Connecticut Health Policy Project

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Attribution and why it's important for Medicaid shared savings

Connecticut's Medicaid program has made a decision move into a shared savings payment model within the next year.[i] Ideally, in a shared savings model, provider networks will improve quality and manage the care their patients receive and, in return, they will share in the resulting savings. However a shared savings model could result in inappropriate savings for provider networks by denying people necessary care (underservice) or through "cherry picking" more lucrative patients (adverse selection).[ii]

Attribution is the process of defining the population that a provider network is responsible for managing under a shared savings contract. Effective attribution helps both consumers and providers. Consumers know who is responsible for their care and who to call with a problem. Providers know who they are responsible for, giving them every incentive to invest in care management and other appropriate services to keep people well. Provider networks share in the savings that consumers and providers generate together through better health. The process of attribution has several parts but two of the most important are **how** people are linked to a network and **when** the linkage occurs.

It is very important to note that under DSS's proposed shared savings model, consumers have the **freedom to choose or change their providers** at any point in their care and at any point in the shared savings contract. Consumer freedom of choice is independent of which attribution model Connecticut Medicaid chooses.

How -- Connecticut's Medicaid program has decided to connect people to networks by searching their usual source of care. People who have historically relied on providers in a network will be linked to that network. According to CMS, "This relationship encourages providers to develop care plans that address person-centered short and long-term needs and goals, maintain continuous outcome and quality data, and allows for payment continuity to reward efforts. It builds trust between a beneficiary and provider, which is key to coordinating effective care."[iii] This model will also reduce disruptions for both consumers and providers as Medicaid shifts to the very new shared savings model. This method is now used by Medicare, most private insurers, and Connecticut Medicaid's successful Patient-Centered Medical Home program.

In either model, consumers must be fully informed. CMS requires "When there is assignment or attribution for purposes of payment calculation . . . the state will be required to notify beneficiaries of the program, describe how personal information will be used, and disclose any correlative payment arrangements (e.g., incentives)."[iv]

When – People can be assigned to a provider network either at the beginning (prospective) or the end (retrospective) of a shared savings contract period.

In a **prospective model**, provider networks start the year knowing which people the shared savings calculation will be based on. They have an incentive to invest in services to keep people well, confident that they will see a return on that investment. In a prospective attribution model, networks cannot “cherry pick" more difficult or less lucrative patients during the year to improve their shared savings calculation.

In a **retrospective model**, the panel of patients who will be assigned to the network for purposes of shared savings is not set until the end of the contract period. Networks could invest in services and care management for patients that end up attributed to another network’s panel. Consequently they would not recoup their investment.

Another concern with retrospective attribution is the potential for cherry picking to improve shared savings payments. While patients may not be officially assigned to a network until the end of the contract year, providers know who their patients are from the beginning and have a great deal of information about their health and care. The incentives in a retrospective model favor de-attributing or rejecting current patients that are unlikely to generate savings over the year. Because attribution is based on where people get appointments for care, networks can control their attributed population in a retrospective model.

