Accountable Care
Organisations and
New Models of Care*

Yorkshire & Humber Academic Health Science Network in partnership with Greg Fell, Director of Public Health, Sheffield.

Formerly a Consultant in Public Health Medicine, NHS Bradford & Airedale

*This document was made up of an extensive review of documents relating to the question of application of the 'Accountable Care' concept to England. Some documents have been summarised, some direct extracts have been taken to lead the reader to the most pertinent points. References are clearly given to the source document.
GF Financial Model /Risk Sharing Gain Sharing contracts

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Payer Provider Risk Share / DeBlanco et al Commonwealth Fund. A key paper

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Introduction
The contract and financial model of the ACO is a key feature.

Contrary to belief, ACO is not a capitation model. The fundamentals of the payment system is still FFS, but moving towards bundled payment for episodes or periods of care, and possibly eventually capitation.

The novel feature is a risk gain share agreement based on the contracted value; with the contracted value being calculated on the basis of the past 3 years claims data. Risk corridors are then calculated on the basis of this.

The provider must meet a certain level of savings to qualify to keep the gain – this provides the incentive to squeeze financially. The release of savings is dependant on holding or improving quality metrics – thus preventing the incentive to strip quality to meet cost targets.

This paper sets out some of the features.

- Important paper. Perhaps the seminal paper. Key points
- Payer–provider shared-risk models are in an early developmental phase; there are few operational shared-risk models aside from the traditional capitated HMO model
- There are varying definitions of shared risk, and shared-risk initiatives use a variety of program designs
- Providers do not currently have the infrastructure required to take on and manage risk successfully, though some payers are providing infrastructure and other support to providers
- Shared-risk models have typically evolved from shared-savings programs
- Particularly important to note the very early stage of development of these population-based, shared-risk contracts. We found few operational shared-risk payment models; most are in development or at an early stage of implementation
- It is the models in which providers take on whole or partial financial risk for a patient population—and move away from the fee-for-service “chassis”—that are arguably of greatest interest
- All of the studied models include the fee-for-service “chassis”; we were unable to find any models currently in place that both move away from fee-for-service and include financial risk to the provider for a patient population
- Providers lack the infrastructure they need to take on and manage risk successfully was also a common theme among the initiatives we studied
• Providers do not have the data they need about the clinical or financial experience of their patients to manage patient care and financial risk effectively—the HIT structure necessary to coordinate care among providers is at varying levels of implementation

• It is too early to identify which payment models best align incentives for ACOs with high-quality, high-value care

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<td>Provider is at risk of not receiving a bonus payment based on quality and/or efficiency performance</td>
<td>Blue Cross Blue Shield of Minnesota Preferred One</td>
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<td>Market Share Risk</td>
<td>Patients are incentivized by lower copays or premiums to select certain providers so providers are at risk of loss of market share</td>
<td>Buyers Health Care Action Group</td>
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<td>Risk of Baseline Revenue Loss</td>
<td>Built on a fee-for-service “chassis”; providers face a financial or payment loss if they fail to meet certain cost or quality thresholds, and/or if actual costs exceed a target cost</td>
<td>Blue Cross Blue Shield of Massachusetts AQC Blue Cross Blue Shield of Illinois— Advocate Health Care</td>
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<tr>
<td>Financial Risk for Patient Population (Whole or Partial)</td>
<td>Providers manage patient treatment costs for all or a designated set of services within a predetermined payment stream and are at risk for costs that exceed payments (e.g., partial/full capitation, global budget)</td>
<td>State Employees Health Commission (State of Maine) (planned) Anthem/WellPoint (planned)</td>
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Anatomy of risk-based contracts

**Terms of Contract**

According to one of Monarch’s contracting specialists, developing the ACO provider-payer contract is not an event, “it’s a process, and it takes a long time.”

The **one-page guiding principles document** outlines the driving forces in the partnership, such as transparency, objectivity, and a commitment to align incentives and pursue the ACO “for the right reasons.”

The **letter of agreement between** Monarch and Anthem was executed in the first quarter of 2011. This **10-page document enabled the organizations to proceed while allowing for flexibility and modification of contract terms** as they learned from early experiences. **This binding agreement outlined the high-level terms of their working relationship and the trajectory of ACO development over the next five years.** It also **enabled Monarch to receive from Anthem the historical claims-based data needed for patient attribution and to coordinate care for the attributed population. Transparency of information led Monarch to identify areas of performance measurement that needed** to be deferred because of a lack of sufficient data.

