



PATIENT ATTRIBUTION WHITE PAPER

Comment Response Document

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Introduction

The Guiding Committee of the Health Care Payment Learning & Action Network (LAN) convened the Population-Based Payment (PBP) Work Group to support the development, adoption, and success of payment models under which providers accept accountability for a patient population across the full continuum of care. The Work Group was charged with developing recommendations on the following four priority issues for these population-based payment models:

- Patient attribution;
- Financial benchmarking;
- Data sharing; and
- Performance measurement.

A White Paper was drafted on patient attribution, the method used to determine which provider organization is responsible for a patient's care and costs.

After the release of the draft Patient Attribution White Paper, a series of Listening Sessions were held to provide information on the preliminary recommendations and, more importantly, to allow LAN participants, stakeholder communities, and the general public to share their concerns and provide suggestions regarding the recommendations.

At the end of the four-week public comment period, 83 submissions were received comprising more than 100 pages of commentary, with 45 comments submitted by individuals and 38 submitted on behalf of organizations. Many stakeholders submitted comments, with 38 percent coming from providers, 13 percent from consumer and patient advocacy organizations, 13 percent from government agencies, 7 percent from insurers, and 29 percent coming from consulting and other organizations.

In response to the public comments, a number of changes were made to the White Paper. The PBP Work Group has summarized the main themes that appeared in the comments received. The Work Group has also provided its perspective on these comments, and, where appropriate, has discussed how the comments were incorporated into the final draft of the Patient Attribution White Paper.

It is the PBP Work Group's hope that this document will be read in conjunction with the final White Paper and that members of the community can use it to gain deeper insight into the thinking behind the White Paper's key findings.

Patient Engagement

Many commenters offered suggestions on how to engage patients for attribution, retain them during the measurement period (the time for which providers are accountable for the population), and more actively partner in the delivery of patient-centered care. Commenters made suggestions regarding the content of communication with patients, the readability and accessibility of materials, and how the information should be communicated. The Work Group agrees that patient engagement is essential to the sustained success of population-based payment models in achieving better quality and outcomes at lower total costs for the covered population. However, the broader important topic of patient engagement is not within the scope of this White Paper. Nevertheless, the Work Group has reviewed several examples of patient communications to understand the content of messages specifically

pertaining to patient attribution, and the White Paper was updated accordingly to include current thinking.

Further, several comments indicated that patient attestation might prove to be inaccurate or insufficient, citing evidence that using an algorithm for harvesting claims or encounter data is more effective. Commenters also cited difficulties with engaging patients in the patient attribution process, collecting the data, and blending the data with claims or encounter attribution when needed. One commenter indicated that holding patient attribution as the “gold standard” may slow the evolution of value-driven payment programs such as population-based payment. Even so, the Work Group stands behind the recommendation to consider patient self-reporting as the gold standard. The process of patient attribution is intended to identify the provider organization that a patient considers to be his or her primary provider, and the patient is the ultimate source of truth regarding this selection. Therefore, where information from a patient self-report is available, it is considered the gold standard. Where self-reporting is not possible, claims or encounter data identify a patient’s revealed preference. Although the White Paper acknowledges that current limitations in available mechanisms to obtain patient self-reports often necessitate a reliance on claims or encounter-based attribution, efforts should be made to actively engage patients in the attribution process.

In addition, several comments were made about the provider verification process. The White Paper has been updated to strengthen the language recommending a process to support patient verification of his or her primary care provider. This follows either an active patient attestation or a claims/encounter data identification of the primary care provider.

Incentives for Using the Attributed Provider Group

Several commenters provided recommendations and approaches to encourage patient use of their attributed provider organization, as well as ideas on provider incentives regarding the treatment of attributed patients. Because the Work Group’s focus was on the methods to attribute patients to a provider group and/or delivery system, patient attribution does not include incentives or restrictions relating to use of the attributed or other providers. Although incentives could be provided by a patient’s insurance, this is not within the scope of this White Paper.

