HCP LAN
Health Care Payment Learning & Action Network

ACCELERATING AND ALIGNING POPULATION-BASED PAYMENT MODELS:

PATIENT ATTRIBUTION

Draft White Paper

Written by:

The Population-Based Payment Work Group

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Executive Summary

[Placeholder: To be developed after incorporating feedback from the affiliate community.]

Overview

The Health Care Payment Learning & Action Network (LAN) established its Guiding Committee in May 2015 as the collaborative body charged with advancing alignment of payment approaches across and within the private and public sectors. This alignment aims to accelerate the adoption and dissemination of meaningful financial incentives to reward providers and systems of care that implement person-centered care and patient-responsive delivery systems. The Centers for Medicare & Medicaid Services (CMS) Alliance to Modernize Health Care (CAMH), the federally funded research and development center operated by the MITRE Corporation, was asked to convene this large national initiative.

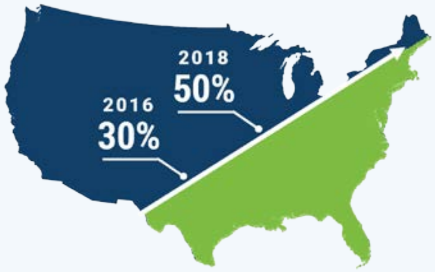
In keeping with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population-based payments by 2016, and 50% by 2018. One possibility for reform is a move away from fee-for-service (FFS) payments to alternative payment models (APMs), such as population-based payments (PBPs) in which providers accept accountability for total cost of care, care quality, and health outcomes for a patient population across the full care continuum. This is a particularly promising approach to creating and sustaining a delivery system that values quality, cost effectiveness, and patient engagement.

The Guiding Committee 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. Such models vary in the mechanism by which payment passes from payers to providers, ranging from those employing a global population-based budget while retaining the underlying FFS payment architecture, to those in which an actual population-based payment is made from payer to provider. All of these population-based models involve provider accountability for a patient population across the full continuum of care, including preventive care to end-of-life care and everything in between – with the

Health Care Payment Learning & Action Network (LAN)

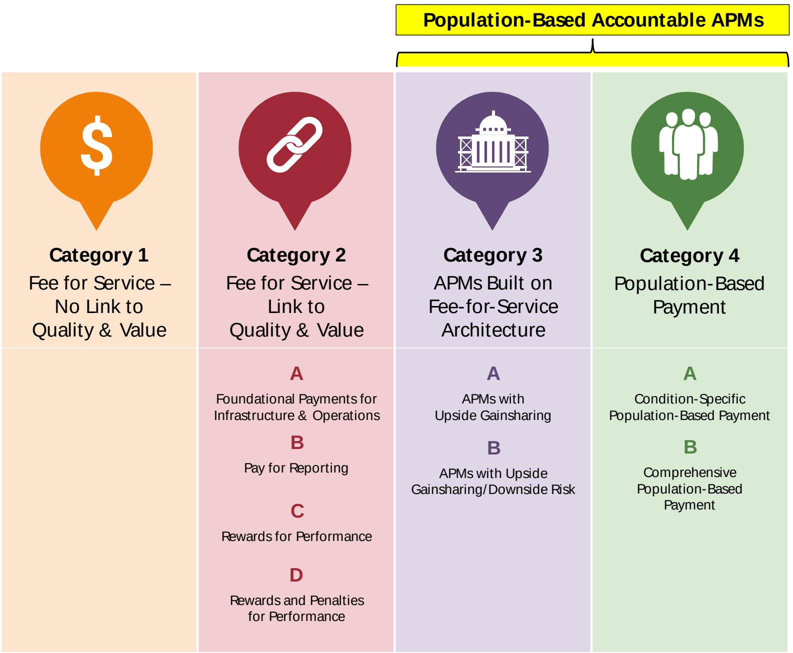
To achieve the goal of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality, health outcomes, and value over volume. Such alignment requires a fundamental change in how health care is organized and delivered, and requires the participation of the entire health care ecosystem. The Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care ecosystem. By making a commitment to changing payment models, establishing a common framework, aligning approaches to payment innovation, sharing information about successful models, and encouraging use of best practices, the LAN can help reduce barriers and accelerate the adoption of APMs.

U.S. Health Care Payments in APMs



goal of achieving better quality and outcomes and lower total cost for the population involved[1]. Referencing Figure 1, below, developed by the LAN's Alternative Payment Model Framework and Progress Tracking Work Group, the PBP Work Group's efforts pertain to the full range of models in Categories 3 and 4 in which providers accept accountability for a population across the full care continuum. The CMS Pioneer ACO Model and Medicare Shared Savings Program (MSSP), and private sector models such as the Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC), represent examples of Category 3; they employ a global population-based budget, but retain the underlying FFS architecture. By contrast, the CMS Next Generation ACO program or commercial models, such as Kaiser Permanente, represent examples of Category 4 in which the population-based payment is made from payer to provider. The PBP Work Group's focus differs from that of the Clinical Episode Payment (CEP) Work Group because, while both share a focus on Categories 3 and 4, in the case of the CEP, provider accountability is for a population with a particular condition, health event, or treatment intervention.

