The attribution challenge that could hamstring Amazon Care

Jessica Kim Cohen and Nona Tepper

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Health plans have been striking more and more risk-sharing agreements with providers and digital health companies as the shift to value-based care intensifies—but that momentum faces challenges, analysts say.

With more value-based contracts come more complication, particularly when it comes to attribution—or trying to figure out how to divvy up cost savings among multiple partners, said Lili Brillstein, a former director at UnitedHealth Group and Horizon Blue Cross Blue Shield of New Jersey.

That's led health plans to pump the breaks on adding more value-based partners, potentially hindering digital health ventures—like Amazon's Amazon Care—from striking value-based deals with health plans that want to pay fee-for-service.

"This is on the mind of most payers today," said Brillstein, who runs the BCollaborative value-based consultancy. "A lot of payers are trying to figure out, 'How do you make sure compensation models and attribution are in the right places, but that you're not paying twice for the same care?' It's a huge concern."

Adding to the complexity are outcomes that are the unexpected result of broader industry trends or other mitigating factors, such as during the COVID-19 pandemic, when utilization sharply dropped—but not due to care improvements.

It's not as easy as seeing an improved outcome or cost saving, and assuming it's the result of a specific organization's care management efforts, said Brian Sweatman, a principal and consulting actuary at consulting firm Milliman.

It's insurers who are tasked with disaggregating which improvements should be attributed to which partner.

Traditionally, payers and providers entered into value-based contracts with primary-care providers, offering clinicians a per-member-per-month care coordination fee along with any shared health savings achieved, Brillstein said, which was pretty straight-forward to calculate. Since then, health plans have started to strike episode-based contracts with specialists, in which insurers generally work with clinicians to carve out an individual's episode of care, like a knee replacement, and offered the specialist shared savings for performing that specific procedure well and without complications.

That can pose attribution issues, if a patient's total cost of care is part of one value-based care agreement—such as an accountable care organization, or ACO—but they also could be undergoing a specific procedure with a surgeon who's part of an episode-based contract.

"That's where things get tricky," said Dr. Mai Pham, president and CEO of the Institute for Exceptional Care and former chief innovation officer at the Center for Medicare & Medicaid

Innovation. "If there's savings generated on that episode, do you give just the orthopedic surgeon that credit? Or do you also give the ACO credit if the ACO referred the patient to a good orthopedic surgeon? Or do you give them both credit?"

Recently, payers have been adding yet another collaborator to the mix, picking up virtual-care partners during the COVID-19 pandemic.

Fifty-four percent of carved-out telehealth contracts offered through employer health benefits last year were based on pure subscription-based capitation fees, without any additional fees that go up with high utilization, according to a survey released by investment bank Credit Suisse late last year. That was the most common structure for telehealth contracts; the second most common (17%) involved only using visit fees without a fixed PMPM fee.

During the first quarter of 2021, venture investment in digital health startups nearly doubled year-over-year to $6.7 billion, according to Rock Health. Many of these companies aim to do business with payers, rather than consumers, as it allows them to charge more and expand their reach. Attribution challenges could slow investment in these young companies, analysts say.

Health plans are more likely to strike value-based payment contracts with digital health companies that provide continuous care to patients, such as if they're a primary-care provider, according to Pham. In that case, the health plan might treat the digital health company similar to an ACO.

But if a digital health company mainly sees patients for one-off visits, such as for urgent care, it's more likely they'll strike fee-for-service agreements with health plans.

That might be the problem for Amazon Care, which is **reportedly struggling** to get big health insurers to pay for its virtual medical care service, said Ari Gottlieb, principal at A2 Strategy Corp. health consultancy. Health insurers may not view it as an effective cost savings tool and may not want to give up their margins.

"They don't view it as an avenue for controlling a lot of their overall medical spend," Gottlieb said.

With individual patient risk distributed across multiple providers and digital health tools, the challenge of attributing cost savings has created a market for analytics engines.

Such products, like **Change Healthcare** and Signify Health, "configure algorithms in their systems that act as jelly bean sorters, if you will, so you're not focused on one member or patient at a time—you're focused on what criteria needs to be included in the contract," Brillstein said.

As insurers continue to ink value-based contracts, investment in provider data management tools will become more critical, said Mike Jasperson, senior vice president of provider network strategy at Grand Rapids, Mich.-based Priority Health. At the start of the year, the not-for-profit insurer launched its **inaugural virtual-first ACA product** through a partnership with Doctor On Demand. Today, more than 5,000 members have enrolled in the plan, Jasperson said. The company pays Doctor On Demand a mix of per-member-per-month fees for managing the care for each enrollee, along with fee-for-service rates for individual visits.

Because multiple providers can carry risk for individual patients, the company has created internal datasets to track which conditions and episodes are attributed to which providers, and has invested in the eVIPs provider data management service to help its clinicians track their up-and-downside risk.

"It does get complicated to try to narrow it down one-to-one, to say intervention X caused savings," Jasperson said. "It's not always that clear. There's just a lot of folks interacting with members to try to move the needle."