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Matching Patients with Their Providers: Lessons On Attribution and Enrollment from Four Multi-Payer Patient-Centered Medical Home Initiatives

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As of May 2014, public and private payers and purchasers in 19 states are participating in one or more multi-payer patient-centered medical home (PCMH) initiatives. When multiple payers participate in a PCMH initiative, it becomes necessary to determine which practice is primarily responsible for managing the care of individual patients for two important reasons: the numbers of patients assigned to each practice influences the amount of supplemental payments paid to practices and which patients are assigned to the practice may affect the practice's performance on specific cost, quality, and utilization metrics. Enrollment and attribution are the two general methodologies used to assign patients. As states begin to develop their assignment model for multi-payer initiatives, they will want to consider the degree of alignment desired across payers within the model and an approach for the collection, aggregation, and distribution of patient assignment data. After implementing their models, states will also want to assess the model's accuracy and sustainability. Challenges and key considerations presented in this brief are gleaned from experiences and lessons learned from current multi-payer initiatives in Maryland, Massachusetts, Michigan, and Rhode Island.

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Currently, 30 states are making payments to support patient-centered medical home (PCMH) programs in their Medicaid and Children's Health Insurance Programs[1,2] as a mechanism to support the Triple Aim: improved population health outcomes, improved patient experiences including both quality and satisfaction, and reduced costs.[3] Both public and private payers and purchasers are participating in one or more multi-payer PCMH initiatives in 19 states.[4,5] Multi-payer initiatives provide a supportive platform for the development of high performing delivery systems by dispersing transformation costs among payers and increasing the financial feasibility of transformation for practices. However, these initiatives vary widely in the degree to which core programmatic features, including attribution and enrollment methodologies, are aligned across participating payers and purchasers.

Background and Methodology

This paper was written, in part, as technical assistance for four states (Montana, Nebraska, Pennsylvania, and West Virginia) that are developing multi-payer PCMH initiatives as part of the National Academy for State Health Policy's Multi-Payer Medical Home Learning Collaborative, supported by The Commonwealth Fund. Background information for this brief was obtained from a review of published literature. The key considerations and lessons learned presented in this brief were gleaned through a review of states with multi-payer PCMH initiatives and interviews with key stakeholders in four of those states—Maryland, Massachusetts, Michigan, and Rhode Island; interviewees included initiative leadership, Medicaid officials, and participating commercial payers. Please see the *Acknowledgments* section for a complete list of interviewees.

What is Enrollment and Attribution? Why Does it Matter?

Enrollment and attribution are processes used to assign patients to the primary care provider (PCP) or practice most responsible for providing their care.[6] Often data-driven, Enrollment and attribution determine "how many" and "which" patients are assigned to each practice's panel. When payers calculate payment and performance metrics based on "how many" and "which" patients belong to each practice, the assignment model takes on great significance since it affects both parties' financial bottom line. If the number of patients assigned to a practice is lower than the practice expected, the supplemental PCMH payments may not be enough to support its PCMH infrastructure; conversely, if the number of patients assigned is higher than expected, payers will make more supplemental PCMH payments than they may have budgeted. In addition, if a practice does not provide care for a proportion of the patients that are assigned to its panel, the quality scores for that practice will not accurately reflect its performance on cost and quality metrics.

PCMH initiatives with multiple payers become even more complex since each initiative must decide whether to use one aligned assignment model across all payers or whether each payer will use its own proprietary assignment methodology. Consequently, the decision to align or not to align assignment methodologies will impact the financial investments made by each payer and the supplemental income received by practices. If each payer utilizes a different assignment methodology, it becomes challenging for practices to anticipate a consistent revenue stream that it can use to make necessary investments in staff and infrastructure to support a PCMH. Additionally, one aligned model for assigning patients might provide payers greater assurance that they are all paying a proportional share toward financing the multi-payer initiative. This brief will discuss salient challenges that multi-payer initiatives may encounter when developing and operationalizing their assignment model to assign patients to practices. The findings and guidance are based on experiences and lessons learned from current multi-payer initiatives in Maryland, Massachusetts, Michigan, and Rhode Island.

