WHITE PAPER

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Accountable Care Financial Arrangements: Options and Considerations

INSIGHTS FROM THE HEALTH CARE TRANSFORMATION TASK FORCE

Introduction

The proliferation of accountable care organizations (ACOs) is a very encouraging development in the industry's move toward value-based payment models. ACOs improve population health by focusing on the Triple Aim goal of providing high-quality care at lower cost for better health. The various types of payment models that ACOs and other delivery systems might employ has led to questions about which types are best-suited for organizations seeking to build their value-based portfolios. While the Triple Aim goals of accountable care are largely agreed upon, the financial arrangements which payers, providers, and purchasers enter into with one another are continually evolving.

This paper delineates the various financial models currently utilized by ACOs, identifying which types of payers and providers typically align with each model, and outlining the associated challenges and opportunities. The information contained in this paper represents the experiences of various Health Care Transformation Task Force[1] (HCTTF) members and ACO leaders currently operating under these models, and reflects the diversity in composition among participants in accountable care.

This paper furthers the work of the HCTTF's Accountable Care Work Group to provide guidance to ACOs and other health care stakeholders in their pursuit of Triple Aim outcomes. Due to the dynamic factors which drive decision making in individual health care markets, there is general consensus that a "one size fits all" accountable care model that will best serve all organizations in all markets simply does not exist. Building on past HCTTF work – most recently, Key Elements to Consider in ACO Agreements, which directs prospective and current ACOs in their preparations for ACO contracting – this paper also serves as a resource for those seeking to better understand accountable care payment arrangements in order to determine which model is best-suited for their organization and market situations.

1) The HCTTF is a group of private sector stakeholders who are committed to accelerating the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—including patients/consumers, purchasers/employers, providers, and payers—we share a common commitment to transform our respective business and clinical models to deliver the triple aim of better health, better care, and reduced costs.

   Our organizations aspire to put 75 percent of their business arrangements into value-based payment models, focusing on the Triple Aim goals, by 2020. We strive to provide private sector leadership through policy, operational, and technical support, and expertise that, when combined with the work being done by CMS and other public and private stakeholders, will increase the momentum of delivery system transformation.

Types of ACO Financial Arrangements in Operation

We sought to develop a comprehensive list of payment models currently used by ACOs. That list, comprised of seven accountable care payment models, includes:

- One-sided risk on total cost of care;
- At-risk care management payments;
- Two-sided risk on total cost of care;
- Capitation on limited cost of care;
- Capitation on limited cost of care with one-sided risk on total cost of care;
- Capitation on limited cost of care with two-sided risk on total cost of care; and,
- Capitation on total cost of care.

For each type of arrangement profiled, we provide the following: 1) Description, 2) Payers currently employing, 3) Provider organization types participating, and 4) Level of risk transfer. Details on each financial arrangement are listed in order of increasing provider risk. Following the analysis of the different payment models, a summary table is provided listing the opportunities and challenges unique to each arrangement.

Definitions and Disclaimers

Certain policies that govern the arrangement are included in every ACO payment model. While specific approaches and methodologies vary, basic, broadly-applicable definitions can be established. It is not the objective of this paper to define and describe these technical policies of ACO payment models; the HCTTF has addressed them in past publications. Rather, its purpose is to offer high-level designations to level set on common understandings used throughout the paper.

- ***Attribution:*** The method used to determine the population of patients for which the ACO is accountable. Also sometimes called alignment.
- ***Budget/Benchmark:*** The spending level an ACO must keep actual costs below in order to earn savings.
- ***Risk adjustment:*** The process by which payers modify the budget to account for an ACO's patient population health status or burden of disease.
- ***Carve-out:*** The exclusion of certain services from an arrangement.

Also included in all ACO payment models are certain elements that are intrinsic to the very concept of accountable care, and are therefore implicit in every arrangement described below. One such element is the presence of quality and performance measurement. Provider accountability for clinical and functional outcomes is essential to achieve true delivery reform. Another implicit element of ACOs, regardless of the payment model, is the concept of "investment risk" (sometimes also referred to as "business risk"). This indirect form of risk represents the upfront investments and ongoing costs of developing the infrastructure to support effective population health management. These investments are made with the assumption of a return, either through near-term shared savings or net capitation revenues, or from long-term efficiencies.

