CAQH Insights℠

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ISSUE BRIEF

Communicating Patient Attribution

A roadmap for reducing administrative burdens in value-based payment initiatives

Introduction

As part of a strategy to improve both the quality and efficiency of the U.S. healthcare system, public and private health plans have implemented value-based payment (VBP) models as an alternative to the traditional fee-for-service (FFS) payment structure.[1,2] In a VBP model, health plans and providers agree to a reimbursement arrangement designed to incentivize better outcomes, rather than higher volume.[3,4]

Patients are assigned to providers participating in a VBP model through a process called "attribution." Attribution methodologies often utilize healthcare claims data (e.g., number of encounters, spend, etc.) to identify the patient populations of which the providers are accountable.[5] Attribution methodologies vary among health plans, and most do not adhere to a single standard for determining how patients are assigned to program participants.[6]

Once attribution has been determined by health plans, they must share the assigned lists of patients with the providers in a VBP arrangement. Due to existing obstacles in communicating attribution, providers may be aware that patients are assigned to them but struggle to understand which patients they are accountable for in the arrangement.

Providers often face challenges with how often and in what way attribution information is shared. This can lead to excess time reviewing and ingesting the data. Understanding how to reduce provider burden associated with attribution can help ensure that VBP models are able to effectively deliver on their promise.

Survey Findings

To better understand how patient attribution information is exchanged and the challenges providers face, the 2023 CAQH Index asked medical providers if they were able to determine patient attribution and common methods used to exchange this information.[7,8] Providers were also asked about the frequency and time associated with the exchange of attribution information. These questions matched those asked in the 2020 CAQH Index, allowing for an assessment of change over time.[9]

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For the 2023 Index, providers were asked two new questions: 1) What percent of your patients are assigned to a VBP contract? and 2) What is the percentage increase in patients assigned to a VBP contract? These questions provide a snapshot into the current progress of VBP saturation within the industry. Additionally, the 2023 Index collected data by provider types — generalists, specialists, and behavioralists — which allowed for VBP participation to be compared between groups.

Determining Attribution

While there are different ways to determine attribution on behalf of a health plan, each option should ultimately result in the provider being aware of the patients for which they are accountable. The 2023 results, consistent with those from the 2020 CAQH Index, indicated that the majority of providers were able to determine if a patient was attributed to them (62 percent).

Are you Able to Determine Your Patients in a VBP Arrangement?	2020	2023
Yes	60%	62%
No	10%	7%
I Don't Know	30%	31%

Also consistent with 2020 results, 38 percent of providers reported that they either did not know or could not determine if a patient was attributed to them (31 and 7 percent, respectively). This can harm optimal care coordination and diminish the return of incentives if contractual obligations — reliant on the correct identification of patients — are not fulfilled.

Exchanging Attribution Information

In addition to varying attribution methodologies, the mode in which attribution information is exchanged from health plan to provider can vary depending on the technology, systems and infrastructure used. Providers reported that the most common method (34 percent) to receive attribution information was by directly interfacing with an Electronic Health Record (EHR) or Electronic Medical Record (EMR). This indicates growth from 2020, when it was the third most common method at 25 percent. This shows that the industry has made progress in integrating attribution data directly into the health record, a key avenue for automating this process and reducing provider burden. Other direct interfaces include the ASC X12N 270/271 transaction, as facilitated by the CAQH CORE Single Patient Attribution Operating Rule.[10]

How are You Receiving Attribution Information from Your Contracted Plan?	2020	2023
Direct Interface with EHR/EMR	25%	34%
Interactive Web-based Portal	30%	29%
Email Attachment	26%	11%
Clearinghouse	2%	10%
Excel File Download	11%	9%
Eligibility and Benefit Transaction (270/271)	7%	4%
Other	0%	3%

Despite the benefits of electronic modes of data exchange, non-automated alternatives still represent nearly half of the methods providers use to receive attribution information from plans (49 percent). In 2023, the second most common method used to receive attribution information was through a health plan web portal (29 percent) which requires staff to manually log into health plan web portals to retrieve the needed attribution data. Non-automated options also include email attachments (11 percent) and Excel file downloads (9 percent).

The consistent use of non-automated options indicates that the industry still has an opportunity to streamline the exchange of attribution information. As part of this effort, CAQH CORE published the CORE Eligibility & Benefits Single Patient Attribution Data Rule in 2020 which allows a health plan to notify a provider if a patient is a part of their VBP contract population within the existing eligibility workflow,

without extra effort on behalf of the provider.[10] While results indicated that only 4 percent of providers received attribution data through the eligibility and benefit transaction, this is anticipated to grow based on the continued increase in adoption of the 270/271 transaction and corresponding operating rule.[8]

Frequency of Exchanging Attribution Information

Similar to results from 2020, the frequency in which providers received attribution data from contracted health plans varied. Slightly over 50 percent of providers received attribution files at least monthly. This is up almost 10 percent from 2020, indicating that attribution information is being exchanged in a timelier manner.

How often Are You Receiving Provider Attribution Information from Your Contracted Health Plan?	2020	2023
At least monthly	45%	54%
Less frequently than monthly	55%	46%

Even with this progress, there is still room for the industry to enhance and standardize how often this information is shared. The CORE Attributed Patient Roster Operating Rule Set establishes consistent intervals for the exchange of attribution information (no less than monthly) through the X12 005010X318 Member Plan Reporting (834) transaction.[11] Recent improvements to the CORE Operating Rule, as determined by CORE Participants, can also facilitate the exchange of socio-demographic information to improve the quality and use health equity data within VBP arrangements. Sharing member information using the transaction and corresponding operating rule benefits participants by arming them with the patient information necessary to be successful in VBP contracts.