Choosing a Model: Overview of Enrollment and Attribution

Assignment of a patient to a provider or practice can be accomplished through both enrollment and attribution methodologies (see Table 1). These assignment methodologies have many nuances, including type of utilization data used to identify eligible providers and frequency of assignment reconciliation. The following section will provide a high-level overview of general enrollment and attribution methodologies as they have been written about in the literature and implemented in practice. Both methodologies, defined below, are generically referred to as 'assignment methodologies' throughout the brief:

- **Enrollment**: Method used by payers to prospectively assign patients or allow patients to designate a primary care provider (PCP) at the point of coverage or participation in an initiative.
- **Attribution**: Method used by payers to assign patients to PCPs or practices based on claims utilization data.

Table 1: Overview of General Enrollment and Attribution Methods

	Enrollment	Attribution	
	Prospective	Prospective	Retrospective
Common Plan Types	Commercial health management organization (HMO); Medicaid managed care organization (MCO) and Medicaid primary care case management (PCCM)	Commercial preferred provider organization (PPO); Medicaid fee-for-service (FFS); Medicare FFS	Commercial PPO; Medicaid FFS; Medicare FFS
Availability of Patient Assignment Reports	Prior to performance period	Prior to performance period	After performance period
Patient Assignment Based on:			
Patient's Designation	Some allow patients to designate a PCP; other plans use algorithm to assign	No	No
Claims Data[a]	Varies[b]	Yes; based on historical claims utilization for period prior to performance period	Yes; based on claims utilization during performance period
Eligible Providers:			
Type of Providers/ Practices	PCP[c]	PCP or practice; certain specialists	PCP or practice; certain specialists
Single versus Multiple Providers	Single	Both; varies by method	Both; varies by method

[a] Payers commonly use current procedural terminology (CPT) codes, including evaluation & management (E&M) codes.

[b] Payer-developed assignment algorithms often consider criteria, such as prior claims history not directly related to utilization of services from a provider or practice, related family member assignment, and geographic location, to make a PCP assignment.[7]

[c] Depending on state and payer, the term 'Primary Care Provider' (PCP) can refer to various practitioners, including, but not limited to, family medicine practitioners, pediatricians, internal medicine practitioners, nurse practitioners, and physician assistants.

Attribution Methodologies

Attribution utilizes claims data to assign responsibility to a PCP or practice, either retrospectively or prospectively, for the provision and coordination of a patient's care.[8] Attribution methodologies vary further based on criteria, including eligible services and providers (see text box), which creates a matrix of attribution options.[9] Medicare and Medicaid fee-for-service (FFS) and commercial plan types, such as preferred provider organizations (PPO), frequently assign patients using attribution.

Retrospective Attribution

Retrospective attribution assigns patients based on actual claims utilization data from a specified, previous

Areas for Variation Among Attribution Methodologies

- Type of claims data used to attribute patient
  - E.g. current procedural terminology (CPT), including evaluation and management (E&M) codes
- Eligible Services
  - E.g. well visits, sick visits, other preventative services
- Eligible Providers
  - Primary care providers
  - Some specialists
  - Nurse practitioners and physician assistants
- Other
  - Length of look back period
  - Majority versus plurality of visits or total cost of care
  - Attribution to provider versus practice
  - Attribution to single versus multiple providers/practices
  - Frequency of attribution reconciliation

period, called the 'performance period' or 'look back period.' This model ensures that payers are only making payments on behalf of patients that utilized specific services during that performance period. Delays in the availability of patient assignment data are often associated with this type of attribution.[10] Lags in this data, and associated quality and performance reports, have the potential to slow down practices' quality improvement and cost containment efforts.[11] This can be detrimental to practices participating in initiatives with performance-based payments where performance is evaluated based only on their assigned patient panel. Proponents of this method suggest that, even though practices may be delayed in knowing which patients will be assigned to them, this method encourages fundamental practice transformation that will ultimately benefit *all* patients, rather than emphasizing targeted improvements for only select patients.[12]

Prospective Attribution

Prospective attribution uses historical claims data to assign patients prior to a performance period.[13] Advanced knowledge of assigned patients can help a practice better manage and coordinate care for its assigned patient population, potentially affecting its performance on cost and quality metrics.[14,15] Similar to retrospective attribution, prospective attribution is limited in that it cannot assign patients with an unknown claims history, a frequent occurrence when patients switch health plans. For patients with a known claims history, prospective attribution is also limited in that it cannot account for when those patients seek care different providers.[16] Because of this, a payer may risk making payments to practices on behalf of patients for which it never provided or no longer provides care.

