# VBP Member Attribution Methodology: Options and Considerations

## Executive Summary

Member Attribution is a key element of any Value Based Payment mechanism. For NYS Medicaid, this means an attribution method is required for the following VBP arrangements:

- Total Care for Total Population (TCTP)
- Total Care for Subpopulation (TCSP)
- Integrated Primary Care (IPC)
- Chronic Bundles
- Episodic Bundles

Because the attribution mechanism chosen determines what patients are assigned to what (groups of) providers, it forms the basis of subsequent analyses of the total costs of care, outcomes, potential shared savings per VBP arrangement per provider combination, and so forth.

The following key options are to be weighed by the Subcommittee[1]:

Per option, the Subcommittee should recommend whether the State should set a *Statewide Standard* or a *Guideline:*

- A Standard is required when it is crucial to the success of the NYS Medicaid Payment Reform Roadmap that all MCOs and Providers follow the same method.

A Guideline is sufficient when it is useful for Providers and MCOs to have a starting point for the discussion, but MCOs and Providers may deviate without that harming the overall success of the NYS Medicaid Payment Reform Roadmap. *In the case of Member Attribution, a Guideline is minimally required because the State will use that Guideline to create the transparency of costs and outcomes promised to Providers and MCOs in the Roadmap.*

| # | Topic | | Choice | | |
|---|---|---|---|---|---|
| | | | i | ii | iii |
| 1a | Who/How | What provider drives the attribution for TCTP, IPC and the Chronic Bundles | *MCO Assigned PCP* | *Actual PCP as determined by claims data analysis* | *Other (e.g. pulmonologists for COPD bundle)* |
| 1b | Who/How | What provider drives the attribution for Total Care for Subpopulations: HARP, HIV/AIDS, MLTC | *Resp. Health Home, HIV/AIDS center, MLTC provider Assigned by MCO* | *Actual HH, HIV/AIDS center, MLTC provider as determined by claims data analysis* | *Other* |
| 2 | When | Are beneficiaries attributed prospectively or retrospectively for TCTP, TCSP, IPC and the Chronic Bundles? | *Prospective* | *Prospective with retrospective reconciliation* | |

[1] This table includes the key options but is not exhaustive. The accompanying document includes some options that were not deemed relevant enough to be included here based on preliminary discussions with stakeholders.

**Introduction**

One of the main goals of DSRIP and VBP is to focus on member health and provider performance, and ensure the improvement of both. As such, it becomes crucial for providers to know for what patients they are responsible – both in terms of outcomes and costs. Attributing patients properly, then, is key.

The attribution mechanism chosen forms the basis of subsequent analyses of the total costs of care, outcomes, potential shared savings per VBP arrangement per provider combination, and so forth. For these reasons, having a diversity of attribution methods per VBP arrangements would lead to patients being attributed to multiple providers or to no provider at all. In addition, differences in attribution methods can create subtle differences in populations, which complicates fair comparisons of the value of care delivered to those populations. Furthermore, utilizing a standardized attribution methodology allows the state to provide both providers and MCOs with the appropriate cost and outcome information, as promised in the Roadmap.

On the other hand, MCOs in NYS already have their approaches for attributing patients to providers, and aligning maximally with what is already in use by DSRIP (attribution for performance) and MCOs for the purposes of VBP is a strong starting point.

Technical Design Subcommittee I is tasked with developing optimal and maximally feasible attribution methodologies for the different VBP arrangements. Given the importance of both alignment with existing MCO practices and the benefits of standardization, careful consideration of the question whether a Standard or a Guideline is required is important.

Per option, the Subcommittee should recommend whether the State should set a *Statewide Standard* or a *Guideline* for the methodologies employed between MCOs and the providers. The State will consistently employ a standard in its own approaches regarding methodologies and data dissemination to both MCOs and providers. The Subcommittee should recommend whether MCOs and providers should adopt the same standard or are free to vary, using the State's methods more as a guideline.

- A Standard is required when it is crucial to the success of the NYS Medicaid Payment Reform Roadmap that all MCOs and Providers follow the same method.
- A Guideline is sufficient when it is useful for Providers and MCOs to have a starting point for the discussion, but MCOs and Providers may deviate without that harming the overall success of the Payment Reform Roadmap.

