NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Brief

ATTRIBUTION THRESHOLDS FOR VALUE-BASED CARE

WHY

are attribution thresholds important in value-based care?

Assessing the number of attributed patients is key to determining eligibility for participating, predicting potential performance, and determining the financial risk of value-based arrangements. This is frequently called 'attribution thresholds' or 'membership thresholds.'

Part of assessing whether a health center is ready for a value-based payment model is evaluating the size of the attributed patient panel with each payor partner. In value-based care models, the significance of patient population size lies in the need for confidence when assessing quality or cost of care performance. The reason attributed patient population size is important is that when performance is measured on quality or cost of care compared to a target or benchmark, there needs to be a degree of certainty that the quality or cost outcomes are truly a result of a health center's performance, and not due to random fluctuations in the patient population. In addition, if cost savings are achieved, these savings are distributed based on attributed panel size. The larger the panel size, the greater the earned savings.

Organizations with fewer attributed patients may experience a greater fluctuation in shared savings. As the size of the patient panel grows, the range of savings outcomes becomes smaller and more predictable. Health centers with large, attributed patient populations should see more consistent results in their performance. They can be more confident that improvements to the total cost of care were due to initiatives and interventions the health center implemented on the population. On the other hand, health centers with a smaller attributed patient population have a higher chance of having wider swings in performance from year to year, which can pose a risk in years with unfavorable swings.

WHAT

are the considerations around attribution thresholds?

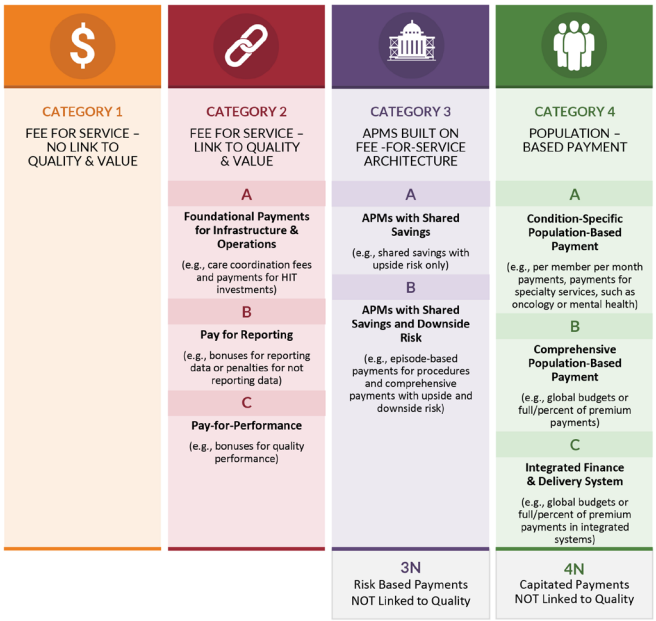
Some CMS Medicare programs, such as the Medicare Shared Savings Program (MSSP) program, require a minimum of 5,000 beneficiaries for participation while other non-CMS value-based payment models, such as those from managed Medicaid or commercial plans, tend to be more flexible.

The type of value-based arrangement will also play a role in determining whether the attributed population size is adequate for participation:

- Pay-for-performance and upside only shared savings models are more flexible regarding member thresholds since there is no liability risk for shared losses. This could include a per member/per month (PMPM) incentive when a health center achieves performance on a measure or set of measures. These models are more appropriate for health centers with smaller attributed patient thresholds.
- Downside risk models require greater consideration of attributed patient panel size. In these cases, it will also be important to consider whether downside risk mitigation options exist, such as risk corridors or limits, when evaluating attributed patient panel size.

ATTRIBUTION THRESHOLDS FOR VALUE-BASED CARE

HCP LAN Alternative Payment Model Framework



Moreover, the payor or line of business can also play a factor in the link between attributed patient population size and model availability of value-based care models. For example, a commercial plan may require at least 3,000 patients attributed to their health center to participate in their shared savings program.

The Healthcare Payment Learning and Action Network (HCP LAN) is a multistakeholder group that assesses and supports value-based payment adoption in the healthcare industry. The HCP LAN Framework offers a national vocabulary for categorizing payment models.

There is more to consideration of contract type and risk level than attributed patient population size, but this is one key factor in your health center's strategy. In the table below are additional considerations when assessing contracts in each HCP LAN framework category.

HCP LAN Category	Considerations
2C - Pay-for-Performance	• Type of incentive model (e.g., pay per activity or gap closure vs. achieving a target for a measure) and how targets are set. Attributed patient panel size will come into play when targets are developed based on a provider's historical performance. • Ideal for health centers with smaller attributed patient thresholds.
3A – Total Cost of Care Shared Savings Model (upside only)	• Provider's objective for moving into a total cost of care-based model. • A higher attributed patient panel may be required for participation. • Anticipated growth of a payer partner's population (e.g., Medicaid expansion event, payer exiting the market).
3B – Total Cost of Care Shared Savings/Losses Model (downside risk)	• Risk mitigation strategies for lower attributed patient panel sizes: - Risk corridors - Risk limits or aggregate caps on losses - High-cost claimant thresholds - Stop-loss insurance - High-quality performance impacting contract economics • Line of business (Medicaid, Commercial, Medicare).

HOW
can health centers approach attribution thresholds?

Health centers can begin their approach to attribution thresholds by understanding payor contracts. It is commonplace to see contract terms that may vary based on the size of the attributed patient population under a value-based arrangement. When considering a contract that involves risk, or even an upside-only contract, it is important to understand your position on the spectrum of attributed patient population size and strategies to mitigate the risk a smaller population poses.

In addition to carefully considering how attributed patient population size affects a health center's decisions regarding the type and risk level of a value-based contract, the below table outlines additional contract elements and negotiation considerations to further help with risk mitigation. This list should not be viewed as more is better, but each approach could mitigate risk depending on the payer's proposed arrangement.

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Considerations in Contract Negotiations	
Minimum Savings and Loss Rate (MSR/MLR)	*Definition: MSR - The threshold of savings an ACO must meet or exceed to share in savings under the MSSP program. MLR - The threshold of losses that an ACO must remain at or below or be liable for shared losses.* Considerations: • As a provider's attributed population size increases, the MSR/MLR will decrease. • This concept is also applied outside of Medicare ACO models in the form of risk corridors.
Risk Corridor	*Definition: A band (usually a percentage) within which a provider is not at risk for losses but may not be eligible for shared savings.* Considerations: • The symmetry of the risk corridor on both losses and savings. • Provider's risk tolerance level.
Risk Limits or Caps	*Definition: An amount (usually a % of a benchmark or target, or a gross dollar amount) over which a provider is not responsible for losses, but also may not be eligible for shared savings.* Considerations: • Main goal is to protect provider against scenarios that fall outside of their risk tolerance.
High-Cost Claimant Threshold or Stop-loss Insurance	*Definition: The dollar amount of cumulative claims expense, after which claims above that amount are not used within the settlement or calculation of savings/losses.* Considerations: • Type of population and line of business. • Clinical intervention model - Is it addressing general avoidable utilization and waste, or is it designed to prevent very high-dollar events (e.g., NICU stays, high-cost drug use)? • Provider's risk tolerance level.

After taking into account attribution thresholds and contract considerations, a health center may determine it is not eligible for more advanced value-based payment contracts. It may partner with like-minded health centers to leverage collective size and more favorable value-based payment arrangements with Clinically Integrated Networks and health center-driven Accountable Care Organizations. As health centers consider options for entering value-based payment arrangements, it is critical to evaluate mission and value-alignment with potential partners.

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