Figure 1: APM Framework (At-a-Glance)



Population-Based Accountable APMs

Category 1 Fee for Service – No Link to Quality & Value	**Category 2** Fee for Service – Link to Quality & Value	**Category 3** APMs Built on Fee-for-Service Architecture	**Category 4** Population-Based Payment
	A Foundational Payments for Infrastructure & Operations **B** Pay for Reporting **C** Rewards for Performance **D** Rewards and Penalties for Performance	**A** APMs with Upside Gainsharing **B** APMs with Upside Gainsharing/Downside Risk	**A** Condition-Specific Population-Based Payment **B** Comprehensive Population-Based Payment

The PBP Work Group is charged with developing recommendations on a set of priority issues where greater consensus or alignment of methods across payers will accelerate adoption of PBP models in Categories 3 and 4 that establish provider accountability for a population across the full care continuum.

Specifically, the GC has charged the Work Group with developing recommendations on four priority issues for PBP. These include:

- Patient attribution;

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[1] This definition is based on definitions found in the following sources: McClellan, et al., "A National Strategy To Put Accountable Care Into Practice," *Health Affairs* **29** (2010): 982–990; and Mark McClellan, James Kent, Stephen J. Beales, Samuel I.A. Cohen, Michael Macdonnell, Andrea Thoumi, Mariam Abdulmalik, and Ara Darzi, "Accountable Care Around The World: A Framework To Guide Reform Strategies," *Health Affairs* **33** (2014): 1507–1515.

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

The Guiding Committee reached a general consensus on the essential components of a PBP model. These components include developing policies to encourage shifts away from FFS payment to enable more substantial reforms in care delivery and that address such issues as attributing patients to a provider group, setting and updating financial benchmarks, sharing data between payers and providers and between providers and other providers in the market, and measuring performance. Although every PBP model must address these issues, there is considerable variation and lack of alignment in the way these components are implemented in the private and public sectors.

The PBP Work Group brings together public and private stakeholders to develop recommendations. A roster of Work Group members, representing the diverse constituencies brought together by the LAN, is provided in Appendix A.

The Work Group is aware that CMS is in the process of soliciting recommendations on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Formal recommendations for implementing MACRA and/or other CMS programs and policies should continue to be made directly to CMS as this is explicitly and intentionally not part of the Work Group's charge.

Purpose of the White Paper

The purpose of this White Paper is to address the first of the four priority areas, patient attribution. Future PBP Work Group white papers will address the other three priorities.

The Work Group believes that patient attribution, which identifies a patient-provider health care relationship, is a foundational component of PBP models because it both designates the population for whom a provider will accept accountability in a PBP model, and forms the basis for performance measurement, reporting, and payment. The White Paper documents principles that can guide payer and provider approaches to these topics in their PBP models. The aim is to support increased alignment in how public and private payers address attribution in their PBP models, and through doing so, to lower barriers to PBP acceptance and adoption.

Even though methods typically begin by identifying a patient-clinician dyad, recommendations are for patient attribution at the provider group or delivery system level. This decision recognizes that a provider group or system, and not an individual clinician, will be accountable for total cost of care and quality outcomes for a patient population. Using claims/encounter data to identify a patient-clinician relationship does not preclude team-based care; rather, it is a starting point for attributing a patient to a provider group or delivery system accountable for the patient's care.

These recommendations are also intended for use in payment models that assume primary care providers are the principal starting point for managing a population across the entire continuum of care. Primary care providers, as discussed later, can include traditional primary care specialties or other providers who accept accountability for coordinating the patient's overall care. As described later in this paper, the provider group or delivery system that accepts accountability for a patient population must first identify the primary care and specialty care providers who will accept the role of primary care provider for patients. The identification of selected providers happens before attribution.

At this stage in the process, the Work Group is requesting feedback on the White Paper and the recommendations, in order to obtain broad agreement on the approach to patient attribution.

Population-Based Payment Model Adoption

The LAN is unanimous in its desire to drive payment approaches that improve the quality and safety of care, and the overall performance and sustainability of the U.S. health system. The Work Group, along with many other stakeholders, envisions a health care system that provides “person-centered care.” The Work Group understands person-centered care to mean *high-quality care that is delivered efficiently, where patients’ and caregivers’ individual preferences, needs, and values are paramount*.

PBP models, in which providers accept accountability for the total cost of care for a patient population across the full continuum of care – that is, models within Categories 3 and 4 of the APM Framework – are a particularly promising approach to creating and sustaining delivery systems that value quality, cost effectiveness, and patient engagement. Recommendations throughout this White Paper refer to PBP models in Categories 3 and 4 in which providers accept accountability for the full continuum of care. Many believe that these types of payment models have significant potential because they give providers more flexibility to coordinate and manage care for individuals and populations. Because PBPs reward providers who successfully manage all or much of a patient’s care, such models enable providers to develop more innovative approaches to person-centered health care delivery.