Payment Models

One-Sided Risk on Total Cost of Care

Under this model, sometimes referred to as "upside only," the ACO has the potential to share in savings against a predetermined budget based on the total cost of care of the attributed population with no or very limited carve-outs of costs (typically for specialty pharmacy and other rare, high-dollar costs). The participating providers are accountable for these costs even though they may not bill for them in fee-for-service (FFS) systems. The providers are not responsible for losses if costs exceed the budget and, therefore, the provider typically retains 50 percent or less of the savings. Most budgets in this ACO type are established by historical costs of the participating providers, are set for anywhere between one to three years, and are updated annually for inflation or, historical cost trend, changes in risk, and the number of at risk patients.

Payers Currently Employing: Most commercial payers, most Medicare Shared Savings Program (MSSP) ACO participants (Medicare Parts A and B), and self-insured employers.

Examples of Provider Organization Types Participating: Nearly all provider organization types may participate in this type of model. Primary care is central to the model, so all organizations include a primary care component. Provider configurations vary from individual primary care practices to fully integrated delivery networks.

Level of Risk Transfer: There is no direct risk of loss to the ACO, as downside risk is not included in the contract. However, the ACO may still be subject to significant investment risk if infrastructure costs are not recouped (as described above). Depending on the risk adjustment methodology, insurance risk could factor into whether the ACO achieves savings.

At-Risk Care Management Payments

In this type of arrangement, a per-member per-month (PMPM) payment is paid to the ACO, typically to support care management or other infrastructure investments, and is accompanied by set performance targets for "earning" the PMPM. These care management fees are typically given in addition to FFS payments, but can exist along with a global budget. The amount of the PMPM payment and the targets are negotiated between the ACO and its health plan or purchaser (e.g., employer group) partners. The PMPM payment may vary significantly depending on what is included, but it is typically given to support patient-centered medical home (PCMH) development or other primary care infrastructure; a portion of this may also be held to fund shared risk bonus distribution based on quality and/or cost performance. A higher PMPM may be allocated for an attributed high-risk population that is documented to be engaged in health management processes. The level of PMPM can vary to reflect any associated risk arrangement (e.g., a lower PMPM used in conjunction with the potential for a higher gainsharing percentage versus a higher upfront PMPM payment matched with lower gainsharing/risk).

Payers Currently Employing: Typically commercial payers, including both insured health maintenance organization (HMO) and preferred provider organization (PPO), and self-funded PPO arrangements.

Examples of Provider Organization Types Participating: Many types of organizations participate in this model, from primary care practices to integrated delivery networks and managed service organizations (MSO).

Level of Risk Transfer: The level of financial risk is determined by the amount of the PMPM payment, though it is typically less than 10 percent of the total cost of care.

Two-Sided Risk on Total Cost of Care

Under this model, the ACO has financial accountability for the total cost of care with no or very limited carve-outs of costs (e.g., patients with ESRD, specialty pharmacy or other rare high-dollar costs, for vision benefits, out-of-area costs, and sometimes for behavioral health services). While the financial arrangement is typically negotiated as a percent of premium or budgeted PMPM, the budgets are adjusted throughout the year and again at settlement to reflect changes in patient population (i.e., demographics, health status) and plan design/benefit changes regardless of financial arrangement.

The ACO experiences a profit or loss depending on whether the actual health care cost for the population is less or more than the budgeted amount, respectively. If the budget is not a percent of premium, then it is typically negotiated between the ACO and the health plan or employer, based on expected cost for the population and its burden of disease or heath status. That expected cost may be derived from the direct historical cost of that population, the expected cost for a similar population, or a blend of the two. It is generally trended based on an agreed upon factor that could include such variables as health care cost inflation or specific cost targets. These budgets are generally set for multiple years. It is common to have a defined or "preferred" networks of providers and other tools to manage cost and utilization. It is also common to have the full claims data set as well as external benchmarking data for population and financial analyses and reporting purposes.

Payers Currently Employing: Most commercial payers, managed Medicaid, Medicare Advantage, and "price guarantee" for self-insured employers.

