CAQH Explorations

ISSUE BRIEF

Communicating Attribution: Accessibility of Information to Support Value-based Payment Initiatives

November 2021

Introduction

Compared to traditional fee-for-service (FFS) models where a provider submits a claim for each medical service conducted and the health plan reimburses the provider per service claim[1], value-based payment (VBP) models are designed to assign accountability to health care providers for the clinical and cost outcomes of their patients.[2] In VBP models health plans assign a fixed payment, or incentive, based on a set of performance and quality measures that each provider or hospital is required to meet during a specified performance period.[3] These performance and quality metrics are critical for providers participating in a VBP arrangement since they form the basis of analyses for total costs of care, patient outcomes and potential health plan and provider shared savings. These metrics may also be publicly reported and used by patients to compare providers based on the quality and cost of services rendered.[4]

Since providers, health plans and patients alike rely on these performance measures, it is critical that VBP structures start by defining accurate assignment of patients to providers. The process that health plans use to assign patients to the providers who are held accountable for their care is called "attribution." The attribution approach is not simple, however, as health plans can use a variety of attribution methodologies to assign risk and patient populations to providers and no uniform attribution standard has been developed or mandated.[5]

Many providers face challenges in understanding which patients are attributed to them in a VBP model due to the varied attribution methodologies used by health plans, the lack of standardization over the modes used to exchange attribution information, and the inconsistencies related to the frequency of data exchange and the time to review attribution information. Understanding provider burden associated with attribution can help health care stakeholders target specific areas of improvement—allowing providers to focus more time on implementing successful care coordination and management strategies for their patients.

Survey Findings

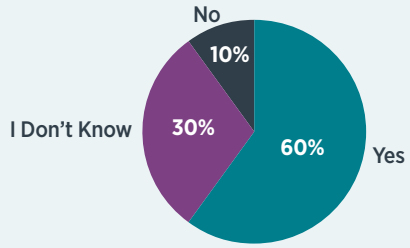
To better understand how patient attribution information is exchanged and the challenges providers face related to attribution, the 2020 CAQH Index[6] asked medical providers if they were able to determine patient attribution and common methods used to exchange this information. Providers were also asked about the frequency and time associated with the exchange of attribution information.

Determining Attribution

Under a VBP contract, health plans may attribute patients to providers in a number of ways. Attribution methodologies may assign patients to the provider who performed the most recent annual wellness visit or to the provider with the most visits. Attribution assignments can also differ by factors like patient choice, geography, and can be assigned prospectively (before the performance period) or retrospectively (after the performance period).[7] Despite varying methodologies which may cause confusion among providers,[8] the CAQH survey results indicated that the majority of providers were able to determine if a patient was attributed to them (60 percent).

While the majority of providers were able to determine if a patient was assigned to them, forty percent of providers reported that they either did not know or could not determine if a patient was attributed to them (30 and 10 percent, respectively). Wrong patient assignments may hold a primary care provider (PCP) accountable for the performance of other providers or specialists that a patient may encounter. Depending on the patient encounter, this could adversely impact a provider's performance, quality metrics and payments.

Are You Able to Determine Your Patients in a VBP Arrangement?



Exchanging Attribution Information

In addition to the varying attribution methodologies used for patient assignment, the mode in which attribution information is exchanged from health plan to provider can vary greatly depending on the technology systems and infrastructure used by both parties. Providers reported that the most common method to receive attribution information was through a proprietary health plan web portal (30 percent) which requires staff to manually log into health plan web portals to retrieve the needed attribution data. The use of web portals to exchange information was followed by email attachments (26 percent). Fully electronic modes, such as directly interfacing with an Electronic Health Record (EHR) or Electronic Medical Record (EMR) and using a HIPAA transaction, were used less often. Despite the known benefits and cost savings opportunities associated with using fully electronic modes of data exchange,[9] only one quarter of providers received attribution information directly by interfacing with an EHR or EMR system and seven percent used the HIPAA eligibility and benefit verification (270/271) transaction.

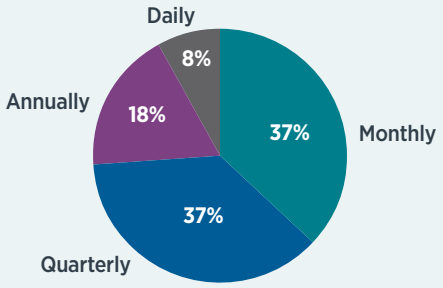
How Are You Receiving Attribution Information from Your Contracted Plan?	
Interactive Web-based Portal	30%
Email Attachment	26%
Direct Interface with EHR/EMR	25%
Excel File Download	11%
Eligibility and Benefit Transaction (270/271)	7%
Clearinghouse	2%

While use of more standardized electronic methods to exchange attribution data is lower than other methods, headway is being made by the industry. To help streamline the exchange of information, in 2020, CAQH CORE published the CAQH CORE Eligibility & Benefits Single Patient Attribution Data Rule to enable provider notification of an attributed patient under a value-based care contract within the eligibility workflow. The rule requires the health plan to return explicit attribution status and effective dates of attribution to the provider in an X12 271 eligibility response. This standardized exchange of attribution information allows a health plan to notify a provider if a patient is a part of their VBP contract population automatically at the time of service, without any extra effort on behalf of the provider.[10]

