Proposed Attribution Model for AHARO Hawaii

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AHARO Hawaii is proposing that the Managed Care Organizations (MCOs) in the State of Hawaii's Medicaid Program adopt the following attribution model to define the patient population for which AHARO Hawaii and its Community Health Center Members (CHC Members or CHCs) will be held accountable for both total cost of care and quality performance.

Background

In general, there are three methods for patient attribution in an accountable care organization (ACO) setting: 1) Prospective Attribution; 2) Performance Year Attribution; and 3) A hybrid of the previous two methods [1-4]. To understand the concepts of these three methods, a definition for each is provided below:

1. Prospective Attribution Method. Under the Prospective Attribution Method, an ACO is given a list of patients for whom it will be responsible at the beginning of a performance year. The list is based on data from the patient's use of services in the previous year[5]. One benefit of this method is that providers can reach out to assigned patients proactively to coordinate care and develop its tailored care management programs[6]. Presumably since the providers know exactly which patients will be included in performance evaluation, they can coordinate with patients. In addition, prospective attribution initially prevents providers from selectively avoiding patients that providers perceive as difficult or likely to negatively affect their performance. Of course, since prospective attribution is updated yearly, providers could selectively avoid patients to favorably alter attribution moving forward[6].

2. Performance Year Attribution Method. The Performance Year Attribution Method is a form of retrospective or performance year attribution. It assigns patients to an ACO at the end of the year based on patients' use of care during the actual performance year. Performance year attribution is believed to provide two major benefits to providers[7]. First, performance year attribution removes patients who no longer receive

care from the organization, including those who have moved or sought care from other providers. Providers are then responsible for the cost and quality of care of only those patients for whom they provided care in the performance year. Second, performance year attribution ensures that ACOs are credited for the care of patients who initiated care during the performance year.

3. Hybrid Method. In the final rule for the Medicare Shared Savings Program, the Centers for Medicare and Medicaid Services elected a third, hybrid approach that it termed a "preliminary prospective assignment methodology with final retrospective reconciliation."[4(p67864)] The hybrid approach begins with prospective attribution; each quarter, program participants receive a list of patients prospectively attributed to their ACOs based on the most recent twelve months of data.

In effect, these are lists of patients who are likely to be attributed to a given ACO. Assignment is regularly updated to include new patients in practices and to remove those who are no longer receiving care from the ACO's providers—a process referred to as retrospective reconciliation.[9] The final reconciliation takes place at the end of the performance year based solely on patients' use of services in that performance year. As a result of the reconciliation, the final attributed population under the hybrid method is identical to a purely retrospective attributed population.

Proposed AHARO Hawaii Attribution Method

AHARO Hawaii is proposing a hybrid method that follows closely the Medicare Hybrid Model. This attribution methodology is summarized as follows:

1. At the beginning of the year and thereafter beginning of each quarter, health plans will provide a list of patients (proposed list) for whom the ACO (and its respective health centers) are responsible. The ACO will have X number of days to remove patients who no longer receive care from the ACO based on a weighted score that takes into consideration the following factors:
    a. Where the patient resides (street address, city and zip code);
    b. Who the patient last saw for his or her primary care needs in the most recent quarter or the previous year;

c. Has the patient been responsible or responsive to the ACO/provider's outreach or engagement efforts; and

d. Other factors (e.g., the provider has previously severed the physician-patient relationship due to compliance or lack thereof).

2. There should be a degree of flexibility afforded the ACO/provider to identify probable assigned patients independent of the plan's proposed list (e.g., patients seen by an ACO/health center provider in prior years who want to return to the ACO/health center provider).

3. Once the list of patients is approved by the ACO and the CHC, the total cost of care and performance improvement program(s) of the ACO/CHC will be based on the approved list.

4. A final reconciliation takes place at the end of the performance year based solely on patients' use of services in that performance year.

References:

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