As the LAN works to accelerate adoption of PBP models, understanding the incentives that motivate patients, providers, payers, and purchasers to participate in these models is paramount. Also, identifying patient-provider relationships through patient attribution yields different benefits for different stakeholder groups:

- **Patients** have an increased likelihood of attaining health goals in a PBP model dedicated to person-centered care and care coordination. Patient attribution signals that a particular provider group is accountable for a patient’s overall care. This is important even if the patient has access to a broad array of providers. In fact, patients can still choose to visit other providers. Attribution does not change the way patients receive care and does not disrupt relationships with providers. It is a mechanism for creating accountability within a provider group to coordinate a patient’s overall care needs.
- **Providers** have more of an opportunity to provide preventive care and manage attributed patients’ complex and long-term health concerns with PBP models. Providers are rewarded for delivering appropriate clinical care and for skillfully managing the care of their attributed patients. Patient attribution identifies a patient population for providers, with incentives for reaching out to patients proactively to help close gaps in care, take preventive measures, connect patients to necessary specialists, and address barriers to adherence or other impediments to achieving favorable health outcomes—all to optimize clinical health outcomes. Finally, since payment to a provider group under PBP models is tied to quality and total cost of care goals, attribution methods need to be accurate and transparent.
- **Payers** develop PBP models to create provider incentives for value rather than volume of services delivered. Patient attribution identifies the group of patients under the care of a provider group and/or delivery system and is foundational to establishing accountability and to measuring, monitoring, and rewarding performance.

- **Purchasers** benefit from PBP models through improved employee health management and a healthier workforce. Patient attribution is an important starting point for PBP models. Even if broad-access programs are promoted, employers should encourage employees to select a provider group and/or delivery system organized to meet the employee's care needs. Studies have shown that patients with a primary care relationship are healthier, have less expensive care patterns, are more productive at work, and miss less work due to illness.

Recommendations

The PBP Work Group, including public and private stakeholders, began with a review of current literature to evaluate the most important aspects of patient attribution. Reference documents consulted in white paper development are provided in Appendix B. Recommendations made by the PBP Work Group are intended for use by payers when determining which patients are attributed to provider groups within the payment model. The Work Group recommends that these guidelines be adopted by commercial insurers and, when possible, government programs.

***Recommendation 1**: Encourage patient choice of a primary care provider.*

The ideal method for patient attribution is active, intentional identification or self-reporting by patients. In simple terms, the patient knows his/her own primary care provider. Primary care is an important starting point in PBP models, which hold primary care providers accountable for managing quality and financial outcomes. The Work Group recommends that key stakeholders encourage patients to select a primary care provider. This may be an opportunity to engage patients around the topic of the importance of a primary care provider. In many PBP models, patients have full access to primary and specialty care; however, patients are often not required to select or declare a primary care provider and may not understand the benefits of doing so. This can create barriers or resistance to patient self-reporting. To increase patient selection of a primary care provider, patient outreach is critical and should be allowed and welcomed by key stakeholders.

Within open-access insurance products, purchasers may be reluctant to allow or facilitate the collection of employee preferences for primary care. Open-access products allow employees and patients freedom of choice without interference. Purchasers are not always motivated to require employee selection of a primary care provider and may not have a mechanism to require employee selection of a primary care provider. This creates a barrier to explaining to patients the benefits of the delivery model supported by PBP and to collecting information on patient choice of a primary care provider.

To enable patient choice, employees and consumers may need to be given information on the benefits of selecting a primary care provider and evaluating performance data. In many markets, this information is lacking. Methods are needed to collect patient-reported selection of primary care providers. Other logistical and operational issues on patient choice need to be addressed.

Patient attribution is the method used to determine which provider group is responsible for a patient’s care and costs.

Patient attestation includes patient self-reporting, declaration, or confirmation of which provider is their primary care provider.

We recommend that employers, purchasers, payers, and health exchanges facilitate the patient selection process, including creating a shared understanding of the necessity for patients to be engaged in the attribution process.

***Recommendation 2**: Use a claims/encounter-based approach when patient attestation is not available.*

When patient attestation cannot be collected, other methods must be used to identify a primary care provider to link the patient to a medical group and/or delivery system. We have found that claims/encounter-based attributions can be valid, feasible, and highly accurate. The evidence-based approach uses historic insurance information about patients’ use of health care services during a defined look-back period. The claims/encounter data demonstrates what primary care providers and services the patient has used over a period of time. Payers can attribute most patients by using claims/encounter data.

Attribution in PBP models is based on the number of services used or the number of claims or encounters, rather than the greatest expenses during a look-back period. Approaches to using claims or encounter data vary, such as by the types of claims used, eligible services evaluated, eligible providers, and length of the look-back period. These issues are discussed below.

***Recommendation 3**: Define eligible providers at the beginning of the performance period.*

The recommendations in this White Paper relate to PBP models that assume primary care providers are the principal starting point for managing a population across the entire continuum of care. Provider organizations must identify the individuals who can serve as primary care providers before the beginning of a performance period. A clear definition of eligible providers, including eligible clinical specialties and provider types, is recommended.

For attribution purposes, primary care usually encompasses traditional general medicine and pediatric specialties, although the provider group and/or delivery system could identify any specialty willing to be accountable for care management as primary care. Traditional general medicine specialties for patient attribution are family medicine, internal medicine, general practice, and geriatrics. The definition should also address which provider types will be designated for attribution, including physicians, nurse practitioners, physician assistants, and other practitioners as mandated by law.

As stated above, if a primary care provider cannot be identified, specialty providers should be considered for patient attribution. Specialties can include endocrinology, oncology, rheumatology, pulmonology, nephrology, cardiology, obstetrics/gynecology, and gastroenterology. This list is not an exhaustive list of the specialties that could be designated as being responsible for overall care management of specific patients. Payers and providers should agree on medical specialty types before attribution. The provider group and/or delivery system accepting the patient population must identify the providers within the specialty who will be accountable for patient care coordination before attribution.

***Recommendation 4:** Provide transparent information to patients about their attribution.*

Whether patient self-attestation or a claims/encounter-based approach is used to determine patient attribution, patients should have access to information on their own attribution. They have a right to know which provider group they have been attributed to and how they were attributed. Transparency is paramount in enabling patients to be proactively engaged in their own health care.

Information on attribution can be provided to patients in many ways. Providers, payers, or purchasers, all of whom have access to this information, can facilitate a process to enable information sharing on patient attribution. Determining who provides the information, and how it is explained to patients, is essential to ensuring that patients understand the goals of PBP models. The choice of which organization informs patients of their attribution should be weighed carefully.

After a patient is linked to a provider group and/or delivery system, the provider, payer, or purchaser can initiate outreach. For example, patients could get a letter from their physician organization, describing how attribution is done and confirming their attribution selection at the group level. In the same communication, quality and service information about the physician organization could be provided. This type of information, already approved in Medicare by CMS, empowers patients with information about their attributed organization, confirms patient attribution, and provides additional information to engage patients in their own health care. Information should indicate who a patient's primary care provider is and that attribution would not change the patient's relationship with other providers.

Safeguards need to be built into this approach to ensure provider groups do not deliberately send information to patients encouraging them to "de-select" the provider, as might happen with complex, high-risk patients. Consistent information should be sent to all patients.

Since payers also have access to information on patient selection, along with the mechanisms for communicating with insured patients, they could also send the letter described above. However, the Work Group has found that many patients prefer to receive information about their care from their providers rather than an insurer as historically, information from payers relates to payment determinations and not care management.

Purchasers can also contact patients with this information, but as stated earlier, purchasers in some markets have been reluctant to be involved in patient attestation or attribution activities that link the patient to a medical group and/or delivery system. Purchasers need to understand how attribution to primary care benefits their employees.

Recommendation 5: *Prioritize primary care providers in claims/ encounter-based attribution.*

Attribution in PBP assigns accountability for the whole-person care of a population over a given time period. Claims data holds information on patient encounters with providers for wellness care, which is a starting point for assigning accountability to a provider group for whole-person care.

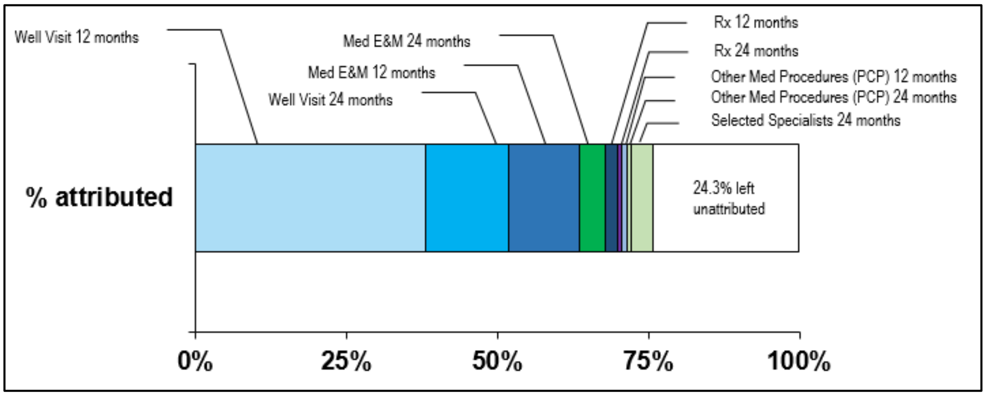
In cases that lack patient attestation, a well-defined algorithm to determine patient attribution is important. The first step in patient attribution is tying patients to primary care by using evaluation and management (E&M) codes for wellness care. A patient's visit for well care is focused on non-acute and preventative services. Using claims and/or encounter data to find a patient well visit is an important step in patient attribution to a medical group and/or delivery system. In a Massachusetts study, one provider group compared the cohort identified by using claims data with internal clinical data and found that "the patient was appropriately attributed 90-100% of the time if he/she had one well visit E&M during the two year look-back period" (Mariotti, 2015).

When no encounter data exists for primary care wellness visits, the second step is evaluating all primary care E&M codes to attribute a patient to a primary care provider. These encounters may cover a host of different issues, such as chronic care management and regular screenings. In the Massachusetts study, providers auditing the data found that this step could attribute another 10–15% of an eligible population to provider groups (Mariotti, 2015).

