Patient Attribution

Presented by David Hochheiser
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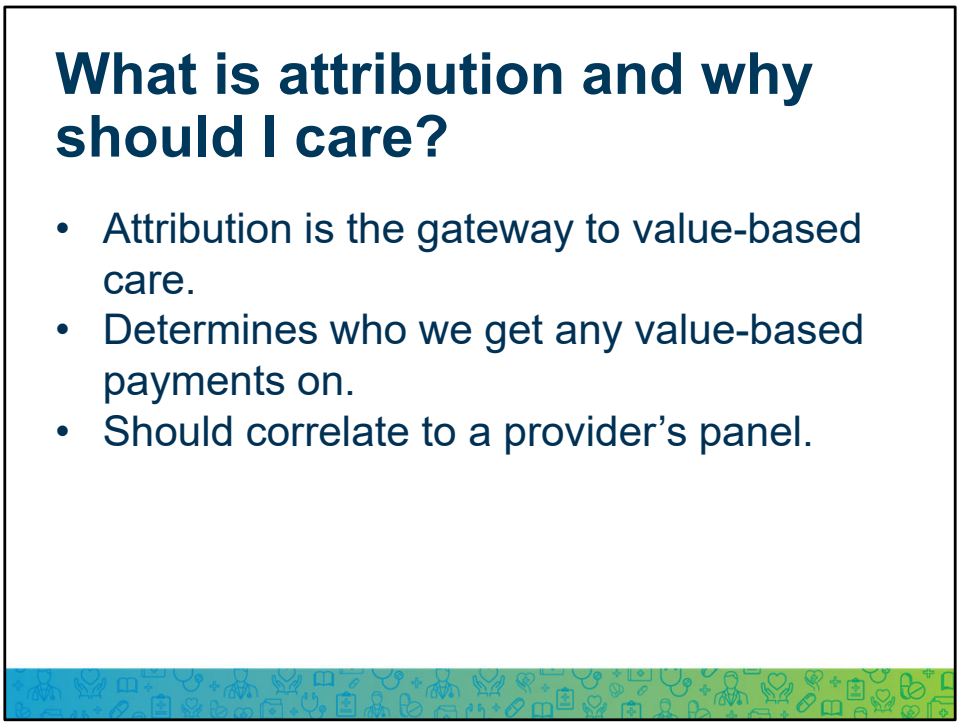
Health Leaders Network



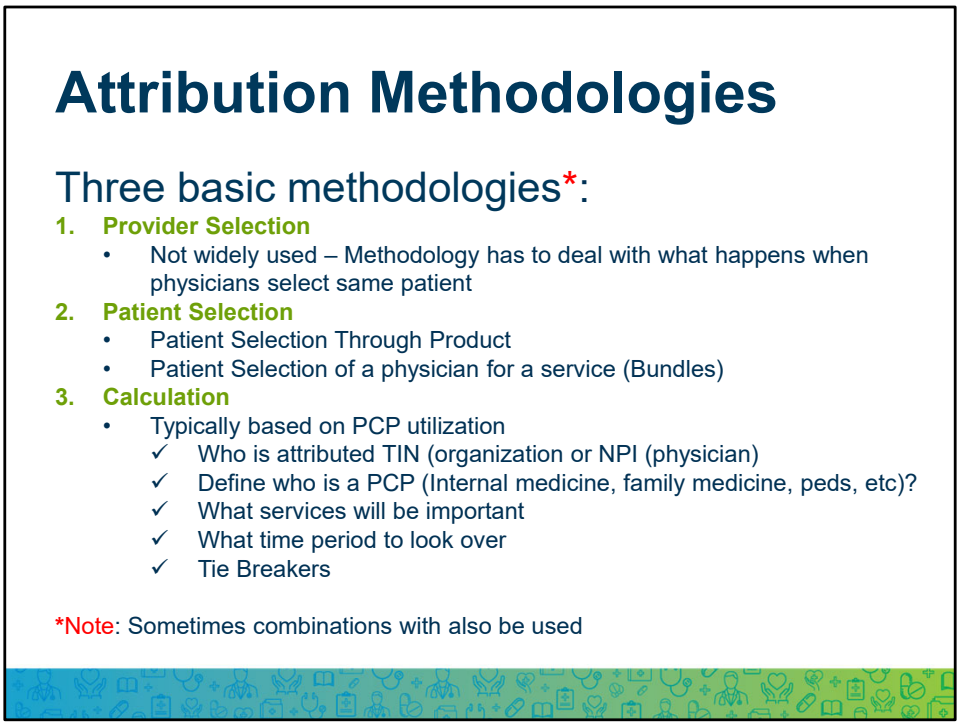
So, what is attribution and why should you care? Why should I care? Why is it important?