Enrollment Methodologies

Enrollment is commonly used by health management organizations (HMO) and managed care organizations (MCO)—including MCOs contracted by Medicaid—to assign patients to a participating provider or practice. Patients designate a PCP or are prospectively assigned using an algorithm developed by the payer; algorithms may assign patients based on criteria, such as historical claims data not directly related to utilization of services from a provider or practice,[17] related family members' PCP assignments, and geographic location.[18] Contracted providers are provided with a list of assigned patients in advance of the performance period, facilitating more opportunities for patient management and coordination of care.[19] In multi-payer initiatives using both retrospective attribution and a prospective assignment method, such as enrollment, payers utilizing prospective assignment may find that they are making a larger financial commitment to the initiative than their counterparts using retrospective attribution. Typically, payers using prospective assignment methods make payments to practices for their assigned patients, regardless of whether or not those patients seek care from their assigned practices; however, payers using retrospective attribution only make payments to practices for patients that utilize specific services during that performance period.

Developing an Assignment Model

An initiative's unique composition of stakeholders, including payers, purchasers, providers, and political environment, will influence how its assignment model develops. States will need to determine the degree of alignment desired across payers within the model and determine a means of data collection, aggregation, and distribution. These key programmatic features are often affected by the initiative's payer market and payment methodology.

Striking a Balance Between Flexibility and Alignment

An initiative's assignment model can be entirely aligned —all payers using a single, agreed upon model—or can allow for varying degrees of flexibility. Advantages and disadvantages of alignment and flexibility are briefly discussed.

Aligned Models:

Advantages

- Payers may make proportional financial contributions to practices when they use the same assignment method.

Table 2: Summary of Enrollment and Attribution Methods Used in Four States

	Participating Payers (by type)			Enrollment		Attribution				
	Medicaid	Medicare	Commercial	Payers involved or participating	Method of assignment	Payers involved or participating	Prospective or retrospective	Aligned across payers[b]	By practice or provider	General method
Maryland Multi-Payer Patient Centered Medical Home Program[20]	Yes; managed care only	No	Yes	MCO; commercial HMO	Prospective assignment; retrospective reconciliation of claims data	5 largest commercial payers in state	Retrospective	Yes	Practice	• Adapted from commercial payer • Claims data reported every 6 months; 2 year look back period • Maryland Health Care Commission calculates attribution centrally
Massachusetts Patient-Centered Medical Home Initiative[21]	Yes; state-operated & commercially-operated managed care	No	Yes	MCO; commercial HMO	Prospective	Commercial PPO	Retrospective	Mostly[c]	Provider	• Massachusetts Health Quality Partners algorithm • 18 month look back period • Claims volumes reported every 12 months • Each payer calculates attribution for PMPM payments; third party makes shared savings determinations
Michigan Primary Care Transformation Demonstration Project[22]	Yes; Medicaid agency making payments on behalf of MCO patients	Yes	Yes	MCO; commercial HMO	Prospective	Commercial PPO; Medicare FFS	Prospective[a]	Yes[d]	Practice	• 'Five-Tiered Approach' adapted from commercial payer • 1st tier – 12 month look back period • Claims reported to Michigan Data Collaborative (MDC) every 6 months in order to calculate incentive payments • Most payers calculate own attribution • MDC prospectively provides multi-payer patient assignment list to physician organizations monthly for dissemination to practices
Rhode Island Chronic Care Sustainability Initiative[23]	Yes; managed care only	Yes	Yes	MCO; commercial HMO	Prospective	Commercial PPO; Medicare FFS	Retrospective	Partially	Practice	• Each payer uses slight variations on similar model • Varied look back periods • Claims reported quarterly • Each payer calculates attribution

[a] Michigan's payment methodology has multiple payment streams, including a performance incentive payment that is paid retrospectively; prospective attribution allows payers making care management PMPM payments on the basis of patients assigned to them in the monthly MDC reports.

[b] Aligned indicates the attribution method used is consistent across payers.

[c] All but one commercial payer is utilizing the Massachusetts Health Quality Partners algorithm while it undergoes final testing by the organization. All commercial payers will use this algorithm once testing is complete.

[d] Substantial alignment with small operational modification made to attribution algorithm for Medicare.

- One consistent assignment method and consistent expectations for payment across payers makes it easier for providers to understand the model.

Disadvantages

- Payers may need to make alterations to their claims and billing administrative systems to accommodate a different assignment method.

Flexible Models:

Advantages

- Flexibility may lessen the administrative investment required for payers to participate and may encourage the participation of those less willing to discuss proprietary information with competitors.