For patients who remain unattributed after this step, the third step is to identify the primary care provider from whom the patient received one or more prescriptions. Studies of attribution efforts find that 70–80% of patients are successfully linked to a primary care provider by these three steps.

Claims and/or encounter data should be used to allow a look-back at actual patient use of services over a period of time; however, certain issues arise in using this data. One consideration is the timeframe for the look-back, which can be from 12 to 36 months. This timeframe can influence the stability of the assignment. In the study conducted by three Massachusetts health plans, the difference in using an 18- versus 24-month look-back was a slight gain in the percentage of the population attributed to the longer look-back with no deterioration in the stability of the results.

Figure 2: Blue Cross Blue Shield of Massachusetts Attribution Levels



Blue Cross Blue Shield of Massachusetts has demonstrated that many patients can be attributed by evaluating claims data for evidence of a primary care wellness visit during a 12- and 24-month look-back period. As Figure 2 shows, nearly 75% of members were attributed based on a combination of wellness visit E&M claims, other primary care E&M claims, and primary care pharmacy claims during a 24-month look-back period. It also shows that if no primary care claims are evident and select specialty claims are evaluated, a small percent of otherwise unattributed patients can be attributed. In Figure 2, 3.6% of patients were attributed by including claims from obstetrics and gynecology, endocrinology, neurology, gastroenterology, rheumatology, hematology and oncology, cardiology, pulmonology, nephrology, infectious disease, and pediatric development. In a claims-based method of attribution, however, some percentage of patients will always remain unattributed because they have not used the system during the relevant period. In this case, 24.3% of patients were left unattributed.

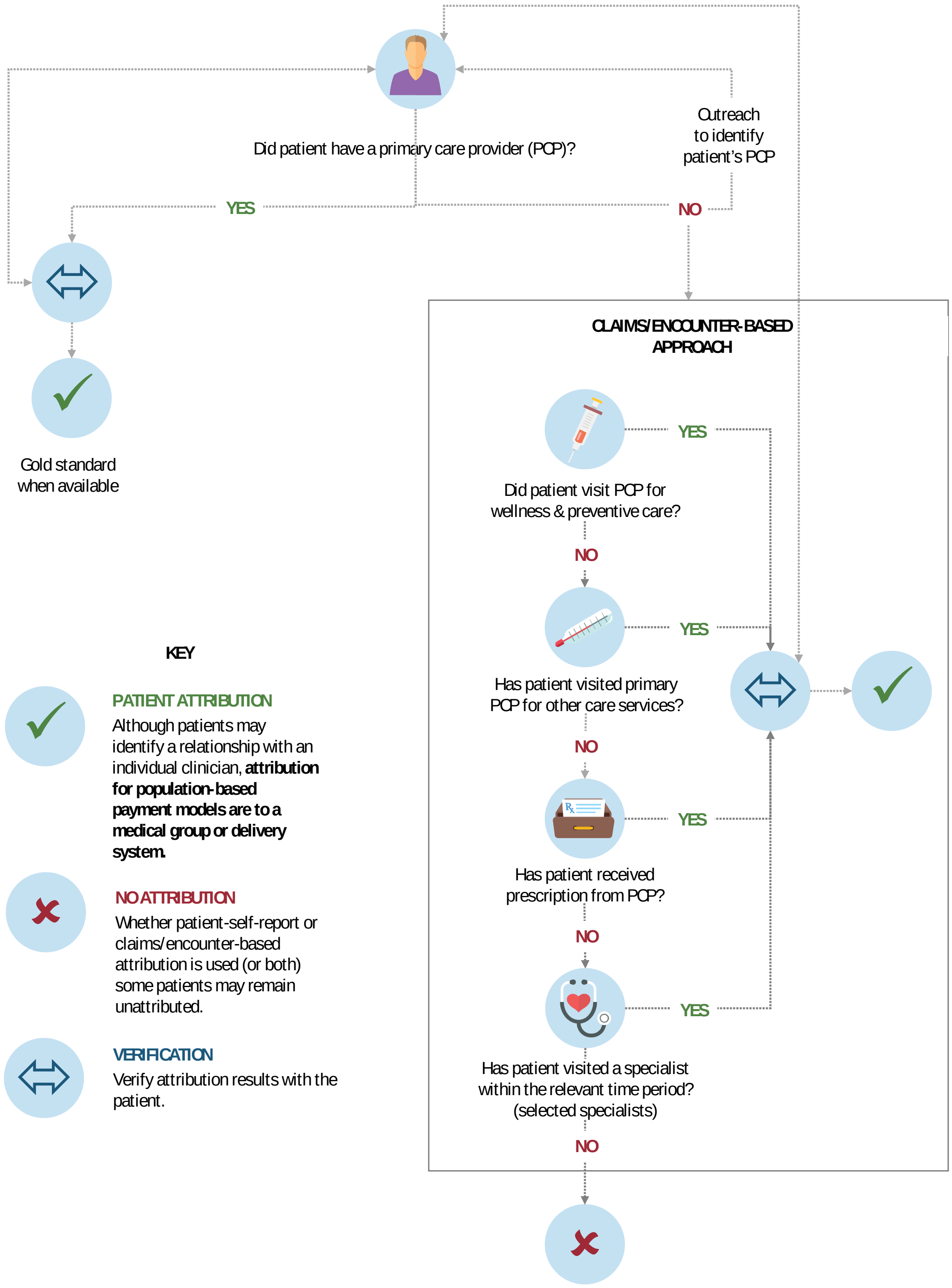
Recommendation 6: *Consider subspecialty providers if no primary care encounters are evident.*

