

Patient Attribution

Background

Implicit in a shared savings program is that a group of providers manages the quality and cost of care for a defined population. The twin goals of such a program are to improve efficiency (typically through methods that improve utilization management) and to improve quality (typically through more effective, consistent clinical performance and through care management and care coordination). When providers achieve these goals they are eligible for incentive payments that supplement their fee-for-service revenue. Often a provider's ability to actually share in any savings achieved is dependent on meeting the quality targets agreed to at the outset of the contract period. The process of defining the population that a given group of providers is responsible for managing under a shared savings contract is called patient attribution. The clinical participants in the shared savings contract, which can include providers, provider groups, hospitals, and other care supplier entities, collectively agree to be responsible for the cost and quality of the patients assigned to them under the contract. We refer here to the organizations or groups of organizations that enter into shared savings contracts as Accountable Care Organizations (ACOs).

Insurance plans have developed a range of methods for attributing patients to provider organizations. Every attribution methodology involves at least three main design decisions:

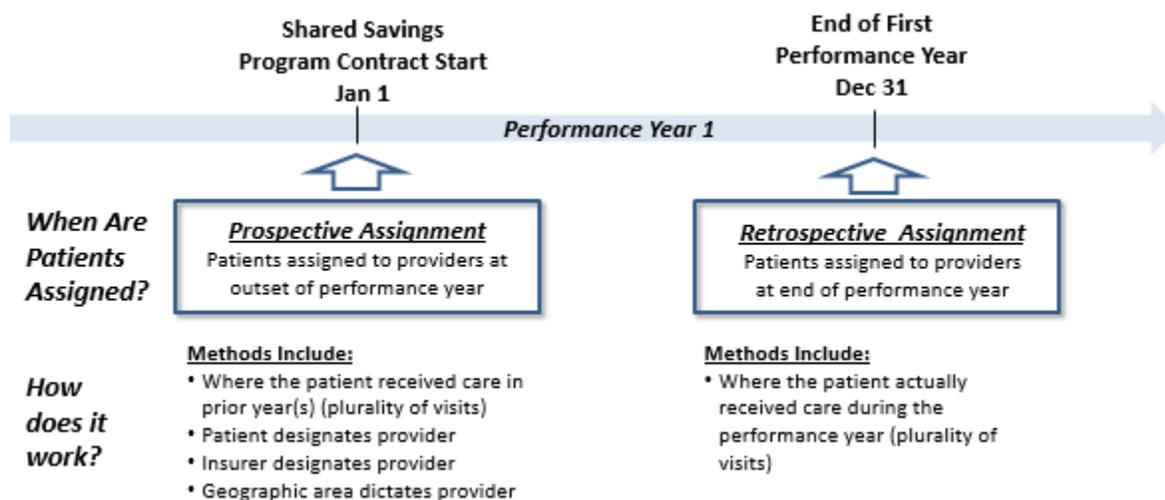
- 1) **How** the patient is assigned to a provider (i.e. the technique or "rule" used to assign a patient)
- 2) To **whom** the patient is assigned (i.e. the type of provider to whom a patient can be assigned)
- 3) **When** during the contract period the patient is assigned

There are several techniques used to assign a patient to a provider in a shared savings program. A plurality of visits technique is used by the Centers for Medicare and Medicaid Services (CMS) in the Medicare Shared Savings Program (MSSP) (CMS, CMS Medicare Shared Savings Program Final Rule, 2011), which makes up the majority of shared savings programs in the market today (CMS, Medicare Shared Savings Program ACO Fast Facts, 2014; Gordon, 2014) . This technique assigns a patient to the provider that the patient saw most frequently within a defined period of time (i.e. the year prior to the performance year or during the performance year). In patient-selected attribution patients designate their primary care provider when they enroll in their insurance plan. This technique, known as "patient attestation" is used by Blue Cross Blue Shield of Massachusetts for their Alternative Quality Contracts (Chernew, Mechanic, Landon, & Safran, 2011), among others. Insurer-selected attribution relies on the insurer to designate the patient's primary care provider when the patient selects the insurance plan (Cromwell, 2011). A geography-based (or "population-based") technique assigns patients to a provider based on where the patients live. This technique was used for the Medicaid patients in New Jersey in combination with a plurality of visits technique (Houston & McGinnis, 2013). The technique was intended to attribute patients who did not regularly see a physician. Attribution techniques are not necessarily mutually exclusive; in some instances using more than one can be useful, as was the case in New Jersey.