Frequency of Exchanging Attribution Information

The frequency in which providers received attribution information from a contracted health plan varied. The majority of providers received attribution files, or rosters of attributed patients, from contracted health plans for a given VBP contract either monthly (37 percent) or quarterly (37 percent). Almost 20 percent of providers reported receiving attribution files annually, while few reported receiving files daily (eight percent). Given that patient attribution for VBP arrangements may change during the year if the patient loses or changes coverage, providers need to know when these changes occur as soon as possible to adjust their care approach and reallocate their practice resources. The CAQH CORE Attributed Patient Roster Operating Rule Set establishes consistent expectations for the electronic exchange of attribution files among stakeholders at predictable intervals (no less than monthly) by supporting consistent data content, infrastructure and a connectivity safe harbor using the X12 005010X318 Member Plan Reporting (834) transaction. These operating rules provide for greater consistency around delivery and content enabling greater automation.[11]

How often Are You Receiving Provider Attribution Information from Your Contracted Health Plan?



Time Spent Reviewing Attribution Information

Due to variability in exchange methods, format and delivery schedules, providers and practice staff may spend a significant portion of their workday determining patient assignments under a VBP arrangement. While almost three quarters of providers (72 percent) indicated that office staff spent two hours or less reviewing attribution data for a VBP contract, nearly 30 percent of staff spent three or more hours. This suggests that practice staff could spend almost half a day reviewing attribution information received from health plans. If there are discrepancies with the attributed patient, an office staff member may need to contact the health plan to determine and work through the issues adding burden to the task.

For a Given VBP Contract, How Long Does It Take Your Office Staff to Review Attribution Information?	
<1 hour	**36%**
1-2 hours	**36%**
3-5 hours	**19%**
>5 hours	**9%**

As VBP contracts continue to increase, streamlining the exchange and review of attribution information will become increasingly necessary so as not to burden providers and reduce the time they spend on patient care. Moving to fully automated systems that support operating rules and standards can help reduce time spent reviewing attribution information as data elements and requirements are defined and delivery schedules set.

Moving Forward

As the use of VBP models continues to grow and expand in an effort to improve the quality and efficiency of patient care, timely communication of attribution information through standardized mechanisms is needed to limit the cost and time to administer these models. Monitoring the administrative challenges and opportunities associated with VBP models is important to developing impactful strategies to improve health outcomes and reduce unnecessary costs.

Methodology

The 2020 CAQH Index included questions related to patient-provider attribution for VBP models. The measurement period was representative of January 1 to December 31, 2019. Results from this survey have been weighted to represent a national distribution of physicians by practice size as reported by the American Medical Association (AMA).[12]

Endnotes

1 "Fee for Service," HealthCare.gov, accessed June 6, 2021, https://www.healthcare.gov/glossary/fee-for-service/.

2 "Value-based Payment," American Academy of Family Physicians, accessed June 6, 2021, https://www.aafp.org/about/policies/all/value-based-payment.html.

3 "Hospital Value-based Purchasing," Centers for Medicare & Medicaid Services, June 30, 2020, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/hospital_vbpurchasing_fact_sheet_icn907664.pdf.

4 "Patient Attribution: Why the Method Matters," American Journal of Managed Care, December 2018, https://www.ajmc.com/view/patient-attribution-why-the-method-matters.

5 Joseph Siemienczuk, "Healthcare's Quality Cycle: Quality Cycle Management And The Challenge Of Patient Attribution," Forbes, March 31, 2020, https://www.forbes.com/sites/forbestechcouncil/2020/03/31/healthcares-quality-cycle-quality-cycle-management-and-the-challenge-of-patient-attribution/?sh=7dea59eb28ed.

6 The 2020 CAQH Index survey questions were developed in collaboration with the CAQH Index Advisory Council which represents organizations across the healthcare industry, including medical and dental plans and providers, vendors, clearinghouses, government and research experts. For more information on the 2020 CAQH Index, please visit: https://www.caqh.org/explorations/caqh-index-report-0.

7 "Accelerating and Aligning Population-Based Payment Models: Patient Attribution," Health Care Payment Learning & Action Network, June 27, 2016, https://hcp-lan.org/workproducts/pa-whitepaper-final.pdf.

8 "All Together Now: Applying the Lessons of Fee-for-Service to Streamline Adoption of Value-Based Payments," CAQH CORE, April 10, 2018, https://www.caqh.org/sites/default/files/core/value-based%20payments/core-value-based-payments-report.pdf.

9 "2020 CAQH Index," CAQH, January 2021, https://www.caqh.org/sites/default/files/explorations/index/2020-caqh-index.pdf.

10 "CAQH CORE Eligibility & Benefits (270/271) Single Patient Attribution Data Content Rule vEB.1.0," CAQH CORE, December 2020, https://www.caqh.org/sites/default/files/core/CAQH%20CORE%20Eligibility%20Benefits%20270_271%20Single%20Patient%20Attribution%20Data%20Rule%20vEB.1.0.pdf.

11 "CAQH CORE Attributed Patient Roster (005010X318 834) Data Content Rule vAPR.1.0," CAQH CORE, December 2020, https://www.caqh.org/sites/default/files/CAQH%20CORE%20Attributed%20Patient%20Roster%20(X12%20005010X318%20834)%20Data%20Content%20Rule%20vAPR.1.0.pdf.

12 Kane, Carol K. "Updated Data on Physician Practice Arrangements: For the First Time, Fewer Physicians Are Owners Than Employees." American Medical Association, 2018, https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf.