Patient Attribution

ACHI
Arkansas Center for Health Improvement

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To support national and state-based efforts to improve patient outcomes and control costs, healthcare payers have implemented new programs that assign provider accountability for patient outcomes. This requires measurement of patient outcomes related to the care delivered by individual providers. However, not all patients select, and many payers do not require the selection of, a primary care provider (PCP). As such, payers may attribute patients to a provider based on prior service utilization. Payers in Arkansas use attribution to support initiatives like the patient-centered medical home (PCMH) program. This fact sheet includes information on patient attribution methodologies and applications.

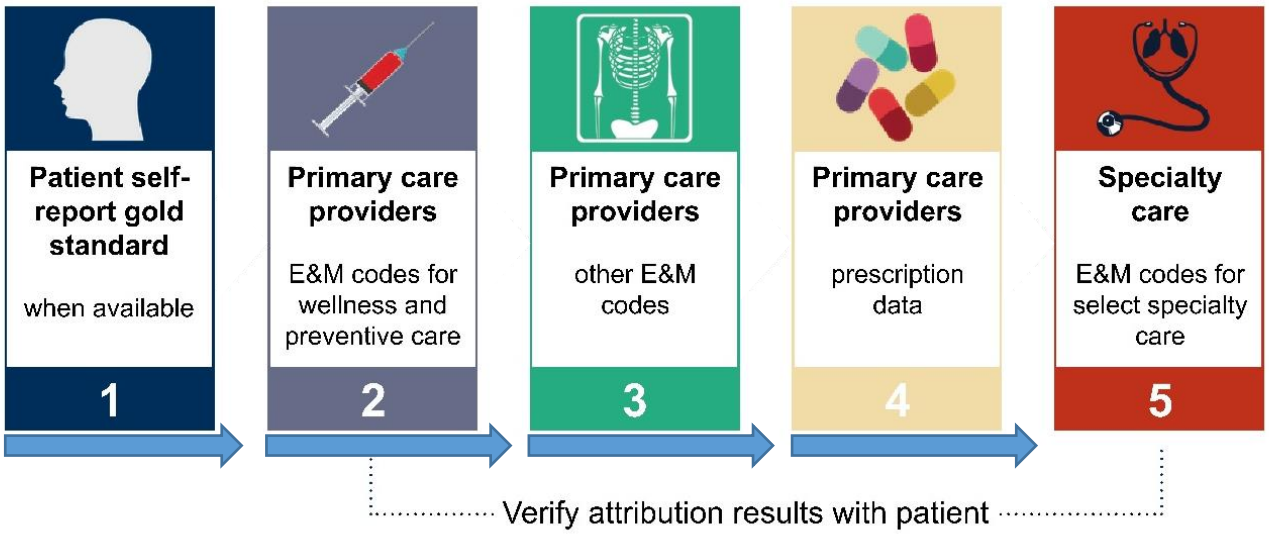
BACKGROUND AND OVERVIEW

Why Patient Attribution Is Necessary

The Healthcare Payment and Learning Action Network (LAN) defines patient attribution as a method of identifying a patient-provider healthcare relationship and a foundational component of population-based payment (PBP) models. In 2015, the Department of Health and Human Services (HHS) set goals for 2018: 90 percent of Medicare payments would be linked to quality and value with 50 percent of payments made under alternative payment models (APMS).[1] Since 2012, Arkansas has become a leader in APM implementation, with public and private payers collaborating to improve quality and contain cost growth.[2]

APMs like Arkansas's PCMH program rely on patient attribution to measure provider performance and population-based patient outcomes. These models reinforce the importance of individuals having a primary care provider who is responsible for preventive screenings and the management of chronic conditions, and who can help patients navigate the healthcare system. When patients' self-reporting of PCP selection is unavailable, attribution is usually based on patients' previous healthcare claims and encounter records. This process is based on primary care evaluation and management (E&M) services and prescription data.[3]

Figure 1: General Patient Attribution Process Flow



Although patients may receive care from multiple providers, most attribution methods assign patients to the provider who has delivered the majority of their primary care services. Figure 1 illustrates the attribution process recommended by LAN, a national public and private stakeholder group initiated by HHS.

