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Fundamental Concepts for Managing Risk and Understanding the Total Cost of Care



This resource is designed to serve as a primer for anyone interested in gaining a better understanding of health payment models in California and nationally. It focuses on concepts and terminology related to value-based payment models and to health care delivery models and systems.

The publication is organized alphabetically by **key concepts** (in **purple**). Terms that are related to a key concept are defined below that concept. Words that are *italicized* are defined elsewhere in the publication.

The publication was prepared by the California Quality Collaborative, a managing partner of the California Improvement Network (CIN). CIN encourages others to share this document broadly with their networks.



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Attribution

The process of matching a specific person to a provider, *accountable care organization*, or *provider organization* in order to determine clinical outcomes and/or total cost of care. Attribution may be prospective (i.e., at the time a member enrolls, before any care is provided) or retrospective (i.e., after care has concluded for the contract period and an evaluation, based on either visits or the total cost of care, has been conducted to determine which provider was responsible for the majority of the person's care).

Capitation payment

A fixed amount of money per patient, per unit of time (e.g., one month), paid in advance by a health plan to a *provider organization* for the delivery of a defined set of health care services to a defined patient population.¹ This amount is paid regardless of whether the patient seeks care or how much care is utilized. The *provider organization* is "at risk" for this amount. That means if the cost of care is more than the capitation payment, the *provider organization* absorbs the loss, and if the cost of care is less than the capitation payment, the *provider organization* retains the savings.

1. **Global capitation:** A capitation arrangement whereby providers deliver or arrange for all health care services a patient may need, rather than for only a subset of all care.
2. **Partial capitation:** A capitation arrangement whereby providers deliver or arrange for a defined subset of services that a patient may need (e.g., primary and specialty care but not hospital services).

- a. **Percent of premium capitation:** A type of *partial capitation* whereby a health plan pays a *provider organization* a percentage of each patient's health insurance premium, for all assigned health plan members. The contracted *provider organization* is at risk for all aspects of patient care defined in its contract with the health plan and also for how well the premiums set by the health plan match the cost of care. Success using this payment model requires savvy on the part of the contracted *provider organization*, to determine whether the premiums set by the health plan appropriately reflect anticipated costs. Percent of premium capitation is a common model used in Medicare Advantage contracting.
 - b. **Primary care capitation:** A type of *partial capitation* in which a *provider organization* is at risk for all primary care services (e.g., preventive, diagnostic, and treatment services; outpatient injections and immunizations; outpatient labs; routine screening; and patient education) used by a defined population of patients. Inpatient care, including acute care hospitalization and skilled nursing, is not included.
 - c. **Professional services capitation:** A type of *partial capitation* in which a *provider organization* accepts financial responsibility for all professional services, regardless of whether such care is delivered in an inpatient or outpatient setting.
3. **Carve-out:** A defined service or set of services not included in a *capitation payment* (e.g., mental health, substance use disorder treatment).

4. **Risk pool:** The percentage of a *capitation payment* that is used by a health plan to pay claims. If there are surplus funds in a risk pool after the contract term ends, any remaining funds are distributed according to the contract (e.g., the contracted *provider organization* might receive a share of the surplus). Conceptually, risk pools are similar to *shared saving arrangements*. Risk pool arrangements also function similarly to *withholds* but are funded through a preset allocation of premium dollars rather than through a deduction.²
5. **Withhold:** An amount of money a health plan deducts (i.e., withholds) from a *capitation payment*. At the end of a defined period of time, either the payer will repay the amount of the withhold to providers who performed well, or the payer will retain the funding to make up for financial losses.³

Clinical integration

An affiliation strategy used by hospitals and providers to align clinical guidelines, protocols, technology, and coordination in order to improve quality, outcomes, and cost. Clinical integration can provide a basis for performance incentives, typically using a risk-sharing methodology. Clinical integration also has legal implications for joint negotiations in contracting.

Delegation

A strategy whereby a health plan gives a *provider organization* financial responsibility for clinical services (e.g., *professional services*, *institutional services*, *ancillary services*) and/or administrative and

population health functions (e.g., *credentialing*, *utilization management*, *quality improvement*).