Presented in this document are attribution options for the Subcommittee to discuss, based on national leading practices. In some cases the SC may find that a combination of different techniques might work best. The Subcommittee is requested to provide the State with its recommendations on what (combination of) option(s) would suit the implementation of the VBP Roadmap best.

Importantly, as in DSRIP, the State will provide both providers and MCOs with attribution lists, so that no organization is forced to run these algorithms themselves.

## Options and Considerations

Overall, there are three facets to consider when developing a member attribution methodology[2]. Listed below are options related to each one of the attribution facets that the SC members are asked to review and discuss.

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

## Facet #1 – When: Prospective, Retrospective, or a Hybrid

The following options are relevant for all (sub)populations based VBP arrangements **(Total Care for Total Population; Total Care for a Subpopulation; Integrated Primary Care)** as well as the **Chronic Bundles**. For the other types of bundles, see further.

### Option 1

**Prospective Attribution**[3]: When using this method, providers are given a list of patients for whom they will be responsible at the beginning of a performance year.

| Pros | Cons |
|---|---|
| Providers know who their patients are and can reach out to assigned patients and engage them proactively in coordinating care and developing specialized care management programs as well as preventative care. | There is greater potential for inaccuracy of attribution, since attribution is based on forecasted utilization and not actual utilization. Thus, it increases the likelihood that some patients will be excluded from the attribution process. |
| Decreases difficulty in tracking utilization and expenditure data. | A PPS or provider is able to recognize those patients that have not been attributed to them, and they may choose to treat these patients differently (i.e., not expend specific resources on these patients). This could result in two standards of care; one for attributed and one for non-attributed patients. |

[2] Background About Shared Savings Program Design Features: Patient Attribution, Cost Target Calculation, and Payment Calculation, and Distribution. (March 2015). "Draft Narratives Developed in the CT SIM Equity and Access Control." Retrieved from http://www.healthreform.ct.gov/ohri/lib/ohri/work_groups/quality/2015-04-01/quality_ssp_contract_design_features.pdf.

[3] American College of Physicians. *Accountable Care Organizations (ACO) 101 Brief Course.* Retrieved from http://www.acponline.org/about_acp/chapters/md/kirschner.pdf on June 12, 2015.

| | |
|---|---|
| There is greater ability to assess and make appropriate mid-year adjustments to processes associated with care delivery since actionable data is available to analyze during the performance year | This method can be flawed when attribution lists are not consistently updated because patients change plans and providers over the course of a year. |

**Option 2**

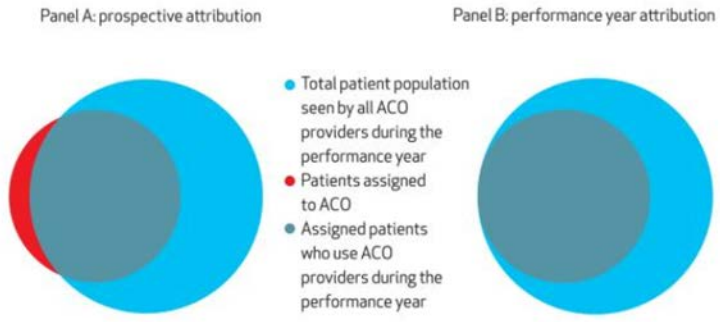
**Retrospective Attribution (Performance Year)[4]:** This method attributes patients at the end of the year based on patients' use of care during the actual performance year based on the actual usage.

| Pros | Cons |
|---|---|
| Ensures accuracy of attribution, since attribution is based on actual utilization and not forecasted utilization. | Retrospective attribution leaves providers guessing who will be attributed to them and designating resources to those that they believe will be attributed. |
| This method is well suited for Medicaid population as the turnover rates throughout the year are high. This method removes patients who no longer receive care from providers including those who have moved or sought care from other providers. | Medicare ACO data shows that approximately 14% will be attributed to a different provider as expected, creating a "free rider" problem[5]. "Free riders" are patients that are being treated by a provider but do not count towards the outcomes of that provider in the end. |
| This method creates a 'veil of ignorance', which increases the likelihood that providers will treat all patients equally since they are unaware of where they may be ultimately attributed. | There is greater inability to assess and make appropriate mid-year adjustments to processes associated with care delivery since actionable data is not available to analyze until the end of the year. |
| For the same reason this method incentivizes greater/improved coordination of care across providers and/or provider organizations. | There is a potential for increased complexity of comprehensive care since the pool of potential attributed lives is inherently larger than the pool of actual attributed lives. |
| It results in a greater concentration of costs for attributed patients increasing the ability to achieve shared savings. | For Level 2 and higher, retrospective attribution introduces a level of financial unpredictability that has proven difficult to address in real-life examples (such as earlier Medicare ACO models). |

[4] Ibid.

