



VALUE TRANSFORMATION FRAMEWORK

Action Brief



ATTRIBUTION

WHAT

is Attribution?

Attribution, or 'assignment,' is the process that payors use to assign patients to a provider for the purpose of tracking accountability for quality, patient experience, and total cost of care. Attribution defines the population for which a provider, accountable care organization (ACO), or Clinically Integrated Network (CIN) is held responsible. It is a foundational component of population health management under value-based payment (VBP) models. Attribution differs from empanelment, which is the internal process used to match all patients with a primary care provider and care team, regardless of the payor.

There are three primary approaches to attribution:

1. **Prospective Attribution.** Patient assignments are determined for the upcoming performance year (PY) based on claims data from a defined look-back period.
2. **Retrospective (Performance Year) Attribution.** Patient assignments are determined based on care and services provided in the completed performance period.
3. **Hybrid (Concurrent) Attribution.** Patient assignments are determined for the upcoming performance period using historical care and services provided with continuous adjustments based on care delivery patterns.

In addition to the primary attribution methods noted above, other attribution methods exist, including auto-assignment, patient selection, and prescription data. Health centers need to understand the attribution methodology, whether the methods above or a combination of approaches. While there are numerous methods to understand, **patient self-reporting, declaration, or confirmation that the primary care provider to whom they have been attributed is their primary care provider is the gold standard for attribution** (HCPLAN, 2016).

WHY

is Attribution Important?

With the growth and spread of VBP models, health centers must understand attribution's operational, financial, and actuarial (i.e., assessing financial and insurance risk) implications. Attribution is foundational to value-based payment arrangements, and therefore, critical for health centers to understand and manage. Patient attribution allows practitioners and care teams to identify the patients for which they are accountable by the payor. Attribution does not change how patients access or receive care but creates accountability within a provider group to coordinate a patient's overall care needs (HCPLAN, 2016). Under VBP arrangements, the health center can receive financial rewards for keeping patients healthy and out of the hospital. It may include current health center patients and patients assigned to the practice who need primary care services for preventive and chronic care needs. Health centers must assess their operations and ability to reach out to patients with whom they have yet to develop a relationship but with whom the health center is being held accountable to a payor.

HOW

can health centers Optimize Attribution for Business Operations?

STEP 1 DEVELOP AN ACCURATE UP-TO-DATE LIST OF PROVIDERS ELIGIBLE FOR ATTRIBUTION.

Processes should be in place to routinely update provider rosters for the health center’s payor partners. If your health center’s provider roster is out of date with the payor partner, patients will still be attributed to providers who are no longer with your health center. Health centers should consider a monthly roster update process to ensure attribution is as accurate and up to date as some payors may update attribution monthly. This process typically includes all new clinicians within the health center who deliver primary care services. However, it could include specialty or other clinicians who may provide primary care services (e.g., obstetrics and gynecology [OB/Gyn], cardiology). Importantly, it also includes the removal of providers who are no longer practicing at the health center. For federally qualified health centers (FQHCs), this list should include all billing clinicians, including physicians, physician’s assistants (PA), and nurse practitioners (NP). Regular updates ensure clinicians who have left the health center are removed from the attribution process; however, there are inherent lags in the attribution process, especially claims-based attribution. Through the monthly provider roster update process, check the latest rosters to ensure the updates have been made through the attribution process and that attribution numbers are still relatively stable.

STEP 2 UNDERSTAND THE ATTRIBUTION METHODOLOGY OF PAYORS.

Understand whether attribution is a prospective, retrospective, hybrid, or another approach. It is important to always have detailed discussions with payor partners about their attribution methods before entering a VBC arrangement.

