ACOs and the Importance of Patient Attribution

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By SUSAN PANTELY

How organizations assign members to providers establishes accountability.

Payers and providers alike are exploring Accountable Care Organizations ("ACOs")—and integrated delivery models in general—as vehicles for better quality and more efficient health care. While ACOs could alleviate system-wide cost pressures, their success depends on careful design, including the process of how they assign patients to physicians.

Beginning in January 2012, a Medicare pilot ACO program, included in the Patient Protection and Affordable Care Act ("PPACA"), will take effect. Meanwhile, several ACO pilot programs have begun in the commercial market, and are at various stages of implementation.

ACOs share many features of Health Maintenance Organizations ("HMOs") such as care coordination, performance measures, and provider risk-sharing. In the 1980s and 1990s, HMOs experienced rapid growth.

Due to increasing consumer dissatisfaction with the HMO's primary care physician ("PCP") gatekeeper role, enrollment has since declined, however.

Most HMOs require members to choose a PCP, whose responsibilities include referring patients to specialists and screening the use of certain services. HMO architects conceived this gatekeeper—or care coordination—role to promote a more efficient health care system that increases quality and reduces cost. The HMO, in fact, pays PCPs bonuses based on cost efficiency and quality achievements.

Because many consumers prefer choice and unrestricted navigation of the health care system, they have opted instead for plans that don't feature PCP gatekeepers.

Attribution

Similar to an HMO, the ACO model centers on provider accountability and care coordination. Likewise, reimbursement schemes compensate providers based on their ability to achieve efficiencies, meet certain quality metrics and reduce costs.
Unlike an HMO, ACOs do not utilize a PCP gatekeeper. Members are able to seek care from any provider they choose.

In order to measure performance, therefore, the ACO must assign—or attribute—its members to a specific provider.

This attribution process requires the organization's sponsors to analyze health care claims data and develop patient profiles.

In a Patient Centered Medicare Home ("PCMH"), another integrated care delivery model that PPACA enables, members choose a PCP, who receives additional reimbursement for care coordination. But dissimilar to the HMO, members retain open access to providers of their choice. As with the ACO, the PCMH would still require attribution methods to produce meaningful cost and quality reports.

**Definition:** In integrated care delivery models, attribution is the process of assigning members to a provider, or providers. Attribution establishes provider accountability, where the organization deems one individual or a group of individuals responsible for efficiency, quality and cost regardless of which providers actually provide the services.

**Choosing an attribution method**
Selecting an appropriate attribution method begins with several decisions about the characteristics of the desired model. Because the selection will produce a wide range of results, a care delivery organization needs to choose carefully a methodology that achieves its stated objectives.

**Patient-based vs. episode-based attribution:** Patient-based attribution assigns the costs of each patient to a provider or providers. This approach is used to hold providers accountable for the entire spectrum of care for a patient. Patient-based attribution is the more common method for ACO performance measurement.

Episode-based attribution assigns each episode to a provider or providers. An episode is defined as all clinical services for one patient from onset of symptoms until treatment is complete.

Several algorithms are currently available to define episodes based on claims data. This approach is used to hold providers accountable for discrete episodes of care.

Some chronic conditions, such as diabetes management, may result in an episode being defined as a 12-month period, rather than the entire course of treatment.

**Single attribution vs. multiple attribution:** Single attribution assigns the patient or episode to the provider with the highest percentage of services or total cost. Typically, the provider must achieve a minimum threshold of being sufficiently involved in the patient’s care to be held accountable.

If the highest percentage is below this minimum threshold, the patient or episode is not attributed to any provider. Common minimum thresholds range from 25 to 35 percent.
Because patients often see more than one provider, it may not be equitable to assume that a single provider is responsible for a patient’s care. Multiple attribution is designed to allocate the patient or episode to more than one provider.

Multiple attribution methods will result in more patients or episodes being assigned to providers than single attribution methods because many patients or episodes will not reach the minimum threshold required under the single attribution method.

Organizations should also take into account these other considerations when attributing members:

- the allocation method may be based on visits or provider payments.
- the attribution method can include evaluation and management ("E&M") codes only or all physician claims.
- the attribution method can be based on a majority—or plurality—methodology. Attribution using a majority approach assigns the patient to the provider that accounts for 50 percent or more of the visits or costs. If no provider accounts for over 50 percent of the costs, the patient is not attributed. Attribution using a plurality methodology assigns patients to the provider with the highest proportion of visits or costs, usually subject to a minimum threshold.
- the attribution method can limit assignment to PCPs or allow assignment to any physician specialty.

Medicare members have substantially more office visits on average than commercial members. Perhaps not surprising, these visits occur infrequently with the plurality provider.

In contrast, even for the high-utilizing commercial members (defined as members with 11 or more office visits in a year), the majority of visits take place with the plurality provider.

The combined effect of Medicare members making frequent office visits and seeing multiple providers adds complexity to patient attribution in the Medicare population.

