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Your Patients, Your Records: Solving Attribution Lag

March 2026

KEY TAKEAWAYS

- Health plans assign patients to providers based on old data. Mobile clinics often deliver care without getting paid or credited.
- Patients can switch their assigned provider in a few days by calling their health plan or signing a form at the point of care.
- Mobile clinics that make attribution capture a routine part of intake will get paid for the care they actually deliver.

The Attribution Lag Problem

More than 70 percent of Medicaid beneficiaries are enrolled in managed care plans. The mobile health programs that care for these members often operate at a structural disadvantage created by attribution lag: the gap between where patients actually receive care and where health plan systems believe they receive care.

Attribution systems assign patients to providers based on historical claims data and update those assignments infrequently. When a mobile clinic serves a patient who remains attributed to a distant provider of record, the mismatch creates problems for everyone involved.

Mobile clinics lose directly. They deliver primary care without receiving capitation payments or quality measure credit. Under fee-for-service, this was annoying but survivable. Under value-based payment, where revenue depends on the populations to which care is attributed, it becomes financially critical.

Providers of record lose too. Practices call these unreachable attributed members "phantom panels." Patients who cannot be contacted drag down HEDIS quality scores because the denominator includes every attributed member, regardless of whether the practice can reach them. Quality withheld goes unearned. Performance bonuses become unattainable. Staff waste time on outreach to patients receiving care elsewhere.

MCOs lose as well. Health plans call this "plan leakage." Care happens outside coordinated networks. Quality measurement becomes unreliable. The total cost of care increases when members receive uncoordinated services. Network adequacy data fail to reflect where care actually occurs.

Because attribution algorithms use 12 to 24 month lookback periods, mobile health programs that begin fixing this problem today will not see full results for a year. Those who wait add months to that timeline.

Why Current Approaches Fall Short

Most mobile health programs treat attribution as something that happens to them rather than something they control. Common responses include billing for visits and hoping the algorithm eventually catches up, assuming that good care will naturally translate into proper credit, or waiting until value-based contracts make attribution urgent enough to address.

These approaches fail because they misunderstand how attribution systems actually work. Attribution uses a two-tier hierarchy that creates different opportunities for intervention:

Tier 1: Voluntary Alignment. When a patient explicitly selects a provider through their health plan portal or enrollment form, that selection overrides all claims data. No volume of visits to another provider will change attribution without patient action. This is the override mechanism.

Tier 2: Claims-Based Attribution. If no voluntary selection exists, algorithms assign patients to whoever provided the plurality of qualifying primary care visits over a 12 to 24 month lookback period. This path works, but only if programs bill the correct codes consistently over time.

Programs that rely solely on claims-based attribution accept a 3 to 12 month delay. Programs that ignore billing code optimization may never trigger the attribution algorithm, regardless of visit volume.

What Attribution Capture Solves

Treating attribution capture as a core operational workflow rather than a billing afterthought addresses a coordination failure that harms multiple parties. Mobile health programs that fix attribution for their patients:

- Capture revenue and quality credit for care they actually deliver, enabling sustainable operations under value-based payment models.
- Reduce phantom panel burden on other practices, removing unreachable patients from denominators and improving quality scores for providers who may be referral sources or clinical partners.

- Improve MCO network performance data by ensuring care delivery aligns with attribution records, reducing plan leakage, and supporting accurate quality measurement.

The approach has two components that work in parallel:

Fast Path (Days): Facilitate voluntary provider selection at the point of care. When a patient signs a designation form or calls their plan from the mobile unit, attribution updates are included in the next monthly file. This path produces results in days to weeks rather than months.

Slow Path (3 to 12 Months): Bill qualifying E&M codes (99202 through 99215), wellness visits (G0438 and G0439), and chronic care management services (99490 and 99491). The algorithm flips attribution when the mobile clinic's visits exceed the current provider of record's over the lookback period.

The fast path should be the default operational approach. The slow path runs automatically in the background when billing practices are optimized. Together, they maximize the rate at which attributed populations grow, reflecting actual care delivery.

The Solution: Simple, Consistent Workflow for PCP Selection

Audit billing codes. Ensure every qualifying visit is billed with E&M codes (99202 through 99215), not generic urgent care codes. Annual Wellness Visits (G0438 and G0439) count heavily in attribution algorithms. Claims that do not use qualifying codes may not trigger attribution regardless of visit volume.

Create a provider designation workflow. Stock mobile units with plan-specific provider selection forms. Train intake staff to assign a designation during registration for every patient. Build this into the standard intake checklist rather than treating it as an optional add-on.

Enable real-time plan calls. For patients without forms, provide a phone and the plan's member services number. A 3-minute call from the mobile unit can accomplish what months of claims cannot.

Track attribution lag by payer. Document which MCOs update attribution quarterly versus annually. Prioritize voluntary designation efforts for plans with longer lags. Create a dashboard comparing patients served to patients attributed, by payer, to identify revenue leakage.

Timeline

Week 1 to 2: Audit current billing codes and identify gaps. Obtain provider selection forms from contracted MCOs.

Week 3 to 4: Train intake staff on the provider designation workflow. Update the intake checklist to include attribution capture.

Month 2: Launch systematic provider designation at the point of care. First voluntary attribution updates begin appearing in MCO files.

Months 3 to 6: Claims-based attribution begins shifting for patients without voluntary designation. Build a tracking dashboard.

Month 12: Full lookback period complete. Attribution should reflect actual care delivery patterns for patients engaged since implementation.

SOURCES

- Centers for Medicare & Medicaid Services. (2024). Medicaid managed care enrollment and program characteristics. CMS.gov.
- National Committee for Quality Assurance. (2024). HEDIS measurement year 2024: Technical specifications for health plans. NCQA.
- Centers for Medicare & Medicaid Services. (2024). Medicaid and CHIP managed care final rule (CMS-2439-F): Managed care access, finance, and quality. 89 FR 41002.

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