Attribution Method*	Pros	Cons
Prospective	<ul style="list-style-type: none"> Fixed patient list for the performance period. Improves ability to conduct patient outreach and prioritize efforts using risk stratification. Prevents clinicians from selectively avoiding high-risk or complex patients (Lewis, 2012). 	<ul style="list-style-type: none"> Accountability is to the original list; it does not account for patients who change clinicians independently or new patients. Clinicians can selectively avoid patients to alter attribution in future years favorably (Lewis, 2012).
Retrospective	<ul style="list-style-type: none"> Clinicians are held responsible for patients who receive care. Ensures most patients receiving care during the performance period are attributed to the provider. 	<ul style="list-style-type: none"> Given that patients are assigned at the end of the performance period, a provider would not know if the patients receiving care during the year will be assigned to them, diluting the ability to receive shared savings to support care redesign (Lewis, 2012). The allocation of resources is more difficult. Adds an administrative burden of trying to predict who will be attributed at the end of the performance period.
Hybrid	<ul style="list-style-type: none"> Accommodates patient changes in clinicians during the measurement period – removes patients who move or seek care elsewhere. Clinicians are rewarded for patients who start care during the performance period. 	<ul style="list-style-type: none"> During the performance period, there is a potential for increased administrative workload when incorporating new patients. It can impact the allocation of care team time and resources though this can be mitigated with proper planning.

*Payors may have unique attribution methods that don't fit the examples above.

Methodologies may also incorporate look-back periods (i.e., periods ranging from 12 to 36 months) during which other attribution methodology criteria will be applied. Understanding how payors assign patients without visits during the look-back period is also important. Payors may use methods to assign patients to the health center who have yet to be seen. It is prevalent in Managed Medicaid Organizations and can often be a source of frustration for health centers. In these cases, it will be important to work with the payor to understand how these patients can be identified in the attribution reporting from the payor.

Methodologies may also incorporate evaluation & management (E&M) codes to determine a care relationship (e.g., codes for wellness care only versus using all or a subset of primary care E&M codes). An example includes the Medicare Shared Savings Program's assignment methodology, which uses Primary Care Service codes such as E&M, Annual Wellness Visits, chronic care management, and transitional care management in their assignment methodology.

Additionally, the type of licensed clinicians eligible for attribution may vary by payor. For example, some commercial plans may only attribute patients to physicians, not to advanced practice clinicians such as PAs and NPs. Additionally, payors may attribute to specialists who provide primary care services (e.g., OB/Gyns). Health centers may employ or contract with specialists to see patients in their facilities. Therefore, health centers must fully understand the attribution method a payor partner is utilizing.

STEP 3 DEVELOP PROCESSES FOR THE INTAKE OF ATTRIBUTION LISTS. Based on the attribution methodology, work with each payor to understand how often patient attribution will be 'refreshed' (i.e., to account for recent patient care information and changes in your health center's provider roster). Also, understand the payor's method to share attribution lists with your health center. For example, some payors will allow select health center staff members to access this information via a portal, some may rely on secure fax or email, and some may rely on an ACO or CIN to distribute attribution lists to applicable health centers. Attribution lists contain confidential patient information; all relevant HIPAA and privacy protocols must be followed.

For each payor, request that the attribution file show the patients' alignment with a health center site or group and the attributed provider. From there, health centers must take additional steps to consider how to integrate attribution information into health center systems (such as the EHR) and utilize it to inform processes. Consider whether clinicians and other staff members would benefit from viewing a patient's attribution information and how access to this information can enhance workflows (e.g., patient outreach). Additionally, some EHRs and population health management systems have functionality that allows for integrating attribution information to drive enhanced quality measures or cost-of-care reporting. Work with your EHR or population health management vendor to understand the functionality available within the health center systems.

STEP 4 LEVERAGE ATTRIBUTION LISTS TO INFORM EMPANELMENT. Attribution differs from empanelment, which is the internal process used by health centers to match all health center patients with a primary care provider and care team, regardless of the payor. Health centers can leverage attribution to inform their empanelment processes. It is important to note that the provider's panel may not always match up with the attribution roster. The goal of leveraging attribution to inform empanelment processes is to recognize differences in empanelment assignments and which assignments require further action by the health center. Action is warranted by the health center (in the form of updating the empanelment assignment and providing patient outreach) when attribution information signifies that the patient needs care (i.e., the health center has yet to see the patient and does not yet have a provider assigned through empanelment).