Although attribution to primary care providers is the starting point, if a primary care provider cannot be identified based on the approaches described above, claims and/or encounter data for subspecialty providers should be evaluated. Often, a patient who has not visited a primary care provider may be seeking regular services from a subspecialty provider. For example, patients in treatment for congestive heart failure or diabetes might seek care predominantly from subspecialists through the course of the year. The attribution algorithm will identify visits to subspecialty providers and attribute the patient to the subspecialty medical group and/or delivery system.

Private insurers report that limited additional patients are attributed through this additional step. For example, Figure 2 illustrates that BCBSMA found that an additional 3.6% of members were able to be attributed if visits to certain specialty physicians were considered among patients remaining unattributed after all primary care visits and prescription claims were considered. However, given the different populations in public programs, this step to attribution might yield a larger “bump” of patients than that which occurs within a privately insured population.

Figure 3, below, illustrates all the steps of attribution outlined above.

Figure 3: Patient Attribution Flow Chart



PATIENT ATTRIBUTION
Although patients may identify a relationship with an individual clinician, **attribution for population-based payment models are to a medical group or delivery system.**

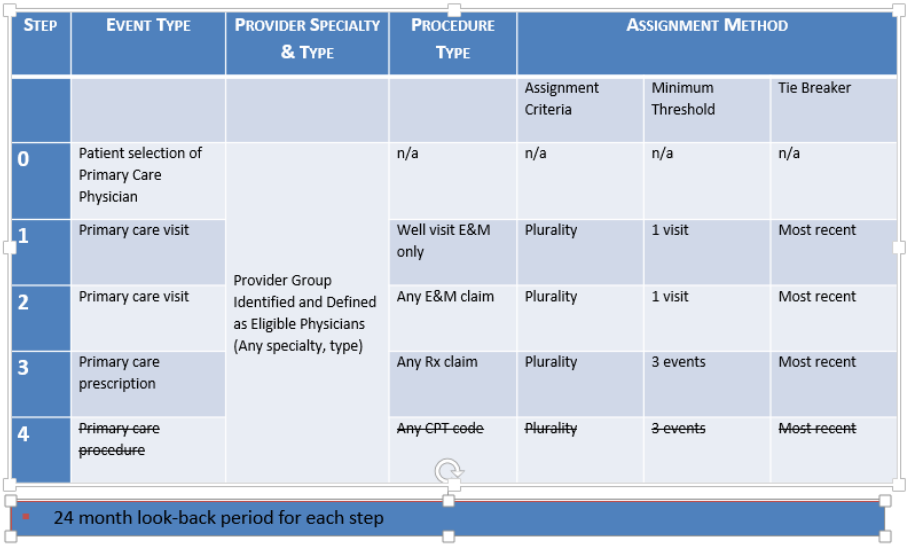
NO ATTRIBUTION
Whether patient-self-report or claims/encounter-based attribution is used (or both) some patients may remain unattributed.

VERIFICATION
Verify attribution results with the patient.

Massachusetts health plans, along with key stakeholders in the market, developed guidelines for a voluntary shared approach to patient attribution for commercial non-HMO members for whom attestation was not available. The approach was not to standardize the methods used by all health plans in the market, but to agree on a core set of elements in patient attribution. The resulting guideline addresses types of data used, the measurement unit, provider types included in attribution, and a specified look-back period for evaluating claims data. Two of the three participating Massachusetts health plans tested the guidelines using historical claims data to identify patient attribution cohorts for provider groups. Three provider groups performed internal validation using the data to evaluate the accuracy of cohort lists. The Massachusetts work group concluded that the methodology was fair and reasonable. Achieving consensus on a feasible methodology led to administrative simplification, with providers and payers spending less time and effort determining patient attribution (Mariotti, 2015).

Figure 4, below, shows a patient attribution guideline created by a multi-payer, multi-provider consensus effort in Massachusetts.

Figure 4: Consensus Non-HMO Commercial Patient Attribution Guideline



STEP	EVENT TYPE	PROVIDER SPECIALTY & TYPE	PROCEDURE TYPE	ASSIGNMENT METHOD		
				Assignment Criteria	Minimum Threshold	Tie Breaker
0	Patient selection of Primary Care Physician	Provider Group Identified and Defined as Eligible Physicians (Any specialty, type)	n/a	n/a	n/a	n/a
1	Primary care visit		Well visit E&M only	Plurality	1 visit	Most recent
2	Primary care visit		Any E&M claim	Plurality	1 visit	Most recent
3	Primary care prescription		Any Rx claim	Plurality	3 events	Most recent
4	~~Primary care procedure~~		~~Any CPT code~~	~~Plurality~~	~~3 events~~	~~Most recent~~

- 24 month look-back period for each step

Source: Massachusetts Multi-Stakeholder Attribution Workgroup, *Consensus Guideline for Commercial non-HMO Attribution Methodology*, August 2015.