The type of provider to whom a patient can be assigned is another aspect of patient attribution. The objective is to assign patients to the providers who are predominately responsible for managing their primary care needs (Cromwell, 2011). While a primary care provider (e.g. internist, family practitioner, general pediatrician) is generally the provider type that would be the most responsible for managing the primary care needs of a patient, in practice that is not always the case. For example, patients who have

chronic conditions (e.g. heart disease or diabetes) that require intensive management from a specialist will often see the specialist provider as their primary care provider. For this reason CMS, in its most recent proposed rule for MSSP, proposes changes to the current patient attribution methodology to exclude specialists in the attribution process whose services are “not likely to be indicative of primary care services” (CMS, Fact Sheets: Proposed Changes to the Medicare Shared Savings Program Regulations, 2014) Many states have followed CMS’s lead in designing their shared savings programs for Medicaid and in some cases taken it a step further. In Minnesota attributing patients to an Emergency Department (ED) was considered if that was the location of the plurality of their visits (Houston & McGinnis, 2013).

A final design consideration concerns the timing of patient assignment to a shared savings program. A patient can be assigned to a shared savings program either retrospectively or prospectively. Retrospective assignment assigns a patient to a provider at the *end* of the first performance year of the shared savings contract. In a retrospective model, providers do not know which patients they will be responsible for at the beginning of the shared savings contract period. Conversely, prospective assignment assigns a patient to a provider at the *outset* of the shared savings contract period. Prospective assignment allows providers to enter into the contract period aware of the population for whom they are managing cost and quality (see figure below).



The MSSP program currently uses retrospective assignment, but is recommending prospective assignment for some of its participating ACOs¹ (CMS, Fact Sheets: Proposed Changes to the Medicare Shared Savings Program Regulations, 2014). Prospective assignment allows providers to know in advance which patients they are managing, potentially improving their ability to proactively manage toward improved outcomes and lower costs in a manner that retrospective assignment does not allow. Many physicians prefer prospective assignment. However, CMS has been historically reticent to utilize prospective assignment because of its articulated concern about associated risks of under-service: “...

¹ In the 2014 CMS proposed rule a third track is proposed that will use retrospective assignment and require that the ACO take on down-side risk.

we agree with the comment that while providing such information may be a benefit to both the beneficiary and the ACO, concerns remain that ACOs could use it to avoid at-risk beneficiaries or to stint on care.” (CMS, CMS Medicare Shared Savings Program Final Rule, 2011). Unlike CMS, commercial insurers more commonly use prospective assignment for a range of value-based contract types, including upside-only and two-sided shared savings programs (Bailit, Christine, & Burns, 2012).

Discussion

The three design decisions outlined in the background section may bear on provider behavior, and in turn have the potential to impact the degree to which patient selection or under-service emerge as unintended byproducts of a shared savings program. In addition, these design decisions have other consequences that have the potential to impact other outcomes – wanted or unwanted – of shared savings programs. For a shared savings program to achieve its objectives of lowering costs and improving the quality of care, the design choices about areas like attribution must yield a healthcare financing method in which all stakeholders (i.e. patients, providers, and insurers) are willing to participate.

Patient selection is the predominant equity and access concern related to choice of patient attribution methodology. However, it is not the only concern. Several implications of attribution design choices are described below:

Techniques	Patient Selection Implication	Other Implications
<i>Plurality of Visits</i>	This method used retrospectively might incent avoidance of difficult patients in the performance year.	Serves as a good proxy for patient choice since it is based on historical patient decisions about where to obtain care.
<i>Patient-Selected</i>	May reduce providers’ ability to avoid patients; however, providers can close their panels.	Active selection of a physician promotes patients taking an active role in their care. If used as a primary attribution method, it also incents physicians to proactively manage patients’ care even if the patient does not schedule a visit.
<i>Insurer-Selected</i>	While this reduces providers’ ability to avoid patients, an insurer could inappropriately influence which patients are attributed to which providers.	Removes patient choice in the process of selecting a physician.
<i>Geographic</i>	Eliminates the possibility of patient selection since attribution is solely based on where a person lives.	Removes patient choice in the process of selecting a physician and exposes the provider to greater financial risk.