1. **Delegated model:** An approach to health care delivery whereby the responsibility and financial risk for providing a defined set of services or functions to a specified population is delegated by a health plan to a *provider organization*, typically a *medical group* or *independent practice association*. In return, the *provider organization* receives a capitation payment. California has a much higher degree of delegation than other states. More information on the delegated model in California can be found on the [California Health Care Foundation website](#).
2. **Division of financial responsibility (DOFR):** A tool used in the contracting process that describes whether it is the payer or the *provider organization* that is financially responsible for delivering a given service.
 - a. **DOFR clinical services:**
 - i. **Ancillary services:** An umbrella term that typically includes diagnostic and therapeutic services (e.g., imaging, labs, home health) that supplement care and services provided by primary care and specialty care providers. For the purposes of *delegation*, ancillary services are defined in the delegation agreement.
 - ii. **Institutional services:** Services provided in hospitals, skilled nursing facilities, or hospice facilities (e.g., nursing, staff, facility operations, some pharmaceuticals). Institutional services do not include services associated with care provided by physicians, nurse practitioners, or physician assistants; such care is known as *professional services*.

- iii. **Professional services:** Services rendered by physicians, nurse practitioners, physician assistants, and sometimes other providers.
- b. **DOFR administrative and population health functions:**
 - i. **Credentialing:** The process of verifying and organizing a provider's professional records, including those related to education, licensing, and malpractice. In the context of *delegation*, credentialing means that the *provider organization* assumes responsibility for vetting a provider's professional records prior to the provider's participation in the network.
 - ii. **Utilization management:** A systematic process of determining medical necessity and the appropriateness of different care options through data analysis, discharge planning, concurrent clinical review, peer review, internal audits, and other activities. Utilization management typically focuses on activities that drive the cost of care and for which there may be alternatives (e.g., specialty referrals, hospital admissions, procedures). For the purposes of *delegation*, a *provider organization* would undertake this process using criteria developed by each health plan. Utilization management is one tool to manage costs and efficiency.

Insurance product

A discrete package of health insurance benefits and services that is linked to a specific provider network.⁵

1. **Health maintenance organization (HMO):** An *insurance product* whereby a health plan contracts with a delivery network to provide care to a defined patient population for a set fee. In an HMO model, patients typically pay extra to see providers who are outside of the contracted delivery network. HMO delivery networks may include:
 - a. **Group model HMO:** An *HMO* that establishes quasi-exclusive contractual relationships with one or more *medical groups*, primarily to treat the medical group's patients.⁶ The Permanente Medical Group and its affiliation with Kaiser Permanente is an example of a group model *HMO*.
 - b. **Network model HMO:** An *HMO* that establishes contractual relationships with one or more *medical groups*, *independent practice associations*, and/or independent physicians in order to treat the patients of participating providers as well as other patients.⁷ Outside of Kaiser Permanente and the Permanente Medical Group, the network model is the predominant provider organization model in California.
 - c. **Staff model HMO:** An *HMO* consisting of a physician group that takes payment directly, rather than contracting through a separate health plan. In a staff model *HMO*, most physicians are employed by the *HMO*.⁸ This model is uncommon in California.
2. **Preferred provider organization (PPO):** An *insurance product* whereby a health plan contracts with a provider delivery network in order to offer the provider network greater patient volume or other benefits in exchange for a discounted fee. Patients using PPO delivery networks have reduced cost sharing or fewer restrictions when receiving care from the contracted delivery network. In

California, PPOs may be regulated by either the *California Department of Insurance* or the *California Department of Managed Health Care*, depending on their structure.

3. **Exclusive provider organization (EPO):** An insurance product whereby a patient must use providers in the contracted delivery network to receive covered services. An EPO is typically considered to be in between a *PPO* and an *HMO*. Unlike patients in a *PPO*, patients in an EPO cannot see a provider outside of the contracted delivery network by simply paying a higher rate of cost sharing.
4. **Provider-sponsored health plan:** An insurance product whereby a health plan is owned or significantly controlled by one or more health care providers. Such a plan may require members to receive services primarily or exclusively from its provider network, or it may allow members to access a broader network. A provider's financial risk is lower in a contract with its own health plan, as compared with another payer, because differences between the payments for services and the costs of those services will ultimately go back to the *provider organization*.⁹

Knox-Keene license

The statutory framework used to regulate risk-bearing organizations (e.g., *HMOs*, managed care plans) in California.¹⁰ Entities that assume *global risk* must apply to the *California Department of Managed Health Care* for a Knox-Keene license. Among other requirements, Knox-Keene requires plans to report operational and financial solvency and to submit corrective action plans when such requirements are not met.¹¹

Payment model

A method of paying providers for health care services. Payment models range from the traditional fee-for-service model to *alternative payment models* that offer flexibility for *provider organizations* with respect to service delivery and the design of mechanisms to impact utilization, efficiency, quality, and outcomes.