This example demonstrates that multiple stakeholders in a market can agree on a common approach. Step 0 is patient selection; step 1 uses claims data to find a single primary care well visit E&M code; step 2 uses claims data to find a primary care visit for any E&M code; and step 3 uses pharmacy data to look for a primary care prescription. A previous version of this guideline included a step to look at primary care procedures, after no evidence of any primary care or specialty office visits was found. The Massachusetts work group decided to remove the step from the final algorithm because the step attributed few additional patients, and providers expressed concerns about the accuracy of attribution resulting from this step.

***Recommendation 7**: Use a single approach for attribution for performance measurement and financial accountability.*

Patient attribution is needed to define provider accountability for patients under PBP models. Although different approaches to attribution may show differential benefits, we recommend a single attribution approach for both performance measurement and financial accountability. A single approach provides clarity, ties together quality and financial goals, and attributes a single group of patients to a provider group. Separate approaches can result in slightly different patient populations.

***Recommendation 8**: Use the patient attribution guideline nationally for commercial products.*

For commercial populations, a claims-based algorithm should be generalized to a national model. That is, commercial claims-based attribution does not need to vary by locality. Key elements of attribution discussed in the recommendations could be implemented.

This recommendation is meant to provide flexibility since, at this point, a best approach to all aspects of the patient attribution recommendations has not been defined. While our recommendation is to use claims or encounter data to identify use of a primary care provider and then a specialty provider to attribute the patient to a provider group, the evidence for the optimal look-back period is not definitive. For example, we do not know of any rigorous testing that compares accuracy, completeness, and stability for 24 versus 36 months.

***Recommendation 9**: Alignment among commercial, Medicare, and Medicaid populations may be possible with adjustments.*

Although creating uniformity within commercial populations seems possible, it is unclear whether alignment between private and public programs is possible or desirable. We recommend further exploring the possibility of attaining as much alignment as possible between commercial populations and Medicare, with exceptions made for special needs populations. Further work is required to understand the potential for alignment with Medicaid programs.

Figure 5, below, compares recommendations in this White Paper to Medicare approaches to patient attribution.

Figure 5: Comparison of the PBP Work Group Recommendations and CMS Program Approaches to Attribution

	PBP Work Group Recommendations	Medicare Shared Savings Programs Tracks 1 and 2	Medicare Shared Savings Program Track 3	Pioneer ACOs	Next Generation ACOs
	1 **Patient Self-Report** Gold standard when it is available	None	None	1 **Patient Selection** Tested 2015 onward	1 **Patient Selection** Beginning 2016
	2 **Primary Care Providers** E&M codes for wellness and preventive care	1 **Primary Care Providers** Plurality of primary care	1 **Primary Care Providers** Plurality of primary care	2 **Primary Care Providers** Plurality of primary care	2 **Primary Care Providers** Plurality of primary care
	3 **Primary Care Providers** Other E&M codes				
	4 **Primary Care Providers** Prescription				
	5 **Specialty Care** E&M codes for specialty care (selected specialists)	2 **Non-Primary Care Providers** Primary care services	2 **Non-Primary Care Providers** Primary care services	3 **Non-Primary Care Providers** Primary care services	3 **Non-Primary Care Providers** Primary care services
Prospective or Concurrent Attribution	**Either is Acceptable** As long as provider has timely, actionable data on the attributed patients	**Concurrent Attribution**	**Prospective Attribution** Limited end-of-year exclusions	**Prospective Attribution** Limited end-of-year exclusions	**Prospective Attribution** Limited end-of-year exclusions

E&M – Evaluation and Management

A number of Medicare programs attribute beneficiaries. In the Medicare Shared Savings Program, beneficiaries do not have the ability to select a provider for the sake of attribution to a provider group; they are assigned to an accountable care organization (ACO) using a two-step process to evaluate encounter data. Step 1 assigns a beneficiary based on the plurality of primary care services provided by primary care physicians within the ACO. Step 2, used if there are no visits to a primary care physician, assigns a beneficiary based on the plurality of primary care services provided by other health care professionals within the ACO, including non-primary care physicians, nurse practitioners, clinical nurse specialists, and physician assistants.

In the Pioneer ACO models, testing of approaches for patient selection of providers started in 2015. If a beneficiary does not select a provider, claims data is used to attribute starting with primary care services from a primary care provider within the ACO. If no services are evident in the claims or encounter data, the attribution models look for primary care services provided by a non-primary care provider. The Next Generation ACO model follows the same steps as the Pioneer ACO model. The programs that rely on the prospective approach to attribution allow for limited exclusions at the end of the year, including exclusions if a patient moves out of the service area or changes to a Medicare Advantage plan.