Given the above implications, the geographic approach arguably provides for the greatest protection against patient selection. However, the geographic approach also removes patient choice and puts a heavy burden on providers to do patient outreach in order to assume responsibility for cost and quality.

It also provides little distinct incentive for the patients to engage in their care and puts the providers at greater financial risk. While this technique may be effective when used in a targeted manner to reach specific populations that are not frequently interacting with the health care system (Houston & McGinnis, 2013), it is unlikely to be the most effective primary attribution technique on a broad scale. Similarly, the insurer-selected method will not allow for patient choice and will minimize provider control, giving rise to the same concerns as the geographic technique.

Patient engagement is paramount in a shared savings program to improve proactive patient care-management and coordination. A primary attribution technique that does not involve patient choice in assigning them to a provider will diminish the level of patient engagement. Allowing patients to choose their providers allows for the greatest amount of patient choice, but unless it is made a requirement will not capture patients who choose not to designate a primary care provider. The patient-selected technique allows for direct patient choice, whereas the plurality of visits method represents a patient's historical choices. The Council believes that allowing for direct patient choice when possible is preferable, and that, in absence of this, the plurality of visits methodology is preferable.

Recommendation #1: Patients should be able to identify their primary care provider through an attestation (designation) process as a primary attribution technique. In the event that the chosen provider's panel is closed, the patient will either select a different provider or be attributed through the plurality of visits process. Patients who choose not to pick a primary care provider through attestation should be assigned based on the plurality of their visits.

Regardless of whether patients designate their primary care provider or are assigned to a provider through a plurality of visits method, making patients aware of the fact that they are seeing a provider who is participating in a shared savings program will also support transparency and patient engagement in the process of managing and coordinating their care.

Recommendation #2: Patients should be made aware when they are attributed to a provider who is participating in a shared savings program. They should also be made aware of the program's goals and the role of the patient and the provider in achieving those goals.

In addition to its equity and access implications, patient attestation also provides an opportunity to embed value-based insurance design features that promote patient engagement. Value-based insurance design refers to structuring insurance plans in a way that incentivizes patients to engage in healthy behavior, participate in their healthcare decisions, and make intelligent use of healthcare resources. For example, patients could be rewarded in some manner for declaring a primary care provider.

While the geographic attribution technique is not broadly desirable as a method of primary attribution, it surfaces an important point: the most common attribution methods used today will not capture patients who do not interact with the healthcare system in a provider office setting. Another manner in which this issue has been addressed in other states is by more broadly defining the type of provider to which a patient can be assigned, such as allowing for attribution to an emergency department if that is where patients are receiving the bulk of their care (Houston & McGinnis, 2013). Secondary attribution, in the context of the recommendations made thus far, would mean that a patient who has not chosen a primary care provider and is not seeing another provider with enough frequency to be attributed through the plurality of visits technique, could be attributed to the ACO based on their visits to an

emergency department. In a vertically integrated ACO that includes a hospital with an emergency department, the benefit of secondary attribution through an emergency department is twofold:

- By placing patients who are inappropriately using an ED into an ACO's attributed population, the ACO will have a financial incentive to coordinate their care such that they begin to receive care in more appropriate, efficient settings; and
- It will render futile any attempt at patient selection, since patients may end up attributed via the emergency department even if excluded from physician panels.

Recommendation #3: Traditional attribution methodologies assume patients are actively seeking care from a provider. They will not attribute patients who seek care only in other settings (e.g., an emergency department or urgent care center). Payers should give strong consideration to using other settings of care for secondary attribution in order to attribute patients and encourage a provider to take accountability for their care.