Disadvantages

- Payers may make uneven financial contributions to practices.
- Providers may find it challenging to understand how patients are being assigned and the frequency and methodology by which they are paid.
- Quality and performance metrics might not be indicative of practices' quality of care due to variances among assignment methods.[24]

In practice, many multi-payer initiatives are allowing for some flexibility in the assignment methodology used based on the payer's needs and capabilities. The trend toward greater payer flexibility is seen in **Nebraska**'s Multi-Payer PCMH Initiative. Their initiative, launched in January 2014, gives payers the latitude to utilize their own proprietary assignment methodology (see text box). In the four initiatives reviewed for this brief (see Table 2), all retained some payer flexibility by at least allowing participating MCOs and HMOs to continue to utilize their enrollment methodologies to assign patients prospectively or based on patient designation.

- In **Massachusetts**, all but one commercial payer modified their approaches and use the attribution algorithm developed by the Massachusetts Health Quality Partners (MHQP);[25] the small proportion of commercial PPO patients is being attributed retrospectively. All other participating payers utilize enrollment.
- **Rhode Island**'s participating commercial plans and Medicare utilize similar retrospective attribution methodologies; each payer has made slight alterations to a generally agreed upon method to best meet their needs.[26]
- In **Michigan**, all FFS/PPO commercial plans and Medicare utilize a common 'five-tiered' attribution methodology. Payers prospectively assign patients to practices based on historical claims data and report this information to the Michigan Data Collaborative (MDC) monthly. The MDC then compiles this information into

Nebraska Multi-Payer PCMH Initiative

Commercial payers and Medicaid MCOs in Nebraska signed a voluntary participation agreement in January 2014, officially launching a two-year multi-payer PCMH initiative.

The initiative takes a wholly flexible approach to payment methodology, quality metrics, and PCMH certification requirements. Each payer, however, is required to contract with an average of 10 PCMH practices annually over two years.[a] As payers begin to contract with practices, they will have to make individualized decisions about how to assign patients to these contracted practices. The participating Medicaid managed care plans are using enrollment methodologies to assign patients to their contracted practices.[b] One large commercial payer utilizes algorithms developed by a data analytics vendor to retrospectively attribute its patients and concurrently report this data to contracted practices.[c]

[a] See Nebraska Participation Agreement for more information: http://news.legislature.ne.gov/dist35/files/2013/12/Final-agreement-on-ltrhd-12-18-2013-corrected.pdf.

[b] Correspondence with Dr. Bob Rauner, SERPA-ACO.

[c] Correspondence with Dr. David Filipi, Blue Cross and Blue Shield of Nebraska.

one multi-payer patient list, which it provides to physician organizations (PO) for distribution to their practices.[27]

- **Maryland**'s MCOs are utilizing preexisting enrollment methods to assign patients, while commercial payers are utilizing an aligned retrospective approach. Based on concerns that MCO patients may not have an association with their assigned practice, MCOs pushed to more closely align with commercial payers' retrospective attribution method by implementing a process for MCOs to reconcile patients' practice assignments every six months. In order to qualify for payment, the practice must see that Medicaid patient for at least one visit per enrollment period (12 months).[28]

An aligned assignment model may be less critical for a multi-payer PCMH initiative to develop if payments are not contingent on number of assigned patients, and instead are at least partially based on other criteria, such as becoming qualified as a medical home recognition or a meaningful user of electronic health record (EHR) systems.

Composition of the Payer and Purchaser Market

Payers participating in the multi-payer initiative will influence decisions about the degree of flexibility or alignment in an assignment model. For initiatives heavily dominated by managed care or HMOs, an aligned assignment model is less of a necessity since these participating entities likely have patient assignment methods in place prior to participating in the initiative. Conversely, in initiatives dominated by commercial plans and Medicaid and Medicare fee-for-service—plans that have not typically required patients to designate a PCP—balancing the flexibility desired by payers and the alignment desired by providers becomes more challenging. Participating national commercial payers may also have their own single-payer programs or participate in initiatives in other markets utilizing different models.[29] Commercial single-payer PCMH initiatives already in place may also have a pre-tested model that can serve as a baseline for the development of a program-wide model.