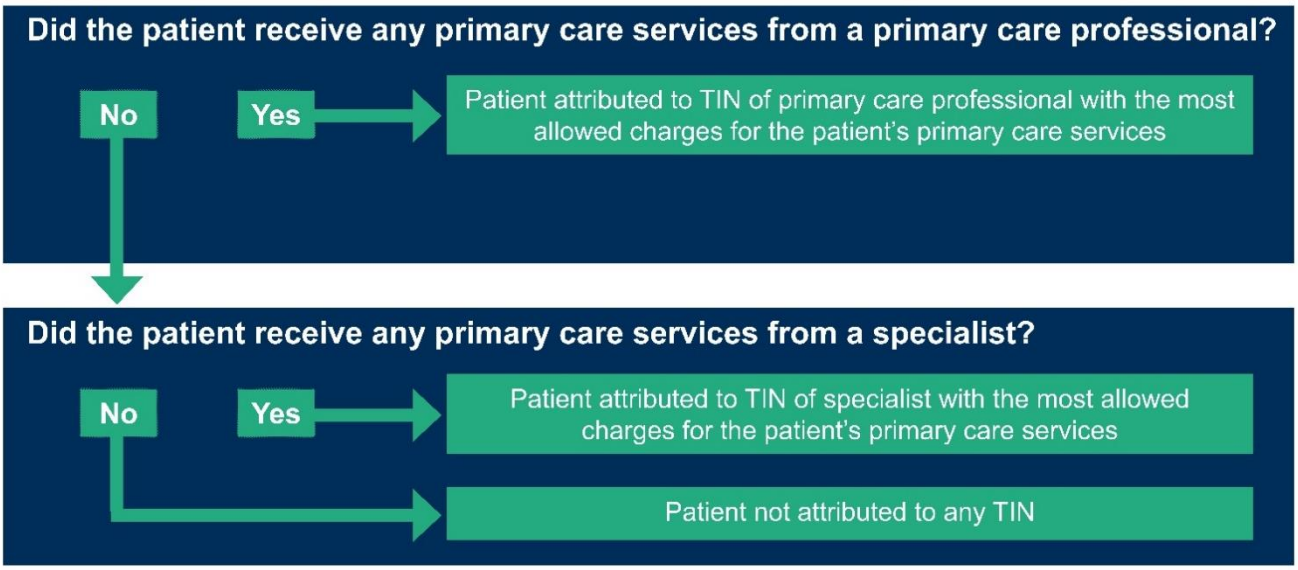
PAYER METHODOLOGIES

Public and private payers have developed tailored attribution methods that are well-documented. Most payers use healthcare claims data to attribute patients based on history of evaluation and management (E&M) codes. Attribution may occur prospectively (either before or during a performance year), or retrospectively (after a performance year). Although typically attributed to a single PCP, providers' patients may also be attributed to a clinic or group.

Medicare

As the single largest purchaser of health care in the United States, the Federal Medicare Program has developed a two-step process for attributing beneficiaries. This method assigns patients to the tax identification number (TIN) of the PCP with the plurality of primary care services. Medicare has developed other related methods tailored for alternative payment models such as the Medicare shared Savings Program (MSSP)[4] and the QPP.[5] Figure 2 illustrates the two-step Medicare attribution process.

Figure 2: Medicare Two-Step Patient Attribution Process



Arkansas Medicaid

As documented in the Arkansas Medicaid provider manual, most beneficiaries must select a PCP under the ConnectCare Primary Care Case Management (PCCM) Program.[6] Beneficiaries must select three options for a PCP. DHS then determines, by beneficiary choice, if the PCP has the caseload capacity to accept new patients. DHS then informs the patient and attributes them to their chosen PCP. In Medicaid's PCMH program, attribution is based on the PCP assignment established in the PCCM program.

The Provider-led Arkansas Shared Savings Entity (PASSE) program was established in 2018 to provide services to individuals with complex behavioral health (BH) needs, developmental disabilities (DD), or those needing long-term services and supports. The PASSE program uses a weighted attribution method based on a points system for BH and DD specialty providers and associated claims costs.[7]

Commercial Payer Methodologies

Commercial payers in Arkansas have implemented patient attribution methods in an effort to improve overall population health management and support the Patient-Centered Medical Home (PCMH) program and other payment models. Arkansas Blue Cross and Blue Shield (ARBCBS) conducted a primary care provider attribution initiative for all beneficiaries in their fully insured plans.

In a process that spanned most of 2015, ARBCBS asked beneficiaries to designate a PCP, then assigned a primary care provider to beneficiaries who did not select one. These newly attributed beneficiaries were then notified by ARBCBS of their assigned primary care provider. Beneficiaries are free to select a different PCP at any time.[8] ARBCBS members are attributed to a physician based on a methodology that includes factors such as claims containing specific evaluation and management CPT codes (99201-99499); assignment through

recent dates of service; and a member PCP selection process. If a member cannot be attributed based on paid claims, or if the member declines to select a PCP, geographic proximity is used to assign the member to a participating practice.