Well, attribution is an association methodology to associate a member or a patient to a specific provider or physician. And it's really the gateway or the connection between physician performance and ultimately our success around value-based care.

The question is, who are we going to be measured on? Who are we going to be paid upon for the quality care that we deliver and ultimately for providers and I know this will resonate with them. It should strongly correlate to your member panel or your patient panel. Those are the people ultimately, that you are providing care for. But it really has as a strong tie back to the payers and what they pay us for.

So, I'm going to spend a little bit of time today talking about some of the various methodologies, some of what you can do about them, and, in particular, how those methodologies are used in a bunch of our contracts. It's probably one of the most common questions that I get when I talk to various

physicians across our network.



So, for attribution, there really are three basic methodologies:

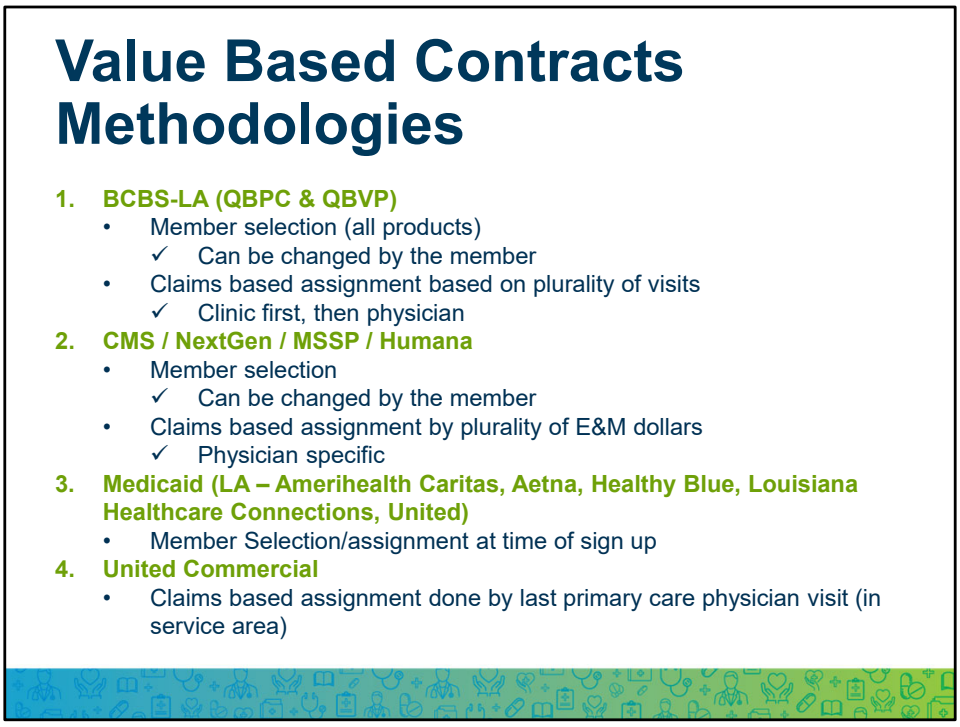
- The first one is provider selection and it's really not very widely used. The idea behind provider selection is it's the provider who's saying these are my patients. These are the ones that I want to be accountable for. The problem with that is really I'll call it a couple fold from the payer's perspective.
    - The first one is that what happens if multiple providers pick the same member? How do they go about trying to decide which member that provider should be associated with? Or said another way, which provider? Should be the accountable provider for that member.
    - The other thing is that payers, as you're well aware are relatively skeptical around provider behavior and what they're worried about by having provider selection is that the providers would only select people that they felt like they had the ability to improve

or properly care for versus people that were a struggle. They would not be selected by anybody and ultimately the payers want everybody. Whether it's somebody who is good at taking care of themselves or somebody who's not taking care of themselves to ultimately have a provider of choice and engaged so for those reasons, provider selection is not widely used.