Unattributed Patients

Several commenters expressed interest in the fact that the recommended approach to patient attribution may not attribute all of a population’s members. There was concern that these patients are not engaged in their own health care, and thus outreach is needed to explain the value of routine patient care. Others expressed a concern that only attributing some of the members would change the financial risks of either the payer or providers, and thus may threaten the economic viability of the population-based payment model. The Work Group notes that a payer’s risk pool is not determined by the number or proportion of patients who are attributed but by the number of lives covered. In addition, financial benchmarks for providers are created based only on the attributed pool of patients. Therefore, unattributed patients are neither an advantage nor disadvantage to payers and providers. Regardless, the Work Group recognizes that in the future, it will be useful to have attribution methodologies account for an entire payer’s population. However, in the interim, the fact that a

percentage of a payer's population is comprised of individuals who are not engaging with the delivery system in any way, and, therefore, are not able to be attributed to a provider organization, poses no threat to the success or sustainability of population-based payment models.

Attribution of High-risk and High-cost Patients

Several commenters indicated concerns about attribution of high-risk, high-cost patients. Some believed that the current recommendation to start with primary care providers will fail to address the needs of high-risk patients, as well as payers' ability to manage high costs. The Work Group employed a widely accepted norm that holds primary care specialties to be the correct and appropriate starting point for accountability in population-based payment models. Moreover, the recommended approach relies on patients' stated preferences regarding the provider organizations that they consider to be their primary providers, and, when this information is unavailable, it is provided by claims or encounter data. Where the stated or revealed preferences point to a primary provider in the traditional primary care specialties, this is accepted as the basis for attribution. Where the stated or revealed preferences identify a subspecialty provider, the model allows for this. In this way, high-risk patients who rely on subspecialty providers for their care will appropriately be attributed. Moreover, it is also important to recognize that patients are attributed to a provider organization, not to an individual clinician. Thus, regardless of whether the provider identified through the attribution process involves clinicians in the traditional primary care specialties or a subspecialty, the accountable organization is responsible for ensuring that high-risk patients receive care from the appropriate set of clinicians.

Another commenter indicated that safeguards are needed so that providers do not avoid accountability for complex, high-need patients. The Work Group agrees that population-based payment models need to safeguard access for all patients, including complex, high-need patients, which is why the recommendations start with a patient's self-report about his or her primary care provider. In addition, regardless of whether attribution is from patient attestation or use of an algorithm evaluating claims or encounter data, the Work Group's recommendations include a process for patients to verify their primary care providers.

Comments on Primary Care

Many comments and suggestions were made about the identification of specialties and types of providers who should be considered primary care providers for purposes of patient attribution. The Work Group appreciates this input, and the White Paper reflects that primary care specialties include family medicine, internal medicine, general practice, and geriatrics. In addition, the White Paper indicates that the types of providers include physicians, nurse practitioners, physician assistants, and other practitioners as mandated by law. The White Paper goes on to indicate a broad set of subspecialties that can be included in the attribution process. It notes that it should be the responsibility of each provider organization, in the context of its arrangements with each payer, to identify which individual physicians in each relevant subspecialty should be included for attribution. In this way, the claims-based algorithm will prioritize attributing patients to traditional primary care specialties and if no match is found, will look to attribute patients to a relevant subspecialty.

Several comments were made about the need for providers to understand the attribution process and agree to the list of attributed patients. The Work Group agrees that the attribution process should be transparent to providers and reliably yield a list of attributed patients reflective of the patient-provider relationships as identified through patient attestation or claims or encounter data on use of services. The Work Group believes that patient attribution is a matter of patient choice, and the providers need not have to agree to their lists of attributed patients. A process by which providers could eliminate individuals from their lists of attributed patients would be inappropriate, given that the lists are based on patients' revealed and/or stated preferences regarding their primary providers. In addition, such a process could create a significant risk of providers' "de-selecting" patients or "cherry picking" patients for which safeguards are needed to protect those patients.

Comments on Specialty Care

Many comments were made about specialty care providers serving as primary care providers who take responsibility for the overall management of a patient's care. Concerns were voiced about the willingness and ability of specialty providers to serve in a primary care capacity. One commenter stated concern about specialty providers "self-declaring" as primary care providers. The Work Group acknowledges that in many cases, a patient may receive care from specialty providers without seeking primary care services. Further, the Work Group acknowledges that specialty care provides an important care service for patients. However, in the population-based payment model, a patient must be attributed to a provider group or delivery system accountable for management of that patient across the entire continuum of care.