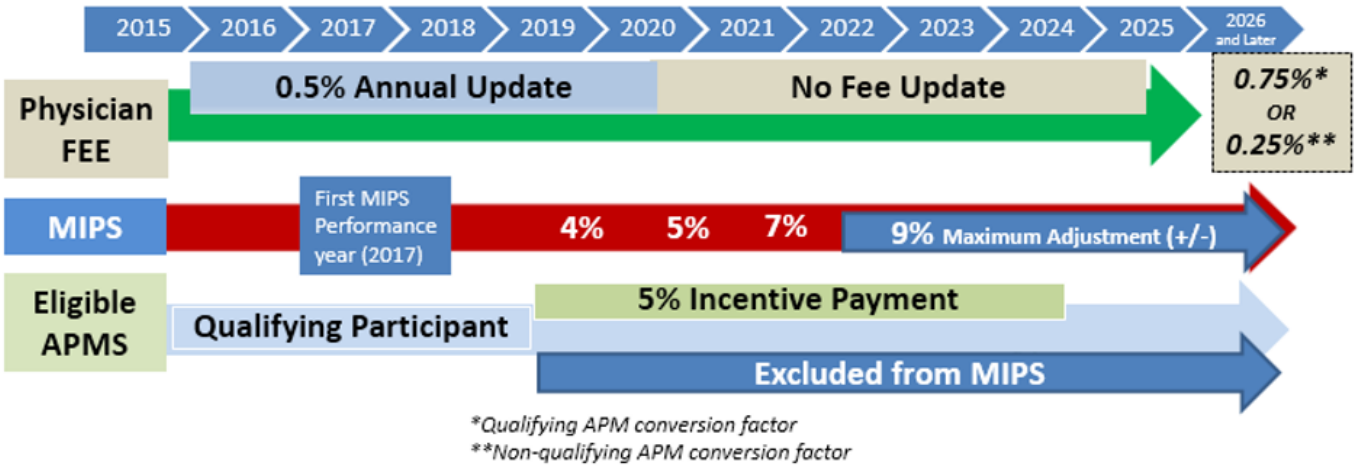
QualChoice of Arkansas uses a similar attribution methodology to that of ARBCBS. QualChoice members in Metallic Health Plans (e.g., Gold, Silver, or Bronze levels) are required to actively select a PCP, to whom they are then attributed. QualChoice non-self-funded members are attributed based on primary care claims history.[9]

PAYMENT APPLICATIONS AND STAKEHOLDER COMMUNICATION

Patient attribution is a core component of efforts to improve quality and efficiency by tying payments to patient outcomes. Most APM and PBP models use patient attribution to assign provider responsibility.[10,11,12] Authorized under the Medicare Access and CHIP Reauthorization Act (MACRA), The Quality Payment Program (QPP) is one of the largest value-based strategies ever deployed and relies on accurate patient attribution for measurement of provider-level quality and cost outcomes.[13]

Under the QPP, many providers either participate in an Advanced Alternative Payment Model (AAPM) and will be eligible for up to a 5 percent lump-sum annual bonus or are subject to the Merit-based Incentive Payment System (MIPS). Under MIPS, providers will face Medicare reimbursement rate reductions or increases beginning in 2019 for 2017 performance. Under MIPS, patients are attributed retrospectively, based on the plurality of Medicare Part B charges for office visits, wellness visits, assisted-living care, and home visits. Providers who participate in AAPMs under QPP are subject to the attribution of the specific AAPM. Figure 3 illustrates the QPP timeline.

Figure 3: MACRA and Quality Payment Program Timeline



As part of the Comprehensive Primary Care Plus (CPC+) Initiative, a prominent AAPM, 182 Arkansas clinics were accepted in 2017 in one of two tracks based on attributed patient risk. The CPC+ attribution methodology for Medicare assigns patients to a practice site rather than an individual physician, and is based on plurality of Chronic Care Management (CCM) services and primary care visits. CPC+ attribution is updated quarterly, and used to determine prospective care management payments.[14]

Communication Between Payers, Providers, and Patients

It is essential that providers be made aware of which patients are attributed to them, and that providers have the opportunity to give feedback to payers about their designated patients. The American Academy of Family Physicians advocates for a simple and transparent appeals process within patient attribution that allows providers the opportunity to decline assigned attribution of a patient based on their utilization patterns.[15]

Gaps in patient attribution underscore the need for patient education about the importance of maintaining a PCP relationship. While many patients proactively choose, or are attributed to, a PCP, some individuals do not have enough prior care history to enable attribution. These individuals should be considered for enhanced outreach and education efforts from community groups and other service providers.

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