It is critical for the health center to develop written processes leveraging attributed patient lists to inform the empanelment process. It will require working across multiple payor attribution lists to define and document a patient-provider assignment process.

STEP 5 IDENTIFY A PROCESS FOR PATIENTS WHO ARE NOT ATTRIBUTED BUT RECEIVE CARE FROM YOUR HEALTH CENTER. Managed Medicaid Organizations often employ an automatic attribution process when patients fail to choose a Primary Care Provider (PCP) themselves. While patients can receive primary care services from any in-network provider, they may not recognize the significance of updating their PCP information with their managed care plan. However, this becomes crucial under Value-Based Payment (VBP) arrangements as the discrepancy could result in providers and healthcare systems not receiving credit for closing gaps in patient care. Additionally, important information about patient transitions, care management, utilization management needs, or shared savings may be overlooked.

Health centers can address this issue proactively by implementing a registration process where front desk staff verifies the patient's attributed provider on their insurance card or the payor's portal. If there is a discrepancy between the attributed provider and the actual provider delivering care to the patient, a PCP change request process can be initiated. Each Managed Medicaid Organization will have its designated form or procedure that front desk staff can assist patients with throughout this process. By ensuring accurate attribution of providers at registration, health centers can optimize getting credit for improved quality of care delivery and financial incentives under VBP arrangements.

STEP 6 USE ATTRIBUTION INFORMATION TO DRIVE PATIENT ENGAGEMENT AND CARE NEEDS. Consider operational workflows for those patients who are attributed yet have not sought care at the health center. Mature value-based care clinicians have processes that regularly review attribution information to understand the new patients attributed but unseen and whether they are existing health center patients. This sets off a series of outreach and engagement efforts for patients new to the health center or who haven't been engaged recently. Attribution churn, or turnover, can vary by line of business but contributes to why health centers must review who is coming on and off their attribution lists. Workflow redesign may be necessary to reach out to patients not yet seen by the health center or not coming in for care. Additionally, while the focus here has been value-based arrangements, the attributed but not seen or not recently seen population offers an opportunity for appropriate additional FFS revenue by engaging new patients or reengaging existing patients needing preventive care.

Patient outreach is critical to managing the entire population for which the provider is accountable and is a key operational competency of successful value-based care clinicians. If participating in a shared savings or risk arrangement, the health center will be accountable for the cost of care, regardless of whether a patient is coming in for care. New patients attributed to the group may not have historical data from the payor, making it critical for clinicians to see and engage these patients to ensure they are managed appropriately, given their clinical risk and social determinant profile.

As mentioned earlier in this brief, there are a number of ways to address inaccurate or outdated contact information from payor partners for patients assigned but not yet seen; however, the use of HIEs has established itself as a best practice. Discuss with payor partners the availability and accuracy of demographic information, as they can often leverage additional sources of information.

References:

- Population-Based Payment Workgroup of the Health Care Payment Learning & Action Network. "Accelerating and Aligning Population-Based Payment: Patient Attribution." June 30, 2016. Accessed August 15, 2023 <https://hcp-lan.org/pa-whitepaper/>.
- Lewis VA, McClurg AB, Smith J, Fisher ES, Bynum JP. "Attributing Patients to Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests. *Health Aff (Millwood)*. 2013 Mar;32(3):587-95. doi: 10.1377/hlthaff.2012.0489.

NACHC would like to acknowledge the contributions of HMA, a Wakely company, in the development of this document.

This Action Guide was developed with support from the Centers for Disease Control and Prevention (CDC) cooperative agreement #NU38OT000310. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, the CDC or the U.S. Government.