Medicaid programs use a variety of approaches. The Work Group is interested in hearing more about Medicaid programs.

***Recommendation 10**: Regardless of whether prospective or concurrent attribution is used, providers should receive clear, actionable information about patients attributed to them.*

At the beginning of a performance period, providers should know which patients they are responsible for managing and the expected time period for management. Updated lists of patients should be shared periodically with provider groups and/or delivery systems in a PBP model, preferably monthly.

Providers need to know the patients for whom they are accountable. One approach is to create regular joint operating meetings between health plans and physician organizations so that providers can coordinate their efforts and programs and apply accountable care initiatives to relevant patient populations. Also, once providers have an accurate patient list, they can reach out to assigned patients and deliver customized care coordination that best suits these patients' health needs.

An industry standard for the length of time a patient is attributed to a provider group and/or delivery system has not yet been set and varies widely among different models. A patient can be attributed for a quarter or a calendar year or on a rolling basis for a 12-month period. This is an evolving practice that may vary depending on the population being managed.

A key methodological question is whether to use a prospective or concurrent attribution model. Published evidence does not clearly identify an empirically superior approach.

Prospective attribution uses a look-back at historic claims to identify patient use of services and then prospectively attributes the patient to a provider group and/or delivery system before the measurement period begins. This attributed list of patients then remains fixed throughout the measurement period (typically, 12 months). In the prospective model, provider groups know the patients for whom they are accountable at the beginning of the measurement period. The locked-in list can help providers prioritize patients for outreach and preventative health care. However, changes in patients' use of care during the measurement period do not change the patient cohort or attribution list. Providers are accountable for their original patient list, regardless of whether patients' care patterns over the year suggest they have changed systems; by contrast, the provider cannot gain formal accountability for new patients during the year, even if those patients' care patterns identify the provider to be their primary source of care.

Concurrent attribution also uses a look-back at historic claims and gives providers a defined list of patients at the start of the measurement period. However, at that time, the patient attribution list is not final or fixed. Patients may be added and subtracted to the attributed list based on care patterns observed throughout the measurement period. For example, patients whose care patterns demonstrate that they have shifted their primary care arrangement to another primary care provider will be removed, while those who manifest as relying on this provider will be added. In the concurrent model, final settlement on cost and quality performance is based on the population of patients who manifest as attributed to the provider at the end of the measurement period. However, this does not imply that the provider is blind to who their attributed population is or unable to manage them. Indeed, a best practice in concurrent attribution models is to provide regular updates to providers throughout the measurement period on how their attributed patient list is changing, and which patients are attributed to them, so that they can proactively manage this population.

While the evidence is not definitive on whether prospective or concurrent attribution achieves better results, a common and essential component of both approaches is that providers have clear, actionable information on the set of patients for whom they are accountable. In prospective models, this list is fixed at the start of the measurement period. In concurrent models, it can evolve over the measurement period and providers receive updated patient lists as it does.

Conclusion

[Placeholder: This section will summarize the PBP Work Group's main findings and recommendations following a process to gather feedback from the affiliated community.]

Appendix A: Roster

Work Group Co-Chairs

Dana Gelb Safran, ScD
Senior Vice President, Performance Measurement and Improvement, Blue Cross Blue Shield of Massachusetts

Glenn Steele, Jr., MD, PhD
Chair, xG Health Solutions, Inc.

Work Group Lead on Patient Attribution

Amy Nguyen Howell, MD, MBA
Chief Medical Officer
California Association of Physician Groups

Work Group Members

Andy Baskin, MD
National Medical Director, Aetna

Mike Chernew, PhD
Leonard D. Schaeffer Professor of Health Care Policy, Harvard Medical School

Steve Hamman
Senior Vice President, Enterprise Network Solutions and Provider Partnerships, Health Care Service Corporation

Kate Kinslow, EdD
President and Chief Executive Officer, Aria Health System

Sanne Magnan, PhD, MD
Former President and Chief Executive Officer, Institute for Clinical Systems Improvement

Elizabeth Mitchell
President and Chief Executive Officer, Network for Regional Healthcare Improvement

David Muhlestein, PhD, JD
Senior Director of Research and Development, Leavitt Partners, LLC

Hoangmai Pham, MD, MPH
Director, Seamless Care Models Group, Center for Medicare & Medicaid Innovation

Tom Raskauskas, MD
Formerly with St. Vincent's Health Partners

Andy Sperling, JD
Director of Federal Legislative Advocacy, National Alliance on Mental Illness

Dawn Stehle
Medicaid Director, Arkansas Department of Human Services

Jeff White
Director, Health Care Strategy and Policy, the Boeing Company

CMS Alliance to Modernize Healthcare (CAMH) Staff

CAMH, sponsored by CMS, is an FFRDC operated by the MITRE Corporation. MITRE is chartered to work in the public interest.

Chris Izui, MS
Lead, LAN PBP Work Group

Grischa Metlay, PhD, MA
Senior Health Policy Analyst and Technical SME

Anne Gauthier, MS
LAN Project Leader

Amy Aukema, MPP
LAN Deputy Project Leader

Leina Slater
LAN PBP Work Group

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