named NGACO provider is their primary care provider. Voluntary Alignment Lists are typically due to CMS in the fall.

MSSP Voluntary Alignment

In response to requests from NAACOS, in the 2017 final Medicare Physician Fee Schedule (PFS) CMS finalized a modification to the MSSP beneficiary assignment algorithm to allow beneficiaries to designate an ACO professional as responsible for their overall care. Beneficiaries note their "main doctor" through https://www.medicare.gov/ to initiate the voluntary alignment. CMS finalized use of an automated approach to voluntary alignment for all MSSP tracks, effective beginning with 2018 alignment. This option is available on medicare.gov, but other than the information in the final 2017 Medicare PFS, CMS has not yet made detailed information on the process available to ACOs. More details on the MSSP voluntary alignment are discussed in the NAACOS final 2017 Medicare Physician Fee Schedule summary. In summary, if a beneficiary meets certain criteria, such as receiving at least one primary care service during the assignment window from a physician in that ACO and the beneficiary designates an ACO professional in that ACO as his/her "main doctor," then the voluntary alignment will take precedence over claims-based attribution.