The ALLIANCE for Technology Driven Health

THE ROAD TO RISK

A TOOLKIT FOR THE MOVE TO TOTAL COST OF CARE ACCOUNTABILITY

About the Alliance

The **Alliance for Technology Driven Health** represents health systems, medical groups and technology companies with the goal of highlighting the role of technology and data in the value movement and evaluating the tools, partnerships and processes necessary to implement capitated payment models. Our Allies are leaders in both Washington, DC, and national markets who are driving discussions with plans and providers to increase awareness and to facilitate participation in performance-based payment models.

Healthcare's ongoing **shift from volume to value** enables providers to take a more holistic approach to managing population health. New payment models encourage greater collaboration and care coordination.

Across the country, healthcare systems, physician groups and technology developers are powering this movement to value.

Members

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The ALLIANCE for Technology Driven Health

Our Work

THOUGHT LEADERSHIP

The Alliance will provide a unique forum for entities committed to advancing the value movement by harnessing the power of technology. The Alliance will convene meetings for member organizations to share best practices, lessons learned and discuss strategies.

POLICY SOLUTIONS

The Alliance staff will identify legislative and regulatory barriers and opportunities for its members. This will include evaluating the regulatory environment and developing policy statements and issue briefs to explain complex issues and recommended solutions.

ADVOCACY

The Alliance will organize direct advocacy meetings. We expect these activities to include outreach to Congressional and Administration staff, occasional face-to-face meetings in Washington, DC, and other activities as identified by the Alliance leadership.

A Message from the Alliance

The US healthcare system has been structured around a fee-for-service (FFS) payment system. With the passage of the Affordable Care Act and the Medicare and CHIP Reauthorization Act of 2015 (MACRA), the Centers for Medicare and Medicaid Services (CMS) took steps to increasingly tie payment for Medicare services to value and to test delivery models, like Accountable Care Organizations (ACOs) in the traditional Medicare program.

In addition, the Center for Medicare and Medicaid Innovation creates and tests payment models designed to improve clinical care outcomes and reduce costs. While the types of models vary in scope and payment mechanism, the agency is creating opportunities for providers to take on increasing amounts of risk for care for assigned patient populations.

The Alliance supports the continued work of Medicare and all payers to advance successful value-based care arrangements. We believe value-based care is the future of the US healthcare system and will improve quality of care for patients, improve the patient and physician relationship, and provide financial stability for the healthcare system.

This toolkit provides an overview of the technology, data and other resources that provider practices need to succeed as they climb the rungs to greater levels of clinical and financial responsibility in Medicare accountable care arrangements. ACOs can successfully implement a value-based care strategy to improve their clinical practice and excel in model performance, resulting in increased financial savings.

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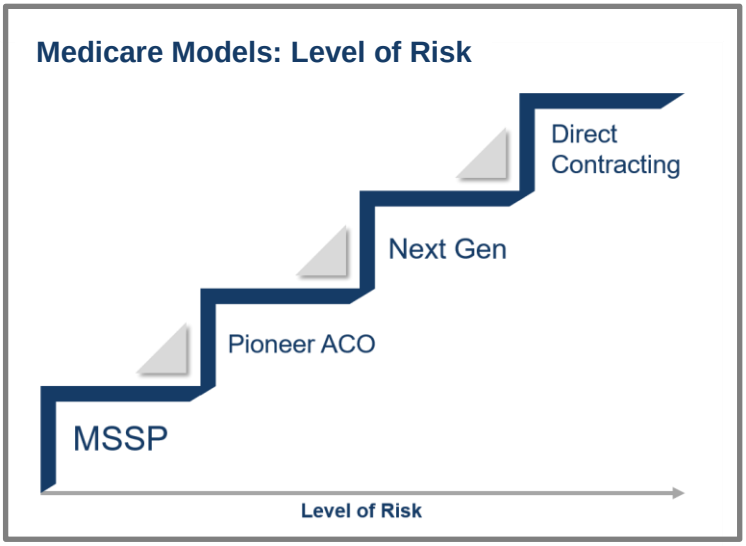
Introduction

Over the past decade, provider organizations have invested in and successfully deployed strategies in their local communities to move from volume to value. Health systems, physician groups and others have made the leap to greater levels of clinical and financial accountability across a suite of models in traditional Medicare.

The traditional Medicare model portfolio of alternative payment models (APMs) managed by the CMS Innovation Center now offers multiple options for providers who want to take risk for total cost of care, including the Medicare Shared Savings Program (MSSP), the Next Generation ACO model (Next Gen), and Global and Professional Direct Contracting (DC). These models encourage participating entities to take on risk for Medicare Part A and B expenditures.