Time Spent Reviewing Attribution Information

Since attribution methods vary in format and frequency, providers spend considerable time reviewing this information and determining patient assignments for their practice. While over three quarters of providers (79 percent) indicated that office staff spent less than an hour reviewing attribution data, 12 percent spent more than 2 hours. Even though reviewing this information remains a burden, fewer staff reported spending over 2 hours reviewing this information in 2023, suggesting increased efficiencies.

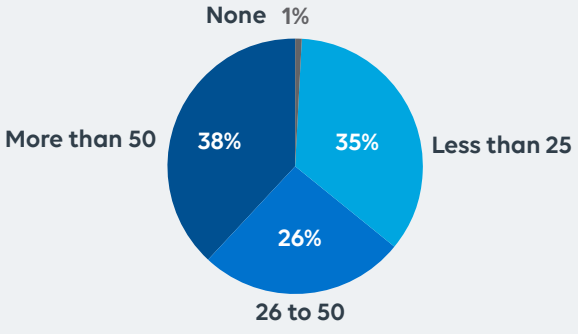
For a Given VBP Contract, How Long Does It Take Your Office Staff to Review Attribution Information?	2020	2023
<1 hour	36%	79%
1-2 hours	36%	9%
>2 hours	28%	12%

Given that non-automated processes remain the most common methods for exchanging attribution information, promoting fully electronic options can help reduce time spent by providers on this task. Adopting existing operating rules and standards can alleviate provider burden, encouraging further use and standardization.

Patients Assigned to VBP Contracts

New in the 2023 Index, providers were asked to report the current percentage of patients attributed to a VBP contract and growth from the previous year. These questions provide a snapshot of the progress made in transitioning from FFS to VBP arrangements.

What Percent of your Patients are Assigned to a VBP contract?



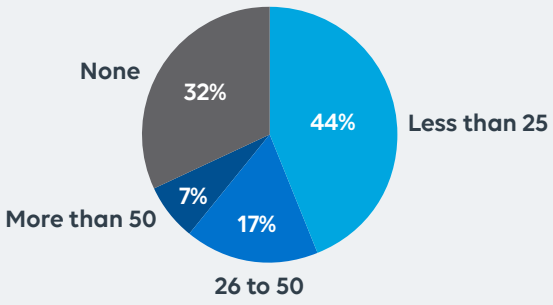
Most providers indicated that less than half of their patients were assigned to a VBP contract. Of these, 36 percent of providers indicated that a quarter or less of their patients were assigned to a VBP contract. As VBP contracts become more widely used, this number is expected to increase.

When comparing these numbers by practice size, larger practices reported that more of their patients were assigned to a VBP contract than smaller practices. This is consistent with past findings on VBP participation, suggesting that practices with greater resources are more likely to participate in VBP contracts.[12]

When evaluating participation by specialty, generalists were much more likely than specialists and behavioralists to report participating in VBP arrangements. Among providers that participated in the 2023 CAQH Index, 44 percent of generalists indicated that they were in a VBP arrangement, as opposed to 15 percent of specialists and 7 percent of behavioralists.

Generalists have more opportunity to benefit from VBP arrangements given care coordination typically begins with them and, if managed well, costly procedures and admissions can be reduced and outcomes improved.[13,14,15] Additionally, the cost constraints and complexities associated with VBP contracts often don't align with the priorities or workflows for specialists.[16] CMS is attempting to resolve this gap, but these results show more work is necessary to incorporate those outside of primary care into a VBP framework.[17]

What is the Percentage Growth in Patients Assigned to a VBP Contract (2022 vs. 2021)?



When asked about growth in the percent of patients assigned to a VBP contract over the past year (2022 compared to 2021), 61 percent of providers reported a modest to major increase (up to 50%) suggesting continued acceptance of VBP contracts. The industry can anticipate the continued growth of VBP as initiatives take on an increasingly larger role in the future.

Moving Forward

Efficient and consistent communication of attribution information continues to be a key area of opportunity associated with complex VBP models. The results from the 2023 CAQH Index are promising and demonstrate that the industry has made progress in increasing the frequency of exchange and reducing the time for review of attribution information. However, improvements can still be made to alleviate the existing burden on providers.

As the use of these models grows and providers continue to experience persistent staffing pressures,[18,19] the opportunity to reduce complexity in communicating attribution is even more important for the industry. Adopting electronic standards and implementing operating rules specific to VBP can strengthen engagement with VBP models, helping to improve health outcomes and reduce unnecessary costs across the U.S. healthcare system.

Methodology

The 2023 CAQH Index included questions related to patient-provider attribution for VBP models. The measurement period was representative of January 1 to December 31, 2022. Results from this survey have been weighted to represent a national distribution of physicians by practice size and specialty as reported by the American Medical Association (AMA) and the American Association of Medical Colleges (AAMC).[20,21] For more details on the methods used to generate results, see the 2023 CAQH Index.

About CAQH Insights

Through research and partnerships across the industry, CAQH Insights identifies opportunities to streamline business practices and measure the impact of a more automated healthcare workflow. For more information about research conducted by Insights, please visit caqh.org/insights.

End Notes

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