1. **Alternative payment model (APM):** An umbrella term for approaches to paying for health care that typically include some mechanism to financially incentivize providers or hold them financially accountable for cost and quality. The *Centers for Medicare & Medicaid Services* (CMS) also has a specific definition for what elements a payment model must include in order to be considered an APM under the Medicare or Medicaid programs.
2. **Advanced APM:** An APM that meets three criteria, described as follows by CMS: it uses certified electronic health record technology, it pays for covered professional services based on quality measures comparable to those used in CMS's Merit-Based Incentive Payment System (MIPS), and it either conforms to the expanded Medical Home Model or requires participants to bear a significant financial risk. Clinicians who bill exclusively through a federally qualified health center, community health center, or rural health center are exempt from MIPS reporting.
3. **Shared savings arrangement:** A *payment model* that includes elements of shared savings and/or shared losses. According to CMS, shared savings arrangements may be either an *APM* or an *advanced APM*, depending upon their specific structure. *Accountable care organizations* (ACOs) are sometimes also referred to as shared savings arrangements.

- a. **First-dollar shared savings:** A model whereby a provider's share of savings is calculated based on the total amount of savings, rather than first being required to meet a minimum savings threshold.¹²
 - b. **Downside risk:** A *shared savings arrangement* whereby participants take responsibility for an attributed population of patients over a specified time period and bear some financial liability for costs that exceed a specified threshold. Downside risk is also referred to as shared losses.
 - c. **Upside risk:** A *shared savings arrangement* whereby participants take responsibility for an attributed population of patients over a specified time period and share in net savings that result from improved care delivery and outcomes. Upside risk is also referred to as shared savings.
 - d. **Two-sided risk:** A *shared savings arrangement* whereby participants take responsibility for an attributed population of patients over a specified time period. Participants either share in any savings or bear some financial liability for any losses, depending on whether the actual cost for services delivered to the population is more or less than expected. Two-sided risk is also referred to as *upside and downside risk*.
4. **Gain sharing:** The sharing of financial incentives as a result of improved cost-effectiveness and/or quality outcomes, often in the form of shared savings or incentive payments.¹³
5. **Bundled payment:** A single price paid for all services needed by a patient for a diagnosis or condition over a specified time period. For example, a bundled payment could cover hospitalization, subsequent outpatient visits, and care coordination for 60 days from the date of hospital admission for a condition like joint replacement, heart attack, or stroke. A bundled payment is also referred to as a case rate or an *episode-based payment*.
6. **Episode-based payment:** See *bundled payment*.
7. **Global budget:** A set amount of money to care for a defined population of patients over a specified time period. If care costs less than the set amount, a health plan would pay the difference to the provider. If care costs more than the set amount, the provider would reimburse the difference to the health plan.
8. **Pay for performance:** Financial incentives paid to providers for meeting a specified benchmark on a set of measures. Measures typically address clinical quality and outcomes, efficiency/utilization, patient experience, and patient safety. In California, the Integrated Health Care Association (IHA) has a statewide pay-for-performance program known as "Align. Measure. Perform." (AMP). Launched in 2001, AMP now includes participation from nine health plans and about 200 California *provider organizations*. More information on AMP is available on the [IHA website](#).
9. **Pay for reporting:** A *payment model* that provides financial incentives to providers for submitting data on performance measures. Pay for reporting differs from *pay for performance* in that its financial incentives reward providers' capability to submit data on an established measure set, rather than their performance on the measure set itself.

Payment model framework

A payment framework developed by the Health Care Payment Learning and Action Network — a public-private partnership supported by the CMS. Its four-tiered framework was developed to establish a standardized approach to track progress on payment reform. The framework includes four major categories of *payment models*: (1) fee-for-service with no link to quality and value; (2) fee-for-service linked to quality and value; (3) APMs built on fee-for-service architecture; and (4) population-based payment.

Provider organization

A group or network of physicians who work together to provide care to a defined patient population through contracts with health plans.