The ACO and DC models seek to promote delivery system reforms and improve quality of care for beneficiaries through several key goals:



- **Moving away from FFS reimbursement**. These models are intended to incentivize providers to move away from a system that reimburses for the number of services provided and transition to a system that pays for value. COVID-19 underscored the vulnerabilities of a FFS reimbursement system—when patients stayed home, providers did not receive FFS payments. As patients abided by stay-home orders and avoided procedures, many physician practices faced revenue shortfalls. Total cost of care models are intended to offer a glide path to other forms of payment, including capitation.
- **Improving beneficiary outcomes**. Total cost of care models aim to improve care for beneficiaries across the continuum. These models typically allow greater flexibility to address the social determinants of health, to integrate community-based care and to engage beneficiaries in primary care services.
- **Engaging providers in the move to alternative payment models**. The more advanced APMs allow ACOs and DC entities (DCEs) to vary the way that individual clinicians are paid. Depending on an ACO or DCE's structure, these models may offer additional tools to engage individual providers, independent physician practices and others along the care continuum in the move to value-based care.

As physicians and providers move to greater levels of financial risk and reward, and work to engage clinicians and patients in new models of care delivery, technology is a key driver of success. For decades, risk-bearing payment models have demonstrated that the right technology can smooth the transition to capitated payment models and greater levels of accountability for population health. This toolkit provides an overview of the key elements of total cost of care models and discusses the types of technology participants may need to deploy to be successful.

Key Model Characteristics

The advanced APM portfolio at CMS and the Innovation Center offers a wide array of risk sharing arrangements ranging in amounts of risk, how beneficiaries are aligned, and how providers are paid under the model. The MSSP is the only APM that is currently written into statute.

	MSSP ENHANCED	Next Gen	Professional DC	Global DC
Participant Types	Considerations for initial evaluation of ACOs include experience in performance-based Medicare ACO (experienced versus inexperienced), revenue (high versus low) and previous MSSP involvement (new versus renewing)	Considerations for initial evaluation of ACOs include experience in performance-based Medicare ACO	Standard: Organizations with substantial experience serving Medicare FFS New Entrant: Limited experience serving Medicare FFS High Needs Population: Beneficiaries with complex, high needs, *i.e.*, dual eligible	
Contract Length	5 years (for new contracts as of 2019)	5–6 years (extended a year because of COVID-19)	5 years (optional implementation period, totaling up to 6 years)	
Beneficiary Assignment Methodology	Prospective or preliminary prospective with retrospective reconciliation	Prospective assignment	Prospective alignment (completed prior to start of performance year); prospective plus alignment (option to add voluntarily aligned beneficiaries on a quarterly basis)	
Medicare Payment	FFS	• FFS • FFS plus per-beneficiary per-month (PBPM) • Population-based payment • All-inclusive population-based payment	Primary care capitation	• Primary Care Capitation • Total Care Capitation
Sharing Rate	Up to 75%	80% or 100%	50%	100%
Discount	N/A but includes variable min savings/loss rates	0.5% or 1.25%	N/A	2%–5%

The Entity

In each of the total cost of care models, an entity holds the financial risk arrangement with CMS. In the MSSP and Next Gen models, the entity is the ACO. In DC, the entity is the DCE. For each model, these entities must meet certain participation criteria.

Each of the different entity types must meet certain model requirements, including the following:

- The entity must be composed of eligible participants (physician groups, individual practices, hospitals, federally qualified health centers, rural health centers and critical access hospitals).
- The legal entity must be identified by a taxpayer identification number and be authorized to conduct business in the state(s) in which it operates, and must capable of (1) receiving and distributing shared savings; (2) repaying losses; (3) establishing, reporting and ensuring compliance with quality performance standards; and (4) fulfilling other ACO/DCE functions.

Participating entities also typically must meet governance standards, which often dictate the creation of a new entity to participate in these models.

The Provider Network

Medicare models require that entities identify their participants to create a provider network. Participant providers are used to determine Medicare beneficiary attribution and overwhelmingly, although not exclusively, tend to be primary care providers.

Models may also allow the creation of preferred provider networks, which are not used to align beneficiaries but provide services to Medicare beneficiaries aligned to the model. Depending on the model, the ACO or DCE may have the ability to negotiate with preferred providers to reduce their FFS claims payments and restructure these downstream payment relationships.

Beneficiary Alignment

Across the ACO and DCE model portfolio, beneficiary alignment determines the Medicare beneficiaries for which the entity is responsible for managing the total cost of care under the selected risk arrangement. CMS also uses beneficiary alignment to determine the entity's performance year benchmark. Across models, entities must maintain a minimum number of aligned beneficiaries.

