FROM THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

# KEYS TO HIGH-QUALITY, LOW-COST CARE:
## Empanelment, Attribution, and Risk Stratification

September 2020

AAFP

## Finding Success in Value-based Payment

Value-based payment (VBP) ties physician payment more closely to improving patient outcomes and reducing costs when compared to the volume-based, fee-for-service (FFS) system. Success in a VBP model relies on identifying and prioritizing patients at risk for poorer health outcomes and directing preventive and other health care services to those patients.

There are two mechanisms to assign patients to a physician or practice during the course of the year: attribution and empanelment.

## Attribution

Commercial and government payers assign patients to physicians or practices who are held accountable for their care and associated costs. This process is known as attribution.[1] As VBP models evolve, attribution will continue to determine payment to primary care physicians in these models. Identifying which payers have attributed which patients to your practice, and the impact of each VBP program your practice participates in will help your practice effectively allocate resources to improve care and reduce costs.[1]

Payers use two types of attribution: prospective and retrospective. Prospective attribution allows physicians to know which patients are assigned to them at the beginning of the measurement year for the next 12-24 months.[1] However, this attribution list may only be updated annually or quarterly, based on the payer contract. Retrospective attribution alerts physicians of their assigned patients at the end of the year, and payers measure performance based on a look-back period—typically the previous 12-24 months.[1]

Attribution methodologies differ by payer and contract. However, some combination of patient choice and/or a claims-based algorithm is typically used to assign patients to physicians. These include:

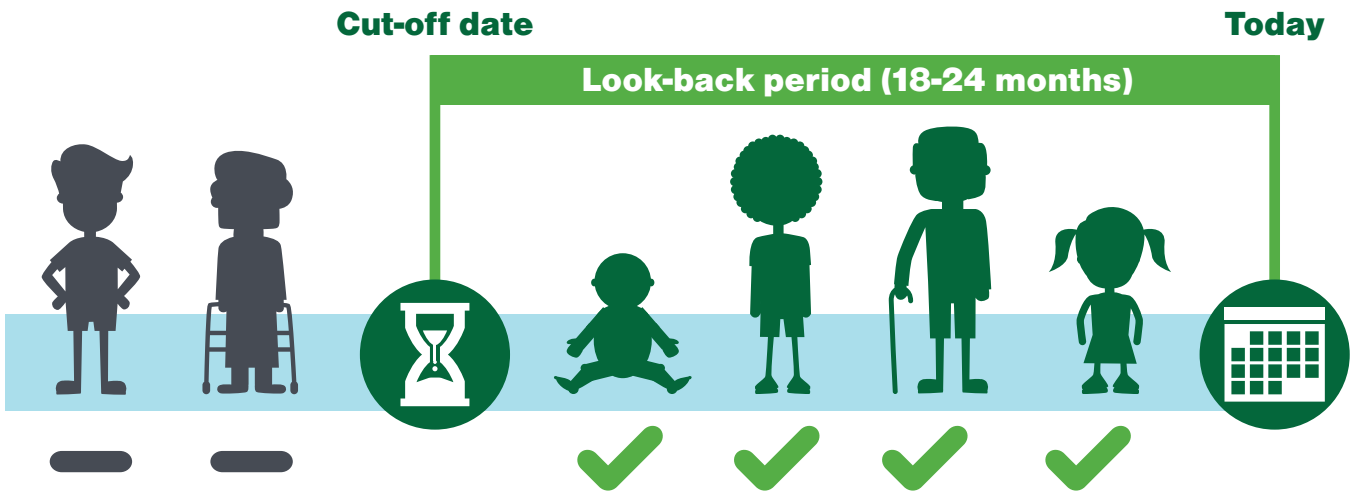
- Voluntary attribution: Process in which patients select their primary care physician
- Claims-based attribution: Methodologies differ for this type of attribution, but some payers assign patients based on which physician was responsible for the majority of a patient's care. Others may assign the patient based on which physician administered the most recent wellness visit or which physician saw the patient most recently.

