Department of Health | Medicaid Redesign Team

Attribution Methodology

Overview of options outlined in Attribution Methodology: Considerations and Options for the Technical Design Subcommittee I, NYS Value Based Payment Workgroup

July 1, 2015

Attribution – starting points - I

Attribution is necessary to determine which providers will be responsible for which members- both in terms in outcomes and costs.

Three Facets to Consider:

#	Facet	Methodological Aspect
1	Who	To **whom** the member is assigned (i.e. the type of provider to whom a member can be assigned).
2	How	**How** the member is assigned to a provider (i.e. the technique or "rule" used to assign a member).
3	When	**When** during the contract period the member is assigned (retrospective or prospective).

Attribution – starting points - II

Attribution methodology is dependent on type of VBP arrangement. To illustrate:

- Acute Bundle: often, attribution is driven by the hospital that delivers the key intervention
- Integrated Primary Care: attribution centers around the Primary Care Provider
- AIDS/HIV subpopulation: attribution centers around the AIDS/HIV center

Attribution – starting points - III

Draw upon leading practices nationwide but also on current practices of MCOs and providers

Remember: Key Questions for all Topics

- Should the State set a *Standard* (or should an issue be left to MCOs and providers)?
  - If yes, the topic merits scrutiny and detailed discussion
  - If no, is it useful to have a *Guideline* to aid in the negotiations between MCOs and providers?
    - If yes, the topic merits adequate discussion
    - If no, the topic does not require additional discussion

- If a topic has relevance for how the State will provide cost and outcome information (including potentially shared savings) to MCOs and providers, a *Guideline* will be required to inform the way this data is calculated and reported

Facet #1 – Who: To What Provider are Members Attributed

- For **Total Care for the Total Population** (TCTP) and **Integrated Primary Care** and the **Chronic Care bundle**, the suggested provider attribution is the Primary Care Provider (PCP).
- For **non-chronic bundles**, the suggested provider attribution is the primary provider of the core service that 'triggers' the bundle.
- For the **AIDS/HIV Subpopulation**, the suggested provider attribution is an AIDS/HIV center.
- For the **MLTC Subpopulation**, the suggested provider attributed is the a MLTC provider (home and/or residential care).
- For the **HARP Subpopulation**, the suggested provider attributed is a Health Home.

Facet # 2 – How are Members Attributed to Providers

There are four options for HOW members can be attributed.

1. The MCO could assign the members (GP, HH)
2. Members could be asked to choose a provider (GP, HH, PPS/hub?)
3. Members could be assigned to a provider by their pattern of use[1]
4. Members could be assigned geographically

1. Defacto method for non-chronic bundles

Facet #3 – When: Prospective, Retrospective, or a Hybrid

1. Prospective Attribution : When using this method, providers are given a list of members for whom they will be responsible at the beginning of a performance year. In most cases, this list is based on data from the members' use of services in the previous year(s).

2. Retrospective Attribution (Performance Year) : This method attributes members at the end of the year based on members' use of care during the actual performance year based on the actual usage.

3. Hybrid of the above (Retro- and Prospective) : An initial prospective assignment methodology is utilized with a retrospective reconciliation. It begins with prospective attribution, final reconciliation happens at the end of performance year.