	MSSP ENHANCED	Next Gen	Standard DC	New Entrant DC	High Needs DC
Min. Aligned Beneficiaries	5,000	10,000	5,000	1,000–5,000*	250–1,400*

* CMS offers New Entrant and High Needs DCEs a glide path to increase the minimum number of beneficiaries over time. The bottom threshold is the minimum for each DCE type in PY1 (2021) and the upper threshold is the minimum for each DCE type in PY5 (2025).

Quality Reporting

Improving quality and care outcomes is a central tenet of total cost of care models. Each of the models assesses and rewards or penalizes quality performance, but does so on a different set of measures. Quality performance is also linked with financial performance. Entities that improve quality see increased savings, while entities that fail to report or perform may see financial penalties.

Financial Management

Total cost of care models require financial management at the ACO or DCE level against benchmarks or targets. Entities that beat their benchmarks can share in savings. Entities that overshoot their benchmarks are required to return funds to CMS. Different models allow ACOs and DCEs to deploy different strategies to achieve these goals, including population-based payments, primary care capitation and total care capitation.

ACOs and DCEs must also determine how they will pay out savings or recoup losses owed in a model. This aspect of financial management is integrated in the network development strategy—determining which participant and preferred providers will share in savings and/or losses and how to manage payments against performance at the individual clinician level.

The Provider Network

Entities participating in total cost of care models should assess their provider network to determine how the ACO or DCE will address chronic conditions, population health issues or other needs present among aligned beneficiaries. This strategy will help ensure that the aligned providers are capable of meeting the unique needs of their market.

Key Considerations

- Selecting participant providers who drive attribution and are eligible for 5% bonus payments under MACRA
- Selecting preferred providers who will not drive attribution
- Designing engagement strategies that optimize care management for your population

ACOs and DCEs should gather and review quality and cost data to identify high-value providers. Comparing providers on performance metrics allows the entity to focus on those who meet the model's goals. A critical factor for success in two-sided risk models is reviewing and sharing claims data with providers to promote transparency and influence clinical care behavior. ACOs or DCEs should also engage with their existing providers, leadership and board members in these decisions.

ACO/DCE-Level Data and Technology to Develop and Tier Your Network

Physician Report Cards to Improve Networks

To better understand the provider relationships, ACOs or DCEs can employ **physician report cards** to provide feedback and additional information about physician performance within the ACO or DCE. Key provider report card metrics include:

- Benchmarking cost and quality data against payer data across the market
- Shortlisting physicians based on volume
- Integrating into physician meetings and selecting the network based on cost and quality
- Communicating how physicians can reach tier 1 status
- Integrating clinical data from every specialty into the EHR
- Using data to help inform provider network/primary care providers which specialists should be used to reduce specialist utilization
- Evaluating specialist care and referrals to determine cost differentials.

Network design is a critical factor for achieving improved health outcomes for beneficiaries, timely access to care, optimized treatments and reduction in unnecessary, wasteful care. Some data about participant and preferred providers may be publicly available, while other data can be retrieved from payer partners or vendors. This data can be used to develop efficiency information for providers across the continuum of care.

Once this data has been developed and organized, it can be used to inform the development of provider agreements, determine appropriate payment models for individual clinicians or partners, and set performance expectations.

Once the accountable entity understands its preferred partner relationships, it can rely on providers to deepen their care delivery and integrated communication. The accountable entity can also build the provider rankings within the electronic medical record so all providers are aware of their efficiency when sending a referral to other clinicians aligned with the entity.

In addition to considering specific provider types to support your DCE, it is important to consider how a preferred provider aligns with the goals of the model. The table below outlines considerations and questions for evaluating certain preferred providers to join your network, and dictates the type of data and information the entity would want to have about a given partner.

Category	Description
Reputation	• Strong relationship with referring physicians in market • Participation in enhanced clinical delivery programs • High patient satisfaction within physician network • Preferred payer recognition (*e.g.*, four stars)
Cost Assessment	• At or below market average costs per episode or efficiency ranking for services • Freestanding versus facility-based • Favorable contracted rates • Par with payers
Quality Assessment	• Better than peers in market based on regional or national benchmarks • Outcomes better than your internal targets • Participation in standardized clinical pathways where appropriate
Geographic Value	• Supports your regions with satellite sites or will build them • Scalable • Brings additional partners
Advanced Practice Structure & Process	• Involved in care delivery strategies that reduce cost (readmission, coaches, post-acute transitions in care, bundled payments) • Patient satisfaction scores above 95%
Size	• Expanded hours and supportive after-hours and weekend coverage • Expansion of services available to reach demand of referrals • Access prioritization for your beneficiaries • Local, regional or national footprint
Cross-Market Value	• Leverages a tested product • Networked relationships and lessons learned across another market under value based care delivery • Builds and measures quality improvement and comparative data
Communication/Feasibility of Data Integration	• Connects real-time data with occurrences • Delivers post-care reporting with 24 hours • IT backbone to support scale

Data to Inform and Improve Network Performance

In order to drive provider performance, ACOs and DCEs should evaluate the data that will be shared with participating providers to influence care practice patterns. Data can help the provider network understand care utilization patterns and inefficiencies.