**Experience with risk-based contracts**

TMC’s history of taking on risk in the 1990s was both a positive and negative experience in preparing them to become accountable for care.

Address the challenges that led to the downfall of managed care two decades prior, including the lack of health IT infrastructure and an overemphasis on cost containment at the expense of the quality of patient care.

**Terms of contract**

Rather than a single ACO contract between the provider and payer organizations, SAACO’s early structure involves several contracts. They are being executed in the following order:
1. **The ACO-Physician Contracts** are executed with independent physicians or physician groups. These contracts were finalized in the summer of 2011. At the time of the site visit, SAACO anticipated that it would have roughly 90 physicians contracted, though it has raised its estimate since then.

2. **The ACO-Payer Letter of Agreement** outlines the high-level and preliminary terms of the arrangement, such as the defined patient population, attribution methodology, distributive theory for shared savings, and length of the agreement.

Six-page LOA is a binding agreement that outlines the core details of the partnership, including:

- The distribution of shared savings and parameters of the patient population. The LOA for the Medicare Advantage population was then restated in a comprehensive LOA, which also included United Healthcare’s commercial PPO population.

3. **The Comprehensive ACO-Payer Contract** is a significantly more detailed determination of the terms of the arrangement stated in the letter of agreement.

**Suggestions for improving the ACO programme**

1. **Make Technical Adjustments to Benchmarks and Payments** - How these benchmarks are set can substantially impact the chances of succeeding as an ACO and being able to attain shared savings.

2. **Consider how to factor in regional variation in financial and quality performance** six quality benchmarks that require **essentially perfect performance** for the ACOs to get full shared savings. Maybe consider using achievable benchmarks of care (methodology behind this).

3. **And risk adjustment** - A central piece of calculating an ACO’s financial benchmark is effective risk adjustment for the attributed patient population.

4. **Refine how national and regional factors are incorporated into the calculation of the baseline.** For example, to reflect regional variations in spending, and refine risk adjustment methods used in calculating benchmarks.

5. **Hold all ACOs accountable to a standard minimum savings rate (MSR) of no more than 2 percent, regardless of number of attributed beneficiaries.**

6. **Add optional years 4 and 5 to performance cycle without spending rebasing, or transition to a rolling average calculation,** in order to allow ACOs more time to succeed in transitioning to accountable.

7. **Create a transitional path towards prospective Population Based Payment or other capitation-based payment models.** How those rates should be set will need to be decided. CMS would require assurances of financial viability such as through capital reserves or surety bonds.
8. **Require two-sided risk for large organizations after first performance cycle**, but permit extended one-sided risk for smaller organizations.

9. **Create opportunities for coordination to improve care** and to share the associated savings and risks between ACOs and groups involved in Part D services.

10. **Extent to which individual employee contracts are bound up with the global ACO contract** – especially medical staff as key decision makers.

**Shared savings rule**

Within this it is critical to understand the shared savings rule.

CMS = 50:50 shared savings.

This is a mixed model of downside risk management – depends on size, level of risk the org is prepared to take.

Speed of movement towards downside risk is key.

Min Savings rate – you have to save x% before you can participate in the shared savings model. In CMS, x = 2.5%. And then your 50% share is everything above that 2.5%.

This effectively cuts out many of the large Pioneer ACOs.

And the Medicare (MSSP). Most – 2/3 to 3/4 don’t qualify for this as they can’t get to the 2.5% saving.

This discourages providers as they have to put in a lot of infrastructure and thus they won’t take this up front risk.

The BSBS ACO offer is 1% minimum savings rate (relative to the reference population) – and above this it’s a 50:50 shared savings model.

For providers not hitting the 2.5% (Medicare and Medicaid) - having made the investment - are not eligible (on account they haven’t got to the 2.5% threshold) thus they are moving away and leaving the ACO market.
**Contextualisation of the evidence on finance**

A recent conversation with a BCBS executive led to his summary on the evidence coming out of ACO experiment in the States (payer side).

Not so great news on CMS evaluations – financially, quality is a different picture – more positive, though not universally.