Examples of Provider Organization Types Participating: Generally, larger health care delivery systems, integrated delivery networks, or MSOs accept total cost of care contracts. A substantial population size is necessary in order to have an actuarially sound population, build care management and data management infrastructures, perform utilization management services, and develop a high-performing provider network. Primary care is central to the model, so all organizations include primary care. Some organizations may only include primary care providers while others may be fully integrated delivery networks.

Level of Risk Transfer: The ACOs in this model typically takes on full risk for the total cost of care, though the ACO and the payer can agree to share risk. Risk can be managed with reinsurance, as well as having a portfolio of similar contracts with different populations (e.g., commercial, Medicare, Medicaid). Risk can also be passed down to providers as needed within fair market valuations.

Capitation on Limited Cost of Care

This payment model consists of a capitated PMPM fee paid for limited services, an intermediate step between FFS and full risk, often referred to as "partial capitation." This model is most often used with portions of a network, such as primary care providers, alongside portions of provider services, such as their professional services (e.g., evaluation and management (E&M) codes). One benefit of this model is, with certain services covered under the capitated payment and others paid FFS, the ACO entity is incentivized to deliver care in the most appropriate setting. Examples of such services could include vaccinations, plane film radiographic studies, EKGs, office-based procedures, and well visits. The determination of what services to include within the capitated payment and what services to carve-out is made based on the behaviors the stakeholders desire to impact. For example, paying FFS for EKGs can help to deter unnecessary referrals to cardiologists. The amount of the capitated payment is calculated by analyzing historical claims to determine the acuity of an ACO's attributed patient population. FFS rates still need to be negotiated for carved-out services, as well as E&M codes for those patients who choose not to select or be attributed to the ACO. The fee structure is more attractive to the ACO than straight FFS model, but falls short of capitation on the total cost of care.

Payers Currently Employing: Medicare Advantage, Commercial, Medicaid.

Examples of Provider Organization Types Participating: This model is mostly used for primary care providers of all types of organizations (independent practice associations (IPA), physician-hospital organizations (PHO), and clinically integrated networks).

Level of Risk Transfer: The risk is transferred to the providers who agree to take the capitated payment for the included services they provide. This risk is colloquially referred to as "having skin in the game." Capitation analysis can be done at the end of a given year to compare payment under this model to what the payments would have been received under FFS.

Capitation on Limited Cost of Care with One-Sided Risk on Total Cost of Care

As its title suggests, this model is a combination of two previously described models, capitation on a limited cost of care and one-sided risk on the total cost of care. Nearly all of these arrangements include capitation covering the cost of care directly delivered by members of the ACO, with one-sided risk for the costs of care delivered by health care providers outside of the ACO. Primarily utilized by primary care-centric ACOs, this combination allows for recognition of differing levels of control an ACO has over the services provided by its participating providers versus services provided outside the ACO. The portion of health care costs under capitation is set in advance, while the shared savings for the total cost of care is determined retroactively based on actual costs compared to the predetermined benchmark.

Payers Currently Employing: Limited commercial utilization. It is more common for ACOs and payers to utilize the next arrangement of "Capitation on Limited Cost of Care with Two-Sided risk on Total Cost of Care." Once an ACO can take some form of capitation, they are likely to be able to handle two-sided risk as well.

Examples of Provider Organization Types Participating: Primary care-centric ACOs and PCMHs or IPAs. Typically, these groups would already have capitation on limited costs of care to which one-sided risk on the total cost of care would be added at a later date.

Level of Risk Transfer: There is no risk of loss to the ACO on total cost of care, so it does not take on risk directly through the contract. Depending on the risk adjustment methodology, insurance risk could factor into whether the ACO achieves savings. ACOs of this type make varying levels of investment in attempts to achieve savings and those investments are at risk. The ACO also takes significant risk on capitation and business risk on its investments in non-billable services.

Capitation on Limited Cost of Care with Two-Sided Risk on Total Cost of Care

Similar to the previous model, under this arrangement, capitated payments are made using a PMPM payment rather than FFS for individual services provided. Typically, the capitation is limited to professional medical services, while facility and prescription drug expenses are paid FFS under a separate budget. This model includes shared savings and downside risk for inpatient services, and occasionally for total cost of care (including pharmacy and other ancillary services). The ACO shares savings against a predetermined budget based on inpatient or total cost of care of the covered persons. The degree of downside risk may be negotiated in conjunction with shared savings, (i.e., a higher degree of shared savings may be associated with greater downside risk, while downside risk within a corridor may be attached to a higher threshold for shared savings or smaller percentage of shared savings). The payer typically retains a portion of the savings based on the level of risk.