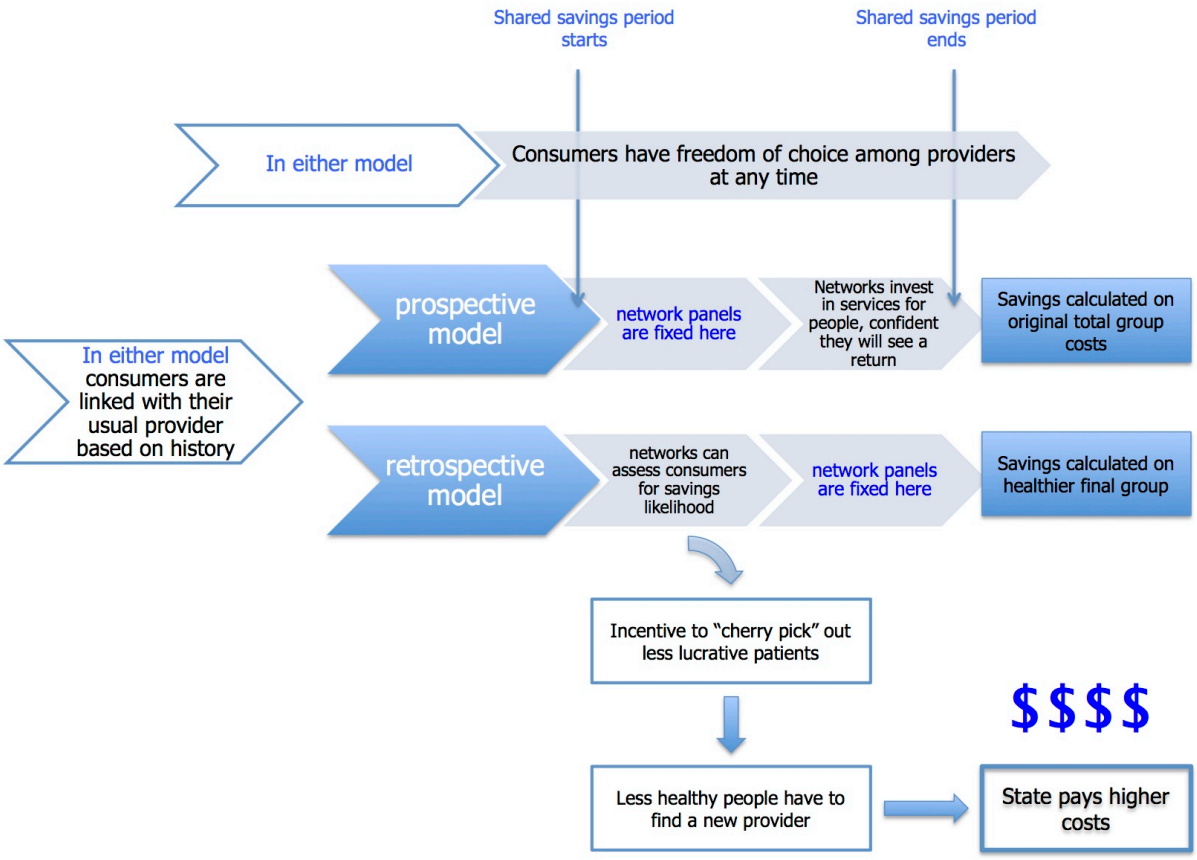
Unfortunately those de-attributed, costly patients would be left searching for a new provider. If they are not able to access preventive and maintenance care for their condition(s), their costs of care could rise significantly. Those higher costs would be fully borne by the state, as those patients would be outside the shared savings model.

Connecticut’s successful Patient-Centered Medical Home program uses a retrospective attribution model. However the current PCMH program is a fee-for-service program, where individual providers are not at financial risk for the costs of their patients’ care but are paid more to provide better care. They have no incentive to de-attribute costly patients. The proposed new shared savings model has very different incentives, which to protect consumers must be recognized in the program’s design.

There is a lot of support for prospective attribution models, in Connecticut and elsewhere. Most private insurers use prospective attribution in their shared savings plans. Medicare’s shared savings program started with a retrospective model, but is now recommending prospective attribution for some networks. After almost a year of research, the Equity and Access Council of Connecticut’s State Innovation Model has recommended prospective attribution for all programs. And because there is less uncertainty, many providers prefer prospective attribution.[v]

In many respects, prospective attribution is similar to the system used in schools. Teachers cannot choose which students remain in their class after they see the results of the first test or see who needs more help. The class they have at the beginning of the year is their class. It is critical that Connecticut’s 750,000 Medicaid members enjoy the same security as our

students and incentives are aligned to improve the quality and value of care, not to shift financial risk.



[i] A Brief Primer on the Medicaid Quality Improvement and Shared Savings Program, DSS, 4/3/15, https://www.cga.ct.gov/med/council/2015/0612/20150612ATTACH_A%20Brief%20Primer%20on%20MQISSP%205-10-15.pdf

[ii] Connecticut Healthcare Innovation Plan, 12/30/13

[iii] CMS State Medicaid Director letter, Re: Policy Considerations for Integrated Care Models, 7/10/12, http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-12-002.pdf

[iv] ibid

[v] Report of the Equity and Access Council in Safeguarding Against Underservice and Patient Selection in the Context of Shared Savings Payment Arrangements, Draft, 6/25/15, http://www.healthreform.ct.gov/ohri/lib/ohri/sim/steering_committee/2015-07-16/eac_phase_i_draft_report_062015.pdf