The use of the plurality of visits method, and to a lesser extent the patient attestation method, in turn affect the way in which timing of patient attribution could come to bear on both patient selection and under-service. In retrospective attribution providers are unaware of who they will be caring for at the outset of a shared savings program. Retrospective assignment in conjunction with the plurality of visits technique could incent providers to avoid patients who are perceived to be riskier in an effort to establish more manageable cost targets. In contrast, prospective attribution will supply the provider with information at the outset of the contract about which patients are part of their shared savings program and therefore whose costs will be attributed to their overall cost and quality targets. This knowledge presents a potential risk that the provider will stint on the care provided in order to meet the identified cost target. While prospective attribution may protect against patient selection, it could also incent under-service. Conversely, while retrospective attribution may protect against under-service, it could incent patient selection.

Prospective assignment helps to prevent patient selection and has the added benefit of promoting transparency by providing information up front to both the patient and provider about who is attributed to whom. This information provides a better platform to achieve a core goal of a shared savings program (i.e. appropriately lowering costs while improving outcomes). Additionally, the prospective assignment methodology financially ties a patient to a provider at the outset, making the provider financially responsible for the patient regardless of where that patient seeks out care. This has the potential to protect against unreasonable patient discontinuation as well as creates the incentive for providers to closely manage and coordinate their patient's care. A potential drawback to prospective assignment (i.e. as articulated by CMS) is the risk for under-service which in theory retrospective assignment eliminates by virtue of blinding providers from seeing who will be attributed to them in advance. However, in practice providers are still aware of their participation in a given shared savings program, and they are aware of patients' insurance status, which together give them a basic understanding that a patient for whom they provide frequent care will likely be attributed to them. Accordingly, any benefit with respect to protecting against under-service of retrospective assignment, as compared to prospective assignment, is likely to be minimal.

After evaluation of the sum of all benefits and risks, the Council believes that the benefits of a prospective attribution method generally outweigh the risks and as a whole provide more benefits than the retrospective method:

Recommendation #4: Prospective attribution will generate provider and patient awareness, promote effective care management and coordination, and protect against patient discontinuation. These benefits outweigh any potential risk of under-service that might be heightened by prospective assignment.

While the Council believes that the benefits of prospective assignment outweigh the risks, the Council recognizes the concern that providers may be assigned a patient at the outset of the shared savings contract who ultimately does not receive care from that provider in the upcoming year. It is important that the provider-patient assignment is as accurate as possible, but there is not one approach that will get it right every time. This makes an end-of-year reconciliation process a potentially important tool. The Council considered reasons for which it might be appropriate or inappropriate to “re-attribute” a patient during a year-end reconciliation. An “unlimited” reconciliation process that removes any patient who at the end of the performance year would no longer be attributed to their original provider opens the opportunity for inappropriate discontinuation of patients. But there are instances in which a patient decides to seek care from another provider that are reasonable and do not present a concern (e.g. moving to another town). To help prevent inappropriate discontinuation it may be useful to evaluate data about patients who are re-attributed during a reconciliation to determine if they are appropriate or if they may represent an instance of inappropriate discontinuation from a provider panel.

Recommendation #5: An end-of-year retrospective reconciliation should be used to un-attribute prospectively attributed patients who no longer qualify (based on plurality of visits or patient attestation) to be attributed to a provider. This process should incorporate sufficient safeguards to ensure patients are not inappropriately discontinued during the performance year.

In considering the Council’s recommendations on the topic of patient attribution, it merits repetition that though the CMS MSSP does not use prospective assignment today, it likely will in the future, in part in response to experienced ACOs’ feedback on what would make the program more effective. In a letter to CMS in response to the MSSP 2014 proposed rule, the National Association of Accountable Care Organizations (NAACOS) supported the use of prospective assignment for track three and it is suggested that prospective assignment will allow ACOs the ability to “...employ data analysis and beneficiary engagement techniques from the start of the performance period on a population for whom they know they are responsible” (Gaus, 2015).

Summary of Recommendations

Recommendation #1: Patients should be able to identify their primary care provider through an attestation (designation) process as a primary attribution technique. In the event that the chosen provider’s panel is closed, the patient will either select a different provider or be attributed through the plurality of visits process. Patients who choose not to pick a primary care provider through attestation will be assigned based on the plurality of their visits.

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