Confounded and made more complex by CMS payment system. CMS need to change the model. Its important to set the CMS ACO findings into context of what's happening elsewhere in the US HC system.

Last few years – trend in US is 5-6% annual increase. The ACO has got to beat the market trend. Thus hospital has got to keep the increase below 3%ln the commercial population that BCBS have some products this HAS happened – seems to have reduced the trend.

**Contractual form and finances**

- 3 yr contracts. Settle every year.
- Block contract - Notional per patient year payment or actual per patient year. Forces the notion of Cheapest setting of care AND “event rate changing interventions” AND population management
- Shared savings. Risk and gain share - Per member month targets. Benchmarked against the baseline year and against comparators. Aim is to decrease the trend in cohort vs compare against a reference cost. Both are valid and actively used. If beat the trend then split 50:50 with provider
- Central is a requirement to get provider to hold line on their price increases - This is part of the deal, and the risk calculation that a provider and a payer makes when they are considering heading down this route. With power and control over the pathway comes an absolute contractual requirement to live within a budget. There are risks and benefits for both parties. What's to stop ACO (the provider) asset stripping and or reducing equity or access??
- in BSBC in THIS ACO model in THIS poulatation there is a 3% ROI - this is unequivocally focused on high risk. MUST have a high risk approach........
Core features of MSSP - Major technical areas of public comment on the Medicare shared savings program

- Transition to Two-Sided Risk Model (including capitated payments)
- Quality-Based Shared Savings and Shared Loss Rates
- Minimum Savings Rate (MSR) and Minimum Loss Rate (MLR)
- Performance Payment Limit and Loss Sharing Limit
- Beneficiary Assignment
- Patient Choice in Assignment
- Financial Benchmark Calculations
- Adjustments for Health Status and Demographic Changes
- Waivers from Existing Medicare Payment Restrictions
- Quality Measures

Proposed Transition Path to Increasing Financial Risk in MSSP

Increasing Financial Risk

- Traditional FFS
- Track 1: One-Sided Risk
- Track 2: Two-Sided Risk
- Track 3: Increased Two-Sided Risk
- Track 4: Partial Capitation
- Medicare Advantage Full Capitation

Increasing Support for Modifications in Clinical Practice
# Paying Providers For Value: The Path Forward

- [http://healthaffairs.org/blog/2016/01/14/paying-providers-for-value-the-path-forward/](http://healthaffairs.org/blog/2016/01/14/paying-providers-for-value-the-path-forward/)

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<td>A: APMs with Upside Gainsharing</td>
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<td>A: Foundational Payments for Infrastructure &amp; Operations</td>
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**Financial Model / Risk Sharing Gain Sharing contracts**
Considerations in developing value based payment mechanisms across multiple stakeholders

http://blog.horne-llp.com/healthcare/5-measures-to-consider-for-a-value-based-distribution-model

- Rewards should represent the relative contributions to overall value each provider and provider class delivers.

- Pooling distributable value by provider class is critical since provider classes ultimately share the reward system based on relative contribution toward overall value. Historically high-cost providers may not represent the largest contributors to high quality at the lowest cost. For example, successful providers that focus on wellness and reduce expensive specialty care and readmissions drive cost savings. In a clinically integrated organization with an effective value-based distribution model, this value is recognized and used to reward appropriate, high-quality, cost-effective care.

- Providers should be incentivised with goals that help meet the system objectives as well as the Triple Aim. The system should encourage cost-effective care, collaborative care, and clinical outcome measures. Better post-discharge care management can reduce hospital readmissions and reduce or eliminate reimbursement penalties while also decreasing direct and indirect patient care cost.

- Teamwork measures can be established to achieve collaborative care goals necessary to reach the overarching organization objectives.

