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State Innovation Model Initiative Primer

Patient Attribution Overview

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:

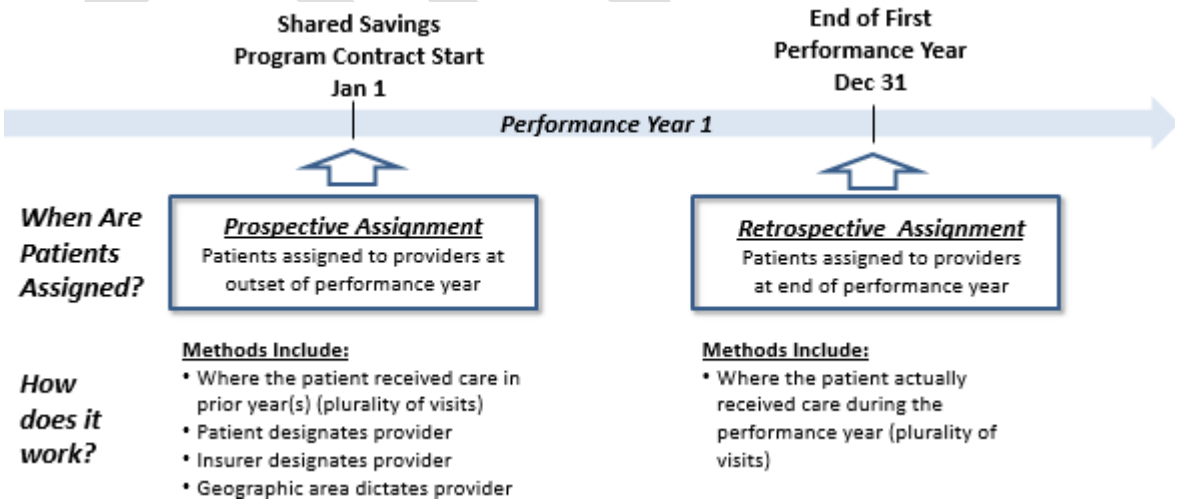
1) ***How*** the patient is assigned to a provider (i.e. the technique or "rule" used to assign a patient)
2) To ***whom*** the patient is assigned (i.e. the type of provider to whom a patient can be assigned)
3) ***When*** during the contract period the patient is assigned

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 ACOs[46] (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: "… 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).

[46] 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.