- The second methodology which is greatly used is patient selection and this is you can think about. It as it's the reverse of provider selection.
    - Now, a patient is selecting their provider the typical way this is done is when a patient or a member enrolls for a product. They sign up saying I'm going to get this insurance and I want these coverages and usually as part of that process, the entity that's doing the enrolling will ask who is your primary care physician and that will be the link that will link that individual member or patient to that specific provider. Of course, that's got its issues as well, because it assumes that the Member knows and is, actually, seeing a provider, and if they haven't, that becomes an issue, and they may not always think of who is the provider that's providing my ultimate care that I want to be taken care of. They often make take a an OBGYN, in the case of a female or a cancer or cardiologist because that's who they see most frequently. Ultimately, mostly what the payers want is somebody that's really a primary care type of physician through those product selection. And of course, if they don't know it, they may just pick somebody at random.
    - The 2nd way that this happens is really when a bundle type reimbursement is going on, they're going to reward for the payers. Going to reward for a specific set of services in those situations, usually, the patient is doing the selection through picking the physician who's going to do whatever. The set of services are being charge of the set of services. So, you can think of it as if I'm going out to get a bariatric surgery and the payers going to pace through a bundle of success around that bariatric surgery. The surgeon that I pick is ultimately my patient selection methodology.
- And then the third methodology is a calculation. Usually, there's a collection of physicians that's being considered for attribution. Typically,

their primary care physicians, and then there's some type of methodology that's used to determine who should be the physician of choice or the attributed physician. There are a whole bunch of different methodologies that can be used in subtleties in the case of, who is? The person that it's attributed to is it to an organization or an individual physician, especially in the world of more team-based care. We're way more interested as a health system of having our health system recognized as the institution of care, and then once we have that person attributed to us, we can talk about who the individual physician is, that is delivering or giving the majority of the care, there's a question of who is defined to be a primary care physician in these situations, internal medicine, family medicine, Pediatrics for the most common. But you end up getting into some areas where some people may think OBGYN should be or should not be primary care physicians. And then what type of services will be counted? Will it be only office visits? Will it be any type of visit? What time period are people going to look for? Look back over. And then you say it's over the last 12 months, the last 24 months, and what do you do if there's a tie? These are all important considerations and really for both the patient selection and the calculation. It's really important that you as a physician. Understand that this is not a one-time process that this is something that needs to be an ongoing exercise. Both in terms of the maintenance of the panel or attributed members as well as making sure that those that are attributed to you are coming in and getting the care that they need. And that's really the key around this is making somebody accountable for this care so that they can be scheduled and seen on a regular basis.

I'll make the one comment that sometimes people combine the latter 2 methodology. So, if somebody's selected but they never go to see them. They may intertwine the two and vice versa. If the calculation. Well, it doesn't resolve in anything. They may default to a patient type selection.