- Quality measures should employ nationally recognized, evidenced-based best practices for care from accredited sources.
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<th>Suggested Improvements</th>
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<td>Incentive given as a lump sum</td>
<td>Divide lump sum into a series of smaller incentive payments. The frequency of the payments can help reinforce the incentive.</td>
</tr>
<tr>
<td>One absolute threshold to surpass in order to satisfy performance standards.</td>
<td>Use a series of thresholds (e.g. 25%, 50%, 75%, 90%). This helps avoid disincentive to improve if baseline performance is very far from the highest threshold.</td>
</tr>
<tr>
<td>Long lag time between care and receipt of incentive</td>
<td>Shorten lag time as much as possible. Rewards received right away elicit stronger behavioral responses, as there is less time for competing priorities and incentives to interfere.</td>
</tr>
<tr>
<td>Use of withhold payments (i.e., loss of income) if performance standards are not met.</td>
<td>Consider instead, allowing physicians to voluntarily put money at risk with the potential to make more in return if they meet performance standards they also choose. Such contracts still take advantage of loss aversion, i.e., the notion that people work harder to avoid losses than to achieve gains of equal value. Moreover, the active choices help ensure physician buy-in into the improvement program. Additionally, physicians may be likely to set more challenging goals for themselves.</td>
</tr>
<tr>
<td>Complex and uncertain structure of program.</td>
<td>Simplify program so that uncertainty is minimized by setting clear and upfront performance targets. People tend to be more risk averse when facing uncertainty.</td>
</tr>
<tr>
<td>Incentive often given as an increase in customary compensation payments.</td>
<td>Decoupling incentive payments so they are more meaningful and salient. Some organizations even hand out paper bonus checks to physicians during staff meetings, making peer recognition an additional incentive.</td>
</tr>
<tr>
<td>Monetary incentives</td>
<td>Use in-kind incentives such as tickets to a ballgame or dinner at a nice restaurant. Such rewards can be more motivating than monetary incentives of the same value. They can attach emotional and social value to what otherwise may be viewed as simply a monetary transaction.</td>
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Method for calculating the initial benchmarks for spending and savings targets

- In the US system this is referred to as “attribution”
- The formula is complicated but in general
- CMS uses three years of historical data for the beneficiaries who would have been assigned to the ACO had it been operational at that time
- To establish the baseline for the first year, CMS takes that number and adjusts it using the national percent change in spending
- Then CMS adds an absolute dollar change in per capita spending, based on national numbers, to predict what spending would be the following year
- That’s the spending target

Some key references for attribution

- Premier submitted a comment letter with suggested improvements to the program related to its approach to financial (and quality) benchmarking, risk adjustment, and attribution of beneficiaries, among other topics
- The Brookings–Dartmouth patient attribution methodology, a 2 percent risk corridor, and a 60/40 shared savings split for the first year
  - [https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf](https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf)
- For more details on the Advanced Payment ACO Model, see Centers for Medicare and Medicaid Innovation, [http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/](http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/)
Conversation with ACO network
Finance issues. Upside and downside risk. Who owns risk??

Key points from a teleconference with key members of ACO network. 2014.

- **In general risk lies with payer. This is as per Medicare**
- ACOs can get gain if they achieve the shared savings target
- Downside risk – really focuses mind.....
- What’s the incentive for provider to take on downside risk – more risk, more reward..... the upside only ACOs can earn 50% of the shared saving if they meet the threshold
- More risk = more reward potential. If they take on the downside risk AND upside risk they can earn 60-70% of the shared saving if they achieve the threshold
- This is based on claims and utilisation data
- In England – dealing with mixed models of payer and provider with mixed incentives will be problematic
- Attribution model – there ARE some commercial companies that can support risk adjustment. But mostly around episodic bundles etc etc.....
- Medicare looks back 3 years – what was the utilisation over last 3 years
- Eventually moving toward a more capitated model

**Contractual issues**

- Risk based contract – defining feature
- Contract form is defined by regulations
- Most wont share their contracts – as proprietary
- Longer contracts – medicare ACO contract is 3 year performance cycle (transition from pay for reporting to pay for performance)
- Some Pioneer ACOs have ended their agreement early (no financial penalty) for this.
- Most contracts min 2-3y as this is the min set up time

**The drop outs - why**

- Viewing as too risky
- The attribution model doesn’t work – doesn’t account for patient population they are responsible for
- No advantage for being in the programme – doing quite well by themselves
- Too much accountability to medicare – not ready or able to take on the risk
Patient engagement and notification

- In order to engage patients in the ACO, Monarch and Anthem sent a co-branded notification letter in May 2011 to all patients who had been attributed to the ACO using the dual ETG-Dartmouth attribution methodologies.
- This letter notifies patients of: 1) Monarch and Anthem’s collaboration in the ACO, 2) changes that they can expect as a result of the ACO, and 3) where to go for more information.