[5] Lewis, V.A. (2013.) "Attributing Patients to Accountable Care Organizations: Performance Year Approach Aligns Stakeholders' Interests." Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4230294/ on June 11th 2015.

The Figure below depicts the comparison of the Prospective and Retrospective attributions (in an ACO setting)[6]:




**Comparison Of Prospective Attribution And Performance Year Attribution To Accountable Care Organizations (ACOs): Mean Population Receiving Primary Care Services From All ACO Providers**

**Option 3**

**Hybrid of the above (Retro- and Prospective)[7]:** An initial prospective assignment methodology is utilized with a retrospective reconciliation. It begins with prospective attribution, but each quarter (or 6 months) providers receive a list of patients retrospectively attributed to them based on the most recent twelve months of data. Final reconciliation happens at the end of performance year.

| Pros | Cons |
|---|---|
| New patients are included in a regularly updated assignment during the retrospective reconciliation, as well as patients not receiving care are removed. This allows for a more accurate measure of actual patients served by the providers on a more frequent basis. | With frequent assignment updates provider administrators may find this method more burdensome. |
| Encourages a greater degree of collaboration/information sharing between providers since they may ultimately be attributed lives not originally attributed to them at the start of the performance year. | Executing the attribution methodology is more complex. |
| Compared to pure prospective attribution, this prevents 'attrition' of the member pool, thus increasing opportunity of shared savings. | There is still some financial uncertainty for providers. |

[6] Ibid.
[7] Ibid.

As stated above, these options are relevant for all (sub)population based VBP arrangements as well as the Chronic Bundles. For the **non-chronic bundles** (such as Maternity Care), attribution is more straightforward: a member is assigned to the primary provider of the core service that 'triggers' the bundle, e.g.:

- The commencement of Pregnancy Care (for Maternity Care)
- The performance of Gall Bladder Surgery (for Gall Bladder Surgery)

***NOTE: Given the disadvantages of a purely retrospective attribution methodology for VBP purposes, this option is not included in the Overview.***

### Facet # 2 – How are Patients/Beneficiaries Attributed to Providers

**Option 1**

**MCO Attribution**

In the case of **Primary Care Providers and Health Homes**, it is often the MCO that assigns the member. Although this could be done for other types of providers as well, this is less prevalent.

| Pros | Cons |
|---|---|
| MCOs, PCPs and HHs know who their patients are and can reach out to assigned patients and engage them proactively in coordinating care and developing specialized care management programs as well as preventative care. | Could potentially limit patient's choice in terms of selecting preferred providers. |
| Decreases difficulty in tracking utilization and expenditure data. | There is greater potential for inaccuracy of attribution, since attribution is based on forecasted utilization and not actual utilization. Thus, it increases the likelihood that some patients will be excluded from the attribution process. Furthermore, this issue may be exacerbated by the fact that patients may be unaware of the providers to which they have been attributed. |
| There is greater ability to assess and make appropriate mid-year adjustments to processes associated with care delivery since actionable data is available to analyze during the performance year. | Primary Care Providers may recognize those patients that have not been attributed to them, and they may choose to treat these patients differently (i.e., not expend specific resources on these patients). This could result in two standards of care; one for attributed and one for non-attributed patients. |
| Helps MCOs, PCPs and HHs manage their resources more effectively based on where beneficiaries are attributed. | Also, this method can be flawed when attribution lists are not consistently updated because |

| | |
|---|---|
| | patients change plans and providers over the course of a year. |
| Assignment can be turned into a process of creating a 'contract' between member and Primary Care Provider (with mutual responsibilities etc). | |
| Aligns with current NYS practice. | |