Payers Currently Employing: Some commercial payers, particularly those with extensive experience in traditional HMO products with delegated provider organizations.

Examples of Provider Organization Types Participating: Fully integrated delivery networks, IPAs, primary care and multispecialty medical groups, health systems.

Level of Risk Transfer: The ACO is at risk for the patient population that has selected participating primary care physicians or that is attributed to them for a defined group of services. For those patients, they agree to provide a full range of services. Any exclusions should be clearly defined in a Division of Financial Responsibility document. The ACOs are not at risk for the total cost of care, but will share in savings if their costs are under budget.

Capitation on Total Cost of Care

As described in the previous capitation arrangements, under this model capitated payments are made to the ACO entity based on a PMPM basis rather than for individual services provided. Different from limited cost of care, total cost of care is defined to encompass all services, including medical, facility, behavioral, pharmaceutical, and laboratory. Even though additional providers might be involved such as through a carve-out behavioral health vendor the associated costs would be included for the purposes of calculating total cost of care. Thus, the ACO assumes risk not only for the services they provide, but for the services that others provide to its patient population as well. Most budgets in this type of payment model are set against historical costs of the participating providers in combination with local market costs. These budgets are set for anywhere between one to three years and are updated annually for inflation and changes in risk. For this reason, understanding the proposed budget (premium and benefit package) compared to the ACO's projected cost trend is critical.

Payers Currently Employing: Most commercial payers (typically in an HMO or Exclusive Provider Organization (EPO) product), Medicare Advantage, and some Medicaid managed care.

Examples of Provider Organization Types Participating: Fully-integrated delivery systems and provider organizations with a defined physician and contracted hospital network. Can also be used with narrow networks in commercial insurance.

Level of Risk Transfer: The ACO agrees to provide services regardless of the ultimate actual costs. ACOs in this arrangement use stop-loss insurance, which establishes a maximum threshold for which the ACO is financially responsible, protecting the ACO from losses due to catastrophic events. In some instances, certain carve-outs (e.g., high-cost conditions) are used rather than stop-loss. Like other models, the risk adjustment methodology plays an important role in compensating for adverse risk selection. The volume of patients covered is another important factor to consider, as larger volumes help cover the fixed costs associated with providing care. ACOs of this type must make significant investments in the infrastructure to support efficient care management.

ACOs in this arrangement must also decide how to allocate risk and reward within its network of providers. In an integrated delivery system or medical staff model, primary care physicians and select specialists are often employed by the ACO. Under an IPA model, ACOs might pay its primary care physicians a capitated PMPM payment. A similar arrangement may apply for select high-volume specialty care, or "contact capitation" covering an episode of care initiated by an identified trigger event. If an ACO maintains a large portion of payments under FFS, a percentage withhold is commonly applied to establish a financial reserve for potential downside risk, and distributed along with any potential budget surplus. Such funds may also be used to support pay-for-performance incentives. Similarly, an ACO may establish fixed PMPM or percentage of premium with its contracted hospitals and/or ancillary providers; alternatively, it may also establish an internal shared risk arrangement.

Opportunities and Challenges

The table below lists examples of the key opportunities and challenges associated with each ACO payment model. It is worth noting that some of the opportunities and challenges apply to all or a broad subset of arrangements.

Type of Arrangement	Opportunities	Challenges
One-Sided Risk on Total Cost of Care	• No direct risk of losses • Variety of providers can participate • Most payers accept ACOs that meet minimum criteria (i.e. covered lives, care management)	• Patients are free to see providers outside of the ACO • Could be subject to significant reduction of savings depending on risk methodology and benchmarking • Reconciliation of paper capitation creates significant cash flow delay
At-Risk Care Management Payments	• Provides additional funding to support care management or PCMH infrastructure • Supports capacity-building in IPAs and provider organizations • Variety of provider types can participate	• PMPM dollars can range significantly – small dollar amounts may not garner the desired attention to provide/implement the desired value-add services if the population is small • Making the business case and demonstration of ROI, particularly for self-funded employers, to support additional funding model if other services such as disease management are already included in ACO fees • If using a higher PMPM to target high-risk individuals, assurance that risk modeling is based on prospective methodologies leading to appropriate member identification and engagement • Agreement on length of PMPM commitment (e.g., “graduation” from a targeted condition management program or change in status once triggers for “high risk” classification are addressed) • Funds are usually insufficient to support full staffing and infrastructure and should viewed as contributory to other investments a provider organization may need to make • Allocation of PMPM between a provider organization and PCPs, if any • Creating the right blend of historical cost vs. target cost