Criticisms of payment reform models that are often cited. Deal with these up front

- The premise is flawed
- Insufficiently disruptive
- No evidence to suggest it will achieve goals. The original rationale offered for payment reform doesn’t match the current objectives.
- Poses a risk re patient-centered care

[http://healthaffairs.org/blog/2014/12/12/why-i-oppose-payment-reform/?cat=once-in-a-while](http://healthaffairs.org/blog/2014/12/12/why-i-oppose-payment-reform/?cat=once-in-a-while)

Financial considerations

- Singular focus on cost / member month
- Patient attribution – providers must believe they are accountable for a patient
- Budget development – benchmarks, case mix adjustment, track and manage. A number of technical methods for this.
- Determine level of risk with payers – upside and downside. Just upside. Total capitation
- Reimbursement for activity. Focus on value not volume. Payment models and incentives, and how best to share upside and downside risk
- MAKE sure you give the providers ALL of the information about the population
- Open book finances - Up front actuarial level analysis
- Payer has all the claims data
- Measured against themselves – historic - Year 1 is baseline, Year 2 is Q premium if no degradation against baseline. Need 2 yrs worth of back claims
- How many pt in population, what morbidities, what services used
- Population health information system
- Payers job is to make available the data for WHOLE population
- There is an ALGORITHM for this
- Split between FFS, outcome oriented, capitation and other
- If you don’t talk costs - at the clinical level - much more likely to lead to downstream less efficient care. Technical inefficiency
- Understand the nature of the business - both from payer and provider level
- Even if the ROI is neutral - consider the LT impact on quality
- Payer should help provider sort their infrastructure
• Real time data needed.....
• Profile individual physicians
• 15% transaction costs
• Complex system, hard to set up

Outcomes are about “relationships, trust and collaboration plus analytics”
• Need to win hearts and minds..... Procurement ain’t gonna do it! it can & sometimes necessary
• There is no single right contractual route to outcomes. It depends on the outcomes being sought and provider landscape
• For the first time, able to pay providers for the absence of something that’s bad”in
• Why NHS is dipping its toes into the OBC pond by
• Very few outcomes can genuinely be delivered by one health provider”
• Changing unit of analysis from provider structure to the patient"
• An outcomes / poulation focus of commissioning needs linked & stratified poulation data
• “We need a tesco clubcard for healthcare - to use data to shape our services”

Data on cost and resources
• Attribution and patient level costing. Attribution model - difficult. V difficult. Lots of moving pieces
• 3-4 years worth of cost and activity data. Again - baseline and trajectories.
• Open book from provider and commissioner
• Including the data that we don’t readily capture - community and GP and social care
• Development of mechanism for live (or live ish) update - cost per patient per month
• Almost needs actuarial level analysis
• Some system investment needed here? Smarter use of existing infrastructure for this.

Contracting and financial issues
• Multi year contract – how long? 3 yr contracts? Settle every year. This deals with infrastructure investments, set up time, ROI for some investments

Payment systems for micro level
• Capitation for macro
• Block contract with outcome measurement? - Notional per patient year payment or actual per patient year. Forces the notion of - Cheapest setting of care AND “event rate changing interventions” AND population management
• Development of micro payment mechanisms that overtly reward quality and outcomes? What’s the split between FFS through to capitation. Strategic use of FFS to stimulate high value care?
Risk based Contract
- If no institutional change in provider land, how does the contract bind existing providers together. **Joint venture or Alliance**?
- Much to learn from that KF publication of Nov 14
- **Risk and gain share** - extent of two sided risk? Speed of movement to full risk share. Assume that most will take upside risk on year 1. What year of contract will provider take on downside risk
- Agree the structure of the risk and gain share - is there a min threshold of performance required to trigger gain or risk share? Does the level of risk and gain share split between provider and payer change with who is taking what risk? what is the shared savings %
- Extent / scale / timing of movement to risk and gain sharing
- A great deal to learn from the US – many technical papers available
- **Per member month targets**. Benchmarked against the baseline year and against comparators. Aim is to decrease the trend in cohort vs compare against a reference cost. Both are valid and actively used. If beat the trend then split 50:50 with provider
- What proportion of savings goes directly to front-line clinical care vs what % used to meet efficiency standards, such as provider internal efficiency goals vs that % is made to infrastructure investments with a future ROI
- What’s to stop the provider asset stripping and or reducing equity or access??