Ingestion of claims and clinical data into a care registry allows clinicians to understand their population health spend, the highest utilization patterns amongst the network, and which care management programs should be offered to their beneficiaries. Often, what is lacking is an episode grouper that combines common episode of care events and compares those costs or quality outcomes to other benchmarks or targets. This allows participants to negotiate with their preferred partners in a sub-capitated financial relationship with actual data among the care continuums. Participants need to have data presented in episodes of care to identify care deviation patterns and necessary changes in partnerships.

Recommendations to Optimize Your Provider Network

1. **Leverage data to critically evaluate your provider network** and ensure providers meet the needs of your patient population. Consider the types of providers aligned and the experience providers have in managing a patient population.
2. **Curate the appropriate data environment to facilitate the appropriate exchange of information between providers**. In order to optimally perform under the model, it is critical to have a team-based approach to care. Mapping out team-based care communication can eliminate redundancy and misaligned health activities.
3. **Provide clinicians with appropriate measures to adjust performance.** In order for both preferred and participant providers to optimally perform within the model, they need real-time data feedback. Without performance evaluations, providers are unable to adjust clinical practice patterns.

Understanding Your Patient Population

Total cost of care models require an in-depth understanding of the patient population being managed. In traditional Medicare models, beneficiaries remain free to see any traditional Medicare provider and therefore cannot be "locked in" to a specific network or set of providers. In contrast, ACOs and DCEs have some tools available to encourage beneficiaries to see the ACO or DCE network of providers. Care management and population health platforms bring in multiple data sources and create workflows to stratify your population, facilitate patient engagement and create care plans specific to those patients' needs.

Key Model Characteristics

- CMS aligns beneficiaries based upon either claims data or voluntary alignment.
- CMS uses beneficiary alignment to determine the performance year benchmark.
- DCEs and ACOs are required to maintain a minimum number of aligned beneficiaries for each performance

Stratifying Your Patient Population

Using technology to engage and manage your patient population is a big advantage in a risk-bearing environment. It is even more necessary in higher levels of risk-bearing arrangements, such as capitated models.

These types of technology systems can provide automated workflows to:

- Efficiently and effectively engage patients and manage their care
- Identify, document and track hierarchical condition categories and improve risk adjustment factor score accuracy.

The ability to see claims, pharmacy and lab information, and facility admit and discharge data gives the care manager a broad, current picture of a patient's needs and assists in identifying the appropriate care and disease management programs and plans. These work flows and data are also critical in creating a better and efficient interaction between provider and patient, which can increase both provider and patient satisfaction.

Facilitating Patient Engagement

Patient portals allow for secure real-time communication with your patient population via reminders and patient education. They also provide access to important care management resources and assist in appointment scheduling.

These platforms also allow provider groups to identify opportunities to capture and document burden of illness in the community and improve accuracy of patient severity of illness information. By creating workflows and dashboards, groups are able to see year-over-year trends, identify variances at the provider and patient level, and use tasking and communication tools to address those variances and ensure that patients are receiving adequate care. The data and dashboards can also highlight opportunities to capture accurate patient information and exchange information among care team members. Being able to aggregate and communicate opportunities during a patient encounter reduces unnecessary outreach and improves patient and provider satisfaction.

Ability to Ingest and Process CMS Data

CMS provides entities with information on their assigned population. CMS data and reports include monthly claim and claim line feed files on Medicare FFS beneficiaries. Receiving claim and claim line feed files is only a small first step toward deriving meaningful insights. Working with the claims data requires specialized knowledge of claims datasets and data programming skills, often held by actuaries, economists or specialized data analysts. Raw data must be cleaned and refined into useable analysis files that summarize information on visit types, event counts, risk score information and other key variables. Creation of analytic files requires development of programing code and logic that implements decision rules, such as the definition of a primary care visit and the definition of an avoidable emergency department visit or unnecessary hospitalization. Development of this code and file design can require a substantial time and resource investment in specialized knowledge and capabilities.