Type of Arrangement	Opportunities	Challenges
Two-Sided Risk on Total Cost of Care	• Largest opportunity for savings • Infrastructure needed for one contract (care management, analytics) can be spread across many contracts • Extensive investments in patient-centered primary care can be made if they are offset by prevention of high-cost acute episodes	• Must have strong financial modeling and be savvy with contracting • Need strong tools for capturing health status • Need enough covered lives to mitigate financial risk • Need infrastructure to manage population health
Capitation on Limited Cost of Care	• PCP support – smooths out cash flow, allows for innovation of care delivery, paid to manage patients and not just see them • Can add additional capitation payments for desired behavior	• Provider education • Accurate attribution • Not all payers able to load capitation schedules • FFS rates for carve-outs • Practices must check eligibility against an attribution file • Creation and maintenance of the DOFR
Capitation on Limited Cost of Care with One-Sided Risk on Total Cost of Care	• Smooths out PCP cash flow • Only introduces risk where ACO has direct cost control • Acknowledges influence of primary care without putting PCPs at risk where they do not have control	• Accurate attribution • Payer concern that ACO will shift services out from under capitation • Difficult for payers to administer

Type of Arrangement	Opportunities	Challenges
Capitation on Limited Cost of Care with Two-Sided Risk on Total Cost of Care	• Encourages management of total cost of care • Aligns incentives across provider segments • Supports improved provider care coordination and integration • Builds ACO capabilities at network management • Incents appropriate care, utilization management and reduction in waste; Deficiencies in cost control cannot be offset with higher volume of services • Depending on the types of provider payments in use, reduces incentives to unbundle, up-code, and recoup losses from other service lines	• Budgeting process if provider-payer negotiations are not aligned and coordinated (e.g., a favorable stop/loss reinsurance term or rate renewal for a hospital could have adverse impact on pool performance) • Steerage to preferred hospital arrangements • Care coordination across different types of providers • Frequency of reporting on financial performance – e.g., impact of high cost claimants • Access to data and integration across providers and facilities • Coordination with health plan or other intermediary to identify and repatriate out-of-network emergency department and/or hospital admissions • May require financial reserves, licensure or compliance with state-specific regulatory requirements for risk-bearing entities • Necessitates learning curve on business operations such as implementing accrual accounting and timing of capitation payments • May incent selective contracting of tertiary facilities to reduce potential adverse risk • Potential for underutilization or avoidance of risk (e.g., selection of surgical cases)
Capitation on Total Cost of Care	• Autonomy and flexibility • Patients see providers within ACO • Greater incentives for care coordination, utilization management, and waste reduction • Supports wellness/prevention • Reduces incentive to recoup losses from other service lines (dependent on provider payment type) • Encourages patient engagement with annual review by PCP; important for attribution.	• Requires network/referral management • Access to data • Coordination with health plan to repatriate out-of-network ED/hospital admissions • May require financial reserves or other regulatory mandates • Learning curve on business operations (i.e. cost accounting) • Need for highly sophisticated financial data analysis and resources

Conclusion

Decisions about which accountable care model to employ is very organization and market-specific, with a focus on the patient population to be served, the relationships between providers and payers, and the goals that the ACO seeks to achieve. Effective execution on an appropriate model requires careful planning, including a thorough self-assessment and an evaluation of available models, their characteristics, and how they are being used by other like organizations who share a goal of achieving Triple Aim outcomes through value-based contracts. The very first step for organizations seeking to enter into or expand their participation in value-based payment models is to learn about the variety and scope of payment arrangements that are available. The HCTTF's goal in providing this paper is to provide interested organizations with a basic understanding of the many complex payment models available to ACOs.