Is there a **threshold for triggering risk or gain share**? What is it?
- **What’s the incentive for provider to take on downside risk** – normally more risk, more reward.
- The upside only ACOs can earn 50% of the shared saving if they meet the threshold
- If they take on the downside risk AND upside risk they can earn 60-70% of the shared saving if they achieve the threshold. Based on claims and utilisation data.
- Dealing with mixed models of payer and provider with mixed incentives will be problematic. If alliance or similar – how is gain and risk shared between partners

**Long term process for development of risk based contract – multiple years?**
- The one-page guiding principles document - the driving forces in the partnership, such as transparency, objectivity, and a commitment to align incentives and pursue the ACO “for the right reasons”
- The letter of agreement - 10-page document enabled the organizations to proceed while allowing for flexibility and modification of contract terms as they learned from early experiences. Binding agreement outlined the high-level terms of their working relationship and the trajectory of ACO development over the next five years
- Full risk based contract
Core elements of the risk based contract include:

- Patient population parameters
- Length and frequency of attribution
- Performance metrics
- Baselines, and targets on quality and cost
- Data collection and reporting
- Budget development and distribution of shared savings
- Governance
- Exclusivity, and
- Length of contract; and
- Transparency and frequency of data sharing

Providers will eventually need to shift to a risk-bearing model, and aim to phase in a global capitation model over the course of the five-year contract. Contractual simplicity important.

Some other considerations re risk sharing

**Speed of movement to risk sharing**

- Assume that most will take upside risk on year 1
- What year of contract will ACO take on downside risk
- As it gains experience as an ACO, it is likely to take on risk in the third year of implementation.
- Proportion of both full up and downside risk that is shared in which year between ACO and payer
- What proportion of savings goes directly to frontline clinical care vs what % used to meet efficiency standards, such as provider internal efficiency goals vs that % is made to infrastructure investments with a future ROI

**Other lessons**

- Successful Risk-Sharing Arrangements Take time
- High-performing systems typically use a highly analytic process to understand their performance over time, rely on financial committees that are clear and “blunt” about the organization’s financial state, have in place multiple targeted financial initiatives, use payment reform to show how expenses could reduce revenue across multiple specific cases, have advanced clinical reporting systems, develop strong partnerships within and outside the organization to transform care, and use “next generation” analytic tools from outside organizations
- Take advantage of “low hanging fruit” that decrease utilization and optimize costs, such as ensuring appropriate use of generic and specialty pharmaceuticals, reducing inpatient stays, increasing use of ambulatory surgery center (ASC), and understanding appropriate use of lab, radiation, MRI, and CT scans
- Both one-sided and two-sided shared savings models can lead to complex calculations in determining the true amount of savings resulting from the arrangement. Incentives that are adequately aligned across the system to reward physicians that are providing not just cost-efficient, but also high-value, care
- Investment in infrastructure (or use resources from aligned partners) to manage utilization and facilitate appropriate organizational culture change. As programs move forward, there may be a combination of approaches used, including broad risk sharing or partial capitation arrangements between buyer and provider organizations.
- Bundled or episode-based payments must clearly determine what is included in specific bundles in order to justify assuming risk for those services.

- **Two sided global budget model featuring shared savings and shared risk** is consistently suggested as the best method to slow cost growth and improve quality (for example most recently in the Song NEJM evaluation of the BCBS Alt Q Contract). Thus it becomes important to define this in contractual terms – with thresholds for realising shared gain and risk.
- Those that have done best have upside and downside risk - the latter being the thing that seems to focus minds.