## Empanelment

Empanelment involves identifying and assigning individual patients to primary care clinicians and/or care teams with the goal of maintaining a consistent patient-provider relationship.[2] Empanelment includes:

- Identifying the ideal panel per clinician (ideal panel may change due to patient population or staffing)
- Developing initial patient panels per clinician
- Refining the panels based on clinician input and ideal panel size
- Managing panel on an ongoing basis[2]

Initial panels can be determined by examining a unique list of patients seen by a physician or care team during a defined look-back period—usually 18-24 months.




After the initial panel has been refined, panels should be reviewed on a systematic basis to ensure accuracy for other practice activities, such as supply and demand, risk stratification, care management, resource allocation, etc.

Goals of empanelment are to increase access to care, improve continuity of care, and implement care coordination. Focusing on meaningful relationships with individual patients ensures optimal care, leading to improved health outcomes and reduced costs.[2]

## Key Difference Between Empanelment And Alignment

- Empanelment is a practice-level activity that assigns patients to a physician and/or care team's panel and is used as the basis for risk stratification.
- Attribution is a payer-level activity that assigns patients to a practice, physician, or clinician through either voluntary or claims-based attribution and directly impacts how physicians are reimbursed in VBP arrangements.

## Risk Stratification

Once you've identified the ideal patient panel for a practice, physician, or clinician, the process of risk stratifying patients will begin to help them manage their health. Under risk-stratified care management (RSCM), a practice assigns a health-risk status to a patient, and care team members coordinate with the patient to plan, develop, and implement an individualized care plan.[2]

Understanding your patient panel will help identify and prioritize patients that may benefit from enhanced care coordination and care management services. These patients often have poor health outcomes and high care utilization. Focusing on these patients can make a significant impact on your practice's quality and utilization performance.

## Risk Stratification Versus Risk Adjustment

Risk stratification guides physicians and care teams to group patients into levels (i.e., strata) of risk that are based on factors such as diagnosis, health severity, social determinants of health, and care utilization. It is implemented at the practice level to support longitudinal care management and allocate practice resources and services proportional to the needs of patients based on their level(s) of risk. Risk stratification ensures that the patients most in need of care management and other key functions receive the most of those services.

Risk adjustment guides payers to modify per patient per month payments based on factors such as demographics, diagnosis, and health severity. It is implemented at the payer level to allocate payer resources proportional to the needs of patients based on their level(s) of risk. Risk adjustment ensures that practices have the necessary resources to care for patients and that care is consistent with the needs of those patients. Risk adjustment in VBP will be covered in more detail in the November/December 2020 *FPM* supplement.

## Payment Impacts of Empanelment, Attribution, and Risk Stratification in VBP Contracts

With VBP tied to performance on quality, cost, and utilization, practices must understand which patients they are responsible for managing. If a practice does not manage its panel, patients assigned to physicians and other clinicians may receive low-quality, high-cost care outside of their practice. The practice may still be accountable for the outcomes and costs associated with those patients—regardless of whether they are seeing the patient.

Low-quality and high-cost services will have a direct impact on the revenue of a small, solo, and/or independent practice in VBP, and, similarly, may affect an employed physician's ability to earn a performance bonus or share in savings.

## Action Steps

Empanelment, attribution, and risk stratification impact your practice's ability to provide high-quality, low-cost care. These three steps can help get you started in VBP models:

1. Know your patients by empaneling, and reviewing and reconciling attribution/alignment lists from payers
2. Risk stratify your patient population
3. Prioritize high-risk and/or high-cost patients (and attributed patients with gaps in care) for focused care coordination and care management services

The American Academy of Family Physicians (AAFP) has developed valuable resources and information about these topics, including:

- AAFP Transformation in Practice Series (TIPS™) Empanelment module (aafp.org/tips-empanelment)
- *FPM* article, *The Right-Sized Patient Panel: A Practical Way to Make Adjustments for Acuity and Complexity* (aafp.org/fpm-patient-panel)
- *FPM* article, *Risk Stratification: A Two-step Process for Identifying Your Sickest Patients* (aafp.org/risk-stratification)
- AAFP Risk-Stratified Care Management and Coordination (aafp.org/risk-stratification-rubric)

## References


1. Fiesinger T. Patient attribution: why it matters more than ever. *Fam Pract Manag*. 2016;23(6):25-30.
2. American Academy of Family Physicians. Care management and value-based care. Accessed June 30, 2020. www.aafp.org/practice-management/payment/value-based-care-payment/empanelment-risk-stratification.html