- **Maryland** and **Michigan** both adapted established commercial models to serve as the basis for their initiative-wide attribution model.[30]
- In the **Massachusetts** Patient-Centered Medical Home Initiative—consisting of approximately 85 percent Medicaid managed care—there was little contestation over assignment models among participating payers.[31]

Payment Methodologies

As of May 2014, 19 multi-payer initiatives are providing practices with additional per member per month (PMPM) payments to support the increased costs of a practices' medical home activities and at least six are also providing performance-based payments based on a practice's ability to achieve cost and quality metrics for their assigned patient panel.[32] Patient assignment can be extremely important to practices' overall financial solvency, especially if the payments they receive for participating in an initiative are paid per member per month (or actuarial equivalent) for assigned patients. Large variations, either in the number of patients assigned each performance period or between the assigned patient panel and a practice's self-identified panel, can impact, for example, a practice's financial bottom line by impacting their ability to make organizational investments in PCMH transformation. Additionally, in initiatives where there are performance-based payments that are calculated based only on assigned patients, practices' performance will vary depending on how patients are assigned. Although no method is perfect, retrospective attribution, for example, may skew practices' performance if the method assigns patients to practices that did not provide care or if the method is not sensitive enough to assign healthy, well-managed patients that seek care infrequently.[33]

- **Michigan** offers fixed PMPM payments (or the equivalent) that include payment for practice transformation, care management, and performance.[34]
- **Maryland**'s shared savings model stipulates that payers make payments to practices based on cost savings and achievement of quality metrics only for patients that can be assigned to that practice for

both a comparison year and current performance year. Payers make shared savings payments proportional to the amount of patients in a practice's panel.[35]

An aligned assignment model may be less critical for a multi-payer PCMH initiative to develop if payments are not contingent on number of assigned patients and instead are at least partially based on other criteria, such as becoming qualified as a medical home recognition or a meaningful user of electronic health record (EHR) systems.

- **Rhode Island** allows practices to calculate and report on required performance metrics based on the *entire* panel recorded in their EHRs, rather than just the subset assigned by payers. Similarly, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is given to all patients identified by the practice, rather than only those assigned by payers. Stakeholders recognized that calculating a practice's performance based exclusively on the subset of patients assigned by payers would likely not yield an accurate representation of the quality and cost of care actually provided. Although practices receive PMPM payments based on the number of patients assigned by payers, the rate of the PMPM payment is set based on practice's self-reported performance data.

Strategies to Collect, Aggregate, and Report Data to Assign Patients

Collecting and aggregating claims data and/or patient assignment information to produce patient lists and performance reports, and then reporting this information to practices is crucial to their understanding of "how many" and "which" patients are on their assigned patient panel. This can be accomplished collectively through a centralized data collection entity or platform or done individually by each payer. Advantages and disadvantages of centralized aggregating and reporting are briefly discussed.

Centralized Data Collection and Reporting:

Advantages

- Centralized data collection entities have the potential to streamline data across payers and minimize confusion for providers.
- Centralized data collection entities allow for participation by payers that do not have capabilities to perform assignment calculations.
- By aggregating data, centralized reporting can create a critical mass of patients necessary to significantly report on practices' performance on cost and quality of care.[36]

Disadvantages

- A centralized data collection and reporting platform may require an all-payer claims database (APCD) or precursor APCD, which can be a significant financial investment for the state.
- The secure transfer of large volumes of data by payers when reporting data can be very resource intensive.[37]
- Delays in reporting of data by payers may result in delays in patient assignment reports and ultimately in payments to practices.

The **Maryland** Multi-Payer Patient Centered Medical Home Program and the **Michigan** Primary Care Transformation Demonstration Project both utilize a centralized data collecting and reporting entity to support their patient assignment models.

- The **Maryland** Health Care Commission (MHCC) operates a centralized platform that calculates patient attribution. Payers report claims or encounter data to MHCC on a semi-annual basis for their participating patient population. The MHCC then attributes the patients to practices and reports this information back to the payers. Each payer crosswalks the attributed patient list with their own membership system to ensure that these patients are still members of their plan and reports the final list to each practice.[38]
- The **Michigan** Data Collaborative (MDC) collects member lists from payers on a monthly basis and integrates them into one multi-payer member list that is distributed to Michigan's physician organizations (PO). The POs disseminate these member lists to its practices. The MDC also uses claims data reported by payers to calculate practices' performance on various utilization and quality metrics and distributes these in "dashboard" reports that are updated every two months.