**“Go large” on analytics**
- Financial Modelling/Budgeting – Actuarial analysis for population; Budget targets set prospectively
- Patient attribution model for defined population – Logic must be coded and tested on population.
- The full understanding of whole population cost of care is necessary. Track back 3-4 years – will allow setting of better trajectories
- Concept of covered lives in ACO equates to registered patients in England
- Retrospective analytic – total population cost of care. Every patient, all care
- Build system to enable to prospectively monitor this, patient level. Quarterly
- Develop home grown competence – more sustainable than bought in
- Focus on cost / member month – however attribution will be difficult – lots of moving pieces etc
- Service level costing may also be needed.
- Budget development – benchmarks, case mix adjustment, track and manage. A number of technical methods for this
- Data needs to be publicly available for whole pop.
- Develop method for high cost outliers
- Negotiate “Shared Savings” percentage and Risk Corridor
- Some system investment needed here? Smarter use of existing infrastructure for this.
- Single system to link finance, quality and outcomes at patient level.
Mistakes to avoid in risk sharing financial nuances could make or break a relationship

**Payers**
- Not adequately incorporating morbidity and severity adjustments into risk sharing arrangements
- Not putting enough revenue at risk in pay-for-performance programs
- Underestimating optimal payment for bundled services
- Failing to raise the bar

**Providers**
- Not fully understanding risk and the types of risk that can be taken
- Failing to consider how risk will be managed
- Being unrealistic about infrastructure needed to manage risk

**Payers and providers**
- Not reporting encounter data and diagnosis information
- Failing to define what is included or excluded from risk-sharing agreements prior to implementation

http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/content/mistakes-avoid-risk-sharing?id=&pageID=1&sk=&date=
Monitor - Local payment examples

Multilateral gain/loss sharing: a financial mechanism to support collaborative service reform. The local payment example on multilateral gain/loss sharing is detailed guidance on developing new financial mechanisms to support service reform.

www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models#multilateral-gain-loss-sharing

- Designed to encourage and provide helpful guidance to local care
- Economies that want to design and implement gain/loss sharing arrangements to change care delivery.
- Single or multiple commissioners, single or multiple providers
- The design could be divided into two closely connected elements:
  - The underlying payment model (step 4a)
  - Possible gain/loss sharing mechanisms (step 4b)

Section 4 below includes three examples of such payment approaches.

When designing a gain/loss sharing arrangement, local care economies should question whether they avoid potential risks, to mitigate them appropriately.

Questions include:

Is the allocation of financial risk appropriate regarding each organisation’s ability to manage risk and cope with potential losses? This could possibly not be the case in a capitation model without any gain/loss sharing.

Does gain/loss sharing incentivise providers to increase activity and revenue in areas not covered by the arrangement (resulting in an unintended overall increase in commissioner expenditure)?

Does the gain/loss sharing arrangement incentivise providers to shift care to services it does not cover, putting the commissioner at risk of paying twice for the same care?

Is the gain/loss share arrangement easily understood? These arrangements range from the simple to highly complex. The right balance must be struck between simplicity and designing incentives that will change organisations’ behaviour.
Design choices for the gain/loss share arrangement.

There are a number of design choices required for a gain/loss share arrangement, these include:

a) duration
b) setting the baseline
c) payment model
d) regular reporting and invoicing
e) calculating the gains/losses
f) sharing the gains/losses between providers and commissioners
g) sharing the gains/losses between providers  - (depends on % share of risk. More risk leads to greater share)
h) sharing the gains/losses between commissioners. - (depends on % share of risk. more risk leads to greater share)

Alternative approaches to sharing gains/losses between providers.

Other bases for determining the split of gains/losses between providers include:

Patient flows and patterns of demand – based on referral, conversion or conveyance rates; this relies on the assumption that in some cases, certain providers’ increased activity could reduce referrals to acute services.

Impact of change on the provider (reduction in activity and revenue) – the lower a provider’s volume of activity, the greater its share of the gains (and the smaller its share of the losses) while the provider reduces its fixed cost base.

Individual provider performance on specific targets – for example, their individual scores against performance and quality metrics.

These options are not mutually exclusive and a combination could be used.
Developing a capitated payment approach for mental health
Monitor / NHSE

Enablers to developing a capitated payment approach

Data

Governance

Robust relationship

Quality and outcome measures

Steps in developing capitation

Identify the population to be covered by capitation

Identify and define services covered

Select a method for determining the price per person per year

Agree contract duration

Design provider-to-provider payment mechanisms

Agree financial gain/loss sharing arrangements

Link quality and outcomes to payment

Further resources, including local payment examples on outcomes-based payment and multi-lateral gain/loss sharing for mental health are available at: www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models