The White Paper emphasizes that prior to the start of a measurement period, the accountable provider organization or delivery system must identify those specialty providers capable of serving in primary care roles. They must make decisions regarding those specialists' abilities to manage the overall care for their patients. Once this list is provided to the payer, the claims-based algorithm attributes a patient to a provider in a primary care specialty or, if there is no evidence that a patient saw a provider in a primary care specialty, to one of the eligible providers in an appropriate subspecialty.

Moreover, several comments were made about the ability of the claims or encounter algorithm to use evaluation and management (E&M) codes effectively because both primary and specialty care providers use the same codes. The current recommendations provide a clear path to appropriate identification of providers because the White Paper's recommendations start with a list of providers who are eligible to serve as primary care providers and then overlays an evaluation of E&M codes. With this approach, patients will be appropriately attributed to the eligible primary care providers.

Comments on Attribution for Measurement of Special Topics

Many commenters agreed with using a single patient attribution approach for performance measurement and financial benchmarks. This approach yields reliable information for multiple stakeholders. One important result is that providers and payers know the population for which providers are accountable, which serves as a basis for measuring cost and quality.

As performance measurement for population-based payment models is moving toward more "macro" metrics at the population level, providers may want and need to measure performance for specific sub-

populations or a particular topic to drive improvement. In fact, because population-based payment models provide economic incentives and encourage providers to actively engage in quality improvement for their covered populations, additional measures may be warranted. One commenter indicated that quality measurement of vulnerable populations may need a different form of attribution to identify a cohort of vulnerable patients for quality improvement activities. Although the White Paper's current recommendations are appropriate for attribution at the macro population level, payers and providers may want to identify specific quality improvement priorities and/or opportunities to drive these macro accountability metrics.

Comments on Regional Variation

A number of comments suggested that the White Paper's recommendations concentrated on an underlying national attribution framework, while citing areas of flexibility that would allow regional stakeholders to vary the approach to attribution. Citing the value of building payer and provider buy-in within a region, one commenter suggested a common methodology for attribution and quality measurement, with some areas that could be customized. Even so, based on the currently available evidence, the Work Group strongly supports alignment to the greatest extent possible at the national level. This national alignment will reduce the burden on purchasers, payers, and providers, and, in turn accelerate the adoption of population-based payment models nationwide.

Additionally, one commenter indicated that use of a national approach might not be possible, specifically noting specific issues such as the lack of primary care providers in rural areas or local laws not allowing nurse practitioners to prescribe medications.

Although determining the feasibility of the population-based payment model is not within the scope of this White Paper, the current recommendations are valuable when purchasers or payers and providers agree to participate in a population-based payment model. Patient attribution is a method used after this agreement has been reached, and the provider organization or delivery system accepting risk for the population identifies those specific providers who will serve in the primary care role.

Comments on Attribution to Delivery Models

Commenters suggested that the Work Group should consider developing recommendations for attribution to patient-centered medical homes (PCMHs) and accountable care organizations (ACOs). PCMHs and ACOs are important care delivery models being pioneered across the country—often times in response to the incentives and requirements of population-based payment models. However, given that the charge of the PBP Work Group was to develop recommendations for patient attribution relating to population-based payment models, and, while often, the resulting attribution identifies the patient as receiving care through a PCMH or ACO, the Work Group's primary charge was to address how these models should attribute patients, not to determine to which types of organizations they can be attributed.

Additionally, one commenter indicated that the White Paper should address the current patient attribution processes used by payers in Medicaid managed care organizations (MCOs). In some cases, although Medicaid MCOs accept beneficiaries, they do not operate alternative payment models. Although the Work Group has gathered information on those emerging models used by state Medicaid

programs to attribute beneficiaries within alternative payment models, data are limited from these emerging models.

Comments on Further Alignment

One commenter suggested that the LAN should continue to connect with other organizations working on similar issues. In particular, there could be coordination with the National Quality Forum (NQF) Attribution Committee, which is working on attribution for performance measurement. Working together could reduce the potential of duplication and conflicting recommendations. The Work Group agrees that efforts to coordinate with other organizations working on parallel activities is valuable. Of note, the LAN continues to partner with several organizations, including NQF, to collaborate on alignment of payment programs.