The Chronic Care Sustainability Initiative (CSI) in **Rhode Island** provides an example of a multi-payer initiative that does not use a centralized reporting entity. Each payer is responsible for reconciling claims data quarterly for their patient population and subsequently sending a list of assigned patients to practices.[39] Payers in the **Massachusetts** Patient-Centered Medical Home Initiative calculate patient assignment in-house.[40]

The Accuracy and Sustainability of Assignment Models

After implementing the assignment model, states will need to review the model to assess if it is assigning accurate and consistent patient panels to practices, particularly for models using attribution. Additionally, the state should plan for the sustainability of the model beyond the initiative's course as a demonstration. Changes in payment models, payer participation, and funding sources will all play a role in the longevity of the model, especially if an initiative intends to transition to a permanent state program.

Addressing the Accuracy of the Model

The accuracy of the enrollment and attribution methods used has significant financial implications for both payers and practices. In initiatives providing enhanced or supplemental PMPM payments, practices depend on these funds to help build their PCMH infrastructure. Similarly, payers want to ensure they are only paying for care being provided to their patients. This section highlights several challenges that surfaced in the four states once their models were in place and how they have worked to address them.

Challenge 1: The assigned patient panel is smaller than practices anticipated.

Practices in **Maryland**, **Michigan**, and **Rhode Island** cited concerns that patient panels were smaller than they had anticipated, which can impact the amount of additional payments they receive. Some patients may be absent from a panel if they had no prior claims history to prospectively assign them to a practice, or, depending on the type of utilization data and eligible codes used, patients may be retrospectively attributed to another PCP or specialist.

Increased education for providers and practice leadership may be key to helping practices anticipate the size of the patient panel, especially in initiatives where each payer is using a different method. **Rhode Island** provided reports to practices at the beginning of their initiative and worked with providers to help them understand the assignment and payment methodologies. The state also examined what proportion of a practice's total patient panel (as reported from their EHR) was being assigned using the initiative's model and determined practices have consistently received payments for between 60 and 70 percent of what they believe was their total patient panel.[41]

Challenge 2: The assigned patient panel size is inconsistent across performance periods.

For practices receiving enhanced payments based on a fixed PMPM calculation, large changes in their assigned panel size may have significant ramifications on their ability to budget and fund medical home activities. In initiatives where Medicare is participating, patient attribution frequently fluctuates due to some patients having seasonal residencies in other states. For Medicaid, income fluctuations may result in patients frequently churning on and off the list of assigned patients during certain performance periods;[42] this has been a challenge for care managers in **Michigan** who have engaged patients in care management services only to have patients churn on and off coverage. In **Maryland**, although the enrollment method for Medicaid was not considered perfect, a review showed those patients that transitioned off coverage roughly equaled those that transitioned on, affording practices relative consistency in the amount of supplemental PMPM payments they received.[43] In **Rhode Island**, to safeguard against frequent variation in practice income across performance periods, the initiative added a 'confidence interval' provision into the original practice contracts. The provision stated that practice payments would not vary as long as its assigned patient panel remained within 5to10 percent of the previous quarter. This clause has since been removed from the practice contracts because the state found patient assignment has remained very stable over time.[44]

Challenge 3: A provider leaves one practice for another.

Inconsistency in patient panel over time may also be due to how patients are assigned when their assigned provider

leaves a practice, once again potentially impacting a practice's financial bottom line. For patients that remain with a practice and receive some level of care, failure to include those patients on an assigned panel may have substantial financial implications, especially for smaller practices. States will want to consider devising timely strategies to reassign patients when they develop their assignment model. For an example, stakeholders involved in the **Rhode Island** CSI created a 'nine month wash-out period.' During this period, the practice that lost a provider will continue to have all of his/her patients assigned to the practice for the subsequent nine months except for those patients that seek care at another practice in the initiative.[45]

Challenge 4: Patients are not being assigned to the practice that is most responsible for their care.

Ensuring a patient is assigned to the PCP most responsible for managing their health care is a challenge cited by payers utilizing both enrollment and attribution. Payers using enrollment have concerns that some payments made during a performance period may be for patients who have no real connection with their assigned practice. To address this concern, **Maryland** now allows MCOs to retrospectively reconcile their patients with claims data showing that these patients sought care from their assigned PCP at least once during the performance period prior to making enhanced payments on behalf of that patient.[46] In **Rhode Island** it is up to the discretion of each payer to select the type of claims data (e.g. CPT codes) and eligible codes that will assign patients to the most appropriate practice.[47]

Challenge 5: Retrospective attribution creates a lag in cost, utilization, and quality data.