1. **Accountable care organization (ACO):** An entity consisting of a group of health care providers (e.g., physicians, medical groups, hospitals, other health care providers) that voluntarily agree to work together and assume responsibility and some degree of financial risk for the care of an attributed patient population.¹⁴ ACOs typically allow patients more freedom to seek care outside of the ACO provider network than do *health maintenance organizations*. An ACO may include different *payment models*, such as fee-for-service, *capitation payments*, and/or shared savings. Providers may participate in an ACO as well as in an *independent practice association* or a *medical group*.
 - a. **Medicare Shared Savings Program (MSSP):** A payment model established by the Affordable Care Act and administered by the CMMI for an ACO that delivers care to Medicare patients. ACOs

must apply to and be accepted into the MSSP prior to their participation. CMMI offers options to allow ACOs to assume various levels of risk. More information on these options is available on the CMMI/Innovation Center website.

- b. **Medicaid ACO:** An ACO within a state's Medicaid program, established under provisions of the Affordable Care Act. States may allow for the establishment of ACOs within their Medicaid programs through either Section 1115 waivers, state plan amendments, or managed care authority.¹⁵ Medicaid ACOs are referred to using a range of terminology (e.g., in Oregon they are Coordinated Care Organizations, in Colorado they are Regional Care Collaborative Organizations, in Alabama they are Regional Care Organizations). California does not currently have any Medicaid ACOs.
2. **Independent practice association (IPA):** An organization that contracts with two or more independent physician practices in order to provide health care services to beneficiaries under contract with a health plan. IPAs often take some degree of risk for the care of a population, receiving either fee-for-service or *capitation payments* for this care. An IPA may also be known as an independent physician association or an independent provider association.
3. **Medical group:** A financially integrated corporate entity whereby physicians are typically partners but may be employees, usually under the same tax identification number.¹⁶
4. **Physician-hospital organization:** An entity formed by a hospital and a group of physicians in order to provide health care services to a defined patient population for a set fee under contract with a health plan.

Per member per month (PMPM) fee

A standard unit of payment to providers or *provider organizations* from health plans for health care services.

Regulatory and oversight agencies

A federal, state, or local government entity that sets standards and ensures compliance with rules and regulations.

1. **California Department of Health Care Services:** State agency that administers and regulates Medi-Cal and Medi-Cal managed care delivery systems.
2. **California Department of Insurance:** State agency that regulates health plans and some *preferred provider organizations*.
3. **California Department of Managed Health Care:** State agency that regulates risk-bearing organizations, including some *preferred provider organizations*.
4. **Centers for Medicare & Medicaid Services (CMS):** Federal agency that oversees Medicare and Medicaid, including oversight of Medicare Advantage Plans (e.g., Medicare HMOs).
5. **Center for Medicare and Medicaid Innovation (CMMI):** Agency that is part of CMS; also known as the Innovation Center. CMMI supports the development and testing of innovative health care payment and service delivery models.
6. **Federal Trade Commission:** Federal agency that, among other responsibilities, sets some clinical integration standards for joint

negotiations and anti-trust actions. In 1996, the FTC released *Statements of Antitrust Enforcement Policy in Health Care*. The statement was jointly issued with the Department of Justice and addresses health care provider networks.

Risk adjustment

An approach to evaluating the relative health of a population in order to adjust health care payments accordingly. There are many different tools and methodologies that are used to support risk-adjustment activities.

Risk-sharing arrangement

An agreement whereby a *provider organization* takes financial responsibility from a health plan for a defined set of services (e.g., *professional services, institutional services*).

1. **Global risk:** A model whereby a *provider organization* assumes the risk for all *professional services* and *institutional services* for a defined population. In California, a *provider organization* cannot enter into a global risk arrangement unless it has a *Knox-Keene license* issued by the *California Department of Managed Health Care*.
 2. **Shared risk:** A model whereby a *provider organization* assumes the risk for all *professional services* and a health plan retains the risk for all *institutional services*.
 3. **Dual risk:** A model whereby a *provider organization* assumes the risk for all *professional services* and a hospital assumes the risk for all *institutional services*. This model is also referred to as full risk.
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Total cost of care

The sum of all health care utilization costs, including both direct and indirect costs (e.g., acute care, ambulatory care, care management, prescription drugs, behavioral health care, physical therapy), for a period of health care coverage, regardless of the provider or setting in which the care was delivered. The cost is typically calculated from the payer's perspective (i.e., how much was reimbursed for a particular service) rather than from the provider's perspective (i.e., how much it cost to deliver the service).¹⁷

Value-based payment

A generic term describing payment models whereby the amount of the payment is tied to the quality or cost of the service. Value-based payment is also referred to as value-oriented payment.

Endnotes

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