The table below illustrates the significant variation between commercial and Medicare populations.

<table>
<thead>
<tr>
<th></th>
<th>Commercial</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number of Annual Office Visits</td>
<td>3.1</td>
<td>7.0</td>
</tr>
<tr>
<td>Percentage of Members with 70% or more of Annual Visits with Plurality Provider</td>
<td>77.6%</td>
<td>27.8%</td>
</tr>
<tr>
<td>Percentage of High-Utilizing Members* with 70% or more of Annual Visits with Plurality Provider</td>
<td>59.0%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

* High-utilizing members are defined as members with 11 or more office visits in a year.


**Prospective attribution vs. retrospective attribution**

Prospective attribution methodologies assign members based on historical claims
data. This method also allows patient and physician notification. Although members are not required to lock in, payers may choose to disclose the physician assignment to the member.

Inherent in the prospective attribution method is the assumption that most members will use the same providers in the future as they did in the past.

The biggest advantage of the prospective attribution approach is its allowance for timely reporting of quality and cost. These reports provide valuable information to providers on performance and allow them to implement the changes necessary to be successful.

A retrospective attribution methodology has the advantage of assigning patients based on their actual utilization. A disadvantage of this method is the inability to provide timely reporting to providers. The ability to provide timely reports allows providers to monitor experience and make prudent adjustments.

Many industry leaders believe that timely reporting is essential to the ACO’s success.

Additionally, providers have voiced concerns that a retrospective attribution methodology does not provide visibility on the patients assigned to them. Supporters of the retrospective attribution methodology argue that a provider should treat all patients in the most efficient manner so advance notification of their patients is unnecessary.

An analysis of Medicare claims from 2007 and 2008 shows that, using a common attribution algorithm, approximately 50 percent of members would be attributed to different providers using a prospective or retrospective approach. Therefore, under a prospective approach, about 50 percent of providers would be accountable for patients that received the majority of their services from other providers.

It may be necessary to perform a retrospective attribution and eliminate patients who chose significantly different providers than in prior years. However, the monthly cost and quality reports would include these patients, making the reports less useful.

Other considerations
The following items should also be considered when developing an attribution method.

Duration: In a commercial population, members may not be enrolled for an entire year. Partial years are less credible so it may be prudent to assign only members with 12 months of experience. In the Medicare population, many members who are not enrolled for an entire year would be members who died.

Because medical costs are higher in the last year of life, consideration should be given to creating cost and quality reporting tools specifically addressing these members in addition to the standard reports.[4]

Members with no claims: Members not having claims during the attribution period
won't be assigned to a provider. These members can be excluded or attributed retrospectively.

Those members with no claims but receiving e-mail consultations or active nurse assistance via telephone may be attributed to the provider offering these services. Because the remote services may have avoided unnecessary office visits, the attribution method should reward and encourage them.

**Member or family unit:** Some attribution methods assign the family unit to the same ACO rather than the individual member. Because families often enter and exit the ACO simultaneously, it may be administratively easier to process the edits and deletes. However, family members may receive services from different providers resulting in a smaller proportion of claims to each provider.

**Credibility:** Providers will need a minimum number of attributed members to produce credible results. PPACA defines a minimum of 5,000 members necessary to form an ACO. Commercial ACOs, with lower average per member per month medical costs, will require a higher number of members to be credible.

**Multiple methods:** Different specialties have different patterns of care. An organization may choose to use different methods for different specialties.

In order to succeed, an organization should consider the following key elements when defining their attribution methodology:

- sensitivity testing of various attribution methodologies on historical claims to identify the specific population's variability and provide insight into possible inequities in the methodology;
- goal alignment where a multiple attribution approach may be better suited for organizations that want to promote more coordination across physicians, and where a single attribution approach may be better suited for organizations that want to increase single provider accountability;
- risk adjustment to account for differences in case-mix or patient morbidity across providers;
- comprehension to providers and other users of the cost and quality reports.

**Conclusion**

As health reform legislation takes effect, government and commercial payers will increasingly utilize cost and quality metrics to assess providers. In many cases, the provider will be accountable for patients without being the sole provider.

Effective attribution answers the question: *Who bears primary responsibility for the continuum of a patient's health care services?* Ineffective attribution will frustrate providers and penalize them for care rendered fully outside their control.

Attribution methods that support valid and actionable cost and quality metrics will be a crucial element in the development of an accountable relationship between provider and patient.
[2] Based on an analysis of Thomson Reuters MedStat MarketScan database. This dataset contains all paid claims generated by over 20 million commercially insured lives, which include claims for self-insured employers and insurers. MedStat is widely used by health services researchers. Contributors are mostly large self-insured employers. For the figures in this report, we used 2008 MedStat and included PPO members only.
[3] Based on an analysis of 2008 Medicare 5% sample. This limited dataset contains all Medicare paid claims generated by a statistically-balanced sample of beneficiaries. Information includes diagnosis codes, procedure codes, and diagnosis-related group (DRG) codes.

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