Retrospective attribution will always inherently have at least some lag in cost, utilization, and quality data since patients cannot be assigned until after the performance period has ended. **Maryland** and **Rhode Island** have both implemented strategies to attempt to mitigate this challenge; Maryland requires payers to submit claims utilization data within 60 days of the close of the six-month performance period in order to ensure that practices are able to implement quality improvement strategies that meet the needs of their assigned patients.[48] Rhode Island requires that each payer reconcile its attribution data quarterly.[49] Although some payers in **Michigan** use prospective attribution to assign patients, the initiative has partnered with a vendor to increase its care managers' timely access to their patient lists by making the lists available electronically..[50]

Sustainability

As initiatives evolve, the method of patient assignment will need to adjust to correspond to changes in payment models, payer participation, and operational funding sources, especially if the initiative is to become a permanent program within the state. For example, if an initiative adds a shared savings component to its payment methodology, the assignment model may need to be altered to more sensitively assign patients to the practices most responsible for managing the cost and quality of their of care. The importance of accuracy in patient assignment—as opposed to simply maintaining consistency—increases substantially as initiatives incorporate additional up and/or downside risks into their payment models.

Operational funding sources, such as those used to operate a centralized data collecting and reporting entity, can also affect the sustainability of an assignment model. These infrastructural investments may initially be funded through grants or absorbed by the state or other convening organizations. **Michigan** included a small administrative fee across participating payers to pay for project infrastructure, services, and coordination. The **Maryland** Patient Centered Medical Home Program's centralized attribution platform, for example, would require a large financial and administrative investment by the state if the program were to expand statewide, and, without a significant influx of funding, may not be able to be scaled to accommodate the increased volume of patient claims data required to perform the assignment calculations.[51] As a result, to continue an initiative, payers may need to alter how data is collected and reported, manage their own assignment models, or share in the operational cost of infrastructure.

Key Considerations

Through review of the literature and conversations with multi-payer PCMH leadership, commercial payers, and Medicaid officials, the following key considerations emerged for states:

- **An aligned assignment model can create consistent expectations for providers across payers, but is not a necessity.** Alignment has varying importance depending on the initiative's specific payer and purchaser composition and payment methodology. For example, in an initiative with a large proportion of MCOs and HMOs—plans that have traditionally continued to utilize their existing enrollment methodology—alignment of attribution methods might not be necessary. However, in initiatives with a high proportion of payers utilizing an attribution methodology, developing one aligned model may help ease the burden on providers to understand how patients are being assigned and the frequency and methodology by which they are paid.
- **Prospective attribution is a less commonly used assignment method that states may wish to consider**. Among the four multi-payer initiatives examined, prospective attribution has been implemented by some payers participating in the Michigan Primary Care Transformation Demonstration Project. Prospective attribution may be a way for public and private fee-for-service payers to assign patients in a similar way to payers using enrollment.
- **Providers tend to value consistency in number of assigned patients over accuracy of assigned panel.** In initiatives that make PMPM payments, patient assignment will greatly affect a practice's financial sustainability. States should develop a means to verify the accuracy of their assignment model to ensure it is assigning patients as consistently and accurately as possible.
- **Patient assignment influences return on investment for payers.** If initiatives calculate practices' performance based only on the cost, utilization, and quality metrics for practices' assigned panels, patient assignment can greatly influence payers potential return on investment.
- **As initiatives evolve, the method of patient assignment may need to be adjusted.** Payment methodologies, payer participation, and operational funding sources may change, especially when an initiative transitions to a permanent program within the state.

Conclusion

Support for multi-payer initiatives will require significant financial and infrastructural investments by the state, payers and purchasers, and providers. Securing broad stakeholder engagement will be paramount in developing an assignment model and data support mechanism that balances both the payers' desires for flexibility and the providers' need for consistency. The model ultimately developed to assign patients to a provider or practice will have ramifications on the financial investments made by payers, the financial sustainability of PCMH for practices, and the accuracy of practice- and initiative-level performance data. Experiences and examples from several states provide a wide range of variable assignment approaches that could guide other states' efforts. As states move further towards accountable care models, they will continue to face challenges related to accurately assigning patients to practices that are most responsible for their quality and total cost of care.

Endnotes

1 National Academy for State Health Policy, "Medical Home & Patient-Centered Care," accessed on April 3, 2014, http://nashp.org/med-home-map.

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