**Option 2**

**Member Choice**

For **Primary Care Providers, Health Homes, (Hubs of) PPSs,** beneficiaries could be asked to choose a provider. Although this could be done for other types of providers as well, this is less prevalent, partly because in many cases, people will already be in care or have no real incentive to choose a particular care provider (e.g. Maternity care) before actually needing the care.

| Pros | Cons |
|---|---|
| Patients have the opportunity to identify their preferred provider(s). | Currently infeasible as a stand-alone method |
| Patients may feel more invested/committed to their healthcare management if they are allowed make choices related to who provides their care. | There will be a time dependency related to data collection from the patients. Especially if this implies that a visit must occur before a member can make a selection. Even if other outreach methods are used, there will be a delay in receiving a response from all patients. |
| Could be incorporated by MCOs and combined with previous option as 'best of both worlds' | |

**Option 3**

**Pattern of use**

Beneficiaries could be assigned to **Primary Care and Health Homes** by their pattern of use of providers. This is the most prevalent method for other types of providers (**PPSs, Hubs, hospitals, medical specialists, home care/nursing home providers, AIDS/HIV centers,** etc).

| Pros | Cons |
|---|---|
| Assignment based on pattern of use would facilitate a more accurate reflection of services rendered. | Diminishes role of MCO; attribution becomes driven by actual member behavior, whether that is responsible care use or not. |

| | |
|---|---|
| Allows for greater flexibility in prioritizing the attribution logic. | Would go against current NYS practice. |
| | This method does not work for beneficiaries who have not used care in the previous year(s) |

**Option 4**

**Attribution Based on Geography**

For **Primary Care**, **Health Homes, PPSs or Hubs**, beneficiaries could be assigned geographically. Although this could be done for other types of providers as well, this is rarely used in practice (except in remote areas)

| Pros | Cons |
|---|---|
| This method is by far the easiest to execute | This method is only useful when there is no other provider in the vicinity. Member utilization patterns show that a pure geographical assignment always contains an error margin. |

## Facet #3 – Who: To What Provider are Beneficiaries/Patients Attributed

**Provider Attribution**

Following the Medicare ACO model and most MCO and commercial models, for **Total Care for the Total Population (TCTP), Integrated Primary Care and the Chronic Care bundle** (with the exclusion of the specialty chronic bundles such as Hemophilia), the suggested provider to whom the member will be attributed is the Primary Care Provider. For Chronic Care bundles, MCOs and providers can also suggest to have e.g. cardiologists or pulmonologists as the focus for the attribution.

- For **non-chronic bundles** such as Maternity care, the suggested provider to whom the episode is attributed is the primary provider of the core service that 'triggers' the bundle (e.g., the obstetrician in the case of the Maternity bundle).
- For the **AIDS/HIV Subpopulation**, the suggested provider to whom the member will be attributed is an AIDS/ HIV center.
- For the **MLTC Subpopulation**, the suggested provider to whom the memberwill be attributed is the a MLTC provider (home and/or residential care)
- For the **HARP Subpopulation**, the suggested provider to whom the member will be attributed is a Health Home.

The provider to whom a member is assigned can be part of a larger entity responsible for the VBP arrangement, such as a PPS, a hub (e.g. one region of a large PPS), or any other combination of providers. This will likely differ per VBP arrangement: a Total Care for the Total Population Arrangement will require a strong combination of Primary Care

Providers as well as Hospital providers; a Total Care for the HARP subpopulation will require strong primary and secondary behavioral and substance abuse care providers, typically part of or associated with a Health Home, for example; Integrated Primary Care will require a strong alliance of Primary Care Providers (including Behavioral Care), and Maternity Care will require Obstetricians and a delivery unit (mostly a hospital).

Although the emphasis on the integrated care services for a member implies that multiple provider (types) will be involved, it is entirely possible that one of the provider (groups) acts as the lead contractor, subcontracting with the other providers in delivering the outcomes for (or below) the expected costs. Also, not all care costs need to be 'in network' (the group of contracting or subcontracting providers): complication costs or drug costs can and will often occur out of network, for example. These costs are included in the bundle or (virtual) PMPM, but contracting these providers might not be feasible or relevant (as in the case of a downstream provider that only touches a small percentage of all cases). These are choices for the providers to make, and the MCO to monitor.