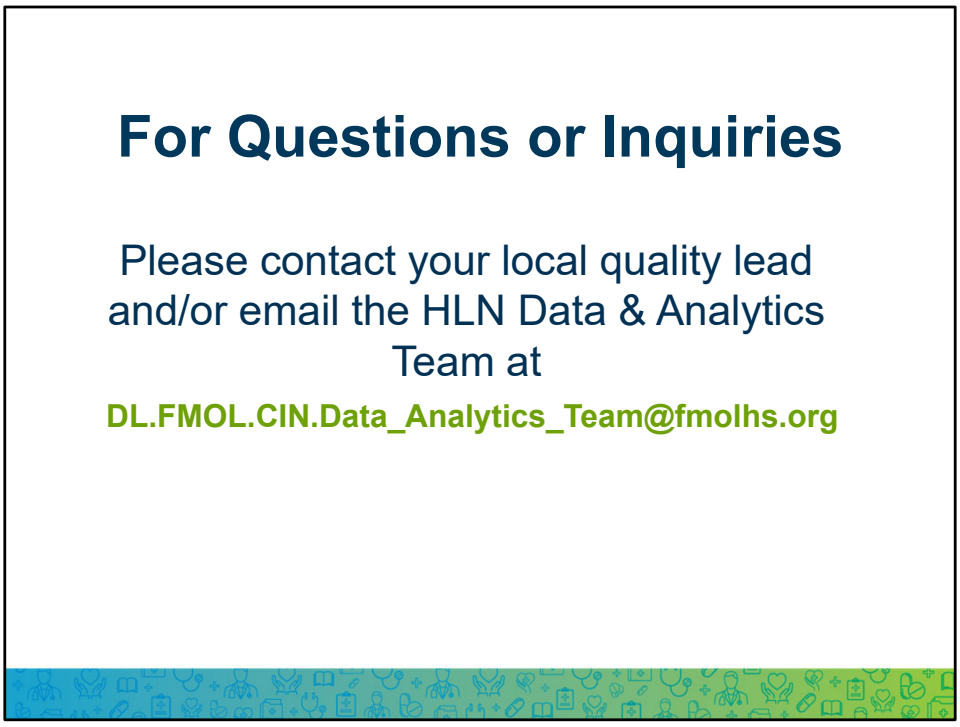
1. So today, in our value-based contract methodologies, our biggest payer on the commercial side is Blue Cross Blue Shield, Louisiana. And they have two programs that they're using today. For them, member selection is the methodology that starts it all out. Although I will say starting in 2022, they are, actually, going to do away with the Member selection. They're instead just going to default to the second methodology which is a Claims based methodology based on the plurality of visits. What physician or what clinic has seen this patient the most and they start with the team-based approach looking at a clinic 1st and then they move on to within that clinic, the physician. And this is from a claims-based methodology. One of our best methodologies. And going forward, we should have less confusion. They've had some issues with their selection methodology. We should have less issues with that going forward. It's really going to be around who is the person seeing the most? Which is why it's really important that you as a physician and you look at your panel and say who have I not had in in a recent period of time for a visit. Ultimately, how do I get that person in? They will use 24 months. So that's the maximum cycle, but you certainly don't want to

let it wait.

2. Then the next is CMS. Today we're in R.E.A.C.H. and this same holds true of Humana, WellCare, Peoples, Vantage, Blue Cross Louisiana, Medicare Advantage, all the Medicare Advantage or Medicare replacement plans and CMS all use member selection as their methodology. And so, it's expected at the time of sign up for the product that the Member is selecting who their primary care physician is. I should note that it can be changed by the Member. CMS has a website that can be leveraged at the member and log on to and change their physician. So, if there's somebody you're seeing that you feel like should be attributed to you, but they're not, then you can have them go to the website. Similarly, Humana also uses a methodology where if somebody's shouldn't be associated with you or should be associated with you. They have a form that can be used to fill out to get that changed. Sometimes we'll see some claims-based methodologies for members who have not provided a selection in all of these plans. And in most cases, usually, it's the E&M dollars that's being used. That is the methodology for members that don't have a primary care physician selection, and it's physician specific for the federal government, meaning they're not taking into account the team-based care

3. For Medicaid, which is all of our Louisiana Medicaid, Amerihealth Caritas, Aetna, Healthy Blue, Louisiana Healthcare Connections and United, member selection at the time of signup is what's used. They will often randomly assign because they often don’t have a good connection with the member for selection process. And that's why open panels are very important for them because they ultimately want to get those people seen and they need people with open panels to be able to accept those individuals for care.

4. And then the last contract that we have on the value-based side where we have any volume is United Commercial where claims-based assignment is done. There they use just the last primary care visit in a specific service area which is not the best choice. We've had some conversations about them changing that methodology. But currently, it's the last visit that is used as their methodology. So, in each and every one of these, you can see that there's an opportunity for you to either engage by getting the member in, or B to work to get people that should be associated with you.



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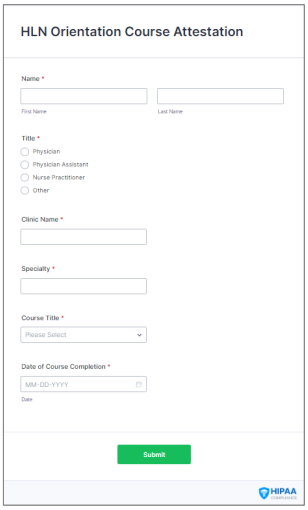

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