Creating Patient-Specific Care Plans

Patient-specific and patient-centered care plans enable the clinical practitioner team to ensure that each patient receives the most highly optimized care catered to their needs. Platforms that manage care plans are essential to monitor and maintain levels of care, especially for patients with chronic conditions or high needs. Patient-specific plans ensure that the patient, provider and entire care team are aligned on the patient's health goals and interests. Having a fully integrated technology platform to manage your capitated population creates a single source of information that drives efficiencies, accuracy, cost savings, improved patient care and engagement.

A team-based approach to care for patients aligned to these models is critical for improving efficiencies and eliminating care redundancies. Technology can support the network participants as they work together to manage care. For example, virtual patient check-ins can aid in preventing unplanned emergency room admissions by creating other points of entry to the care delivery system.

It is essential to have a "high-touch, high-tech" solution for providers to conduct interval assessments after the initial disposition plan is finalized upon admission. This way, everyone on the care team is on the same page, striving to have the patient arrive at home in the safest, most efficient and most supportive way.

Recommendations to Engage Your Patient Population

1. **Stratify your patient population** to better understand the needs and resources required to manage patient care. Identifying which patients require what type of care can eliminate inefficiencies.
2. **Facilitate patient engagement** with the care team to ensure alignment of goals.
3. **Create patient-specific care plans** to align patients, providers and the care team. Deploying technology to manage a care plan will ensure that resources are efficiently used to manage patients with chronic conditions or high needs.

Quality and Care Management

Key Model Characteristics

- ACOs and DCEs are assessed on quality performance for each performance year.
- CMS has increased accountability in these models by raising the stakes progressively on quality performance.

Quality and performance measurement are core elements of the move to APMs. Quality and performance measurement has been held out as a defining feature that separates ACOs and DCEs from previous managed care movements that were criticized for trying to achieve cost savings by withholding care. Performance measurement can serve as a mechanism for the payer to ensure that care is appropriately provided to patients. However, providers in these models today face a wide array of quality measures that they must manage against, including in traditional Medicare models and with commercial payers and Medicaid. Technology will play a critical role in improving your quality strategy in traditional Medicare models and managing your quality strategy in the move to value-based care.

Technology to Enable Your Quality Strategy

Entities need a fine-tuned quality performance strategy in order to facilitate successful care and financial management strategies. Participating entities should invest in three key components of their quality strategy:

1. Develop a data and reporting strategy
2. Select internal and external standards of performance
3. Develop a process for engaging clinical and administrative leadership.

Data and Reporting Strategy

Integrate Real-Time Data: Data from your electronic medical record infrastructure and clinical registries must be integrated in order develop metrics that reflect the practice's current state. This type of data is used to better understand treatment, outcomes and patient data over time and to provide meaningful insights about utilization and patient outcomes.

To be successful under a quality improvement strategy, you need timely insights into how your providers and broader organization are performing. Organizations should restructure their dashboards and reporting tools to be as close to real time as possible. Under the APM framework, it is not sufficient to rely on historical claims data alone or cookie-cutter feedback reporting for which performance measurement lags can span months or even years. While many quality measures under the Medicare models are claims-based, a comprehensive quality strategy should be actionable and informed by data that maps to the current state of clinical care delivery.

Fill the External Data Gap: What happens to patients after they leave your organization can represent a major gap in your quality data and analytics strategy. Your organization should seek out opportunities to fill these gaps through vendor-created tools or acquired longitudinal claims data.

This aspect of your data and analytics strategy may require a focus on historical as opposed to real-time data. Understanding drivers of historical care delivery patterns can inform your real-time clinical transformation strategy. Understanding these historical drivers for the claims-based measures selected under each model is essential for your successful performance.

Select the Appropriate Unit of Analysis: Map performance assessment to a meaningful unit of analysis to drive clinical delivery and patient impact. Feedback data may need to be mapped to service lines, or even to specific floors or units.

Your data reporting should be at a level where the information is actionable, and performance data should be viewable through a lens that is meaningful for your organization. Granularity of data matters—consider the clinical stakeholders and management structure involved when determining the right metrics and level of data to incorporate into your performance tools and dashboards.

Select Internal and External Standards of Performance

Your organization needs a clear process and a set of clinical leaders engaged in developing your standards of performance. Standards of performance should be driven by both external benchmarks aligned with the model framework and internal benchmarks that align with your clinical strategy and provider knowledge of high-quality clinical care delivery.

External Benchmarks: You will ultimately be measured and rewarded based on the quality measures selected under the model and the aligning performance benchmarks. Your organization should track these measures internally over time and set annual targets focused on achieving success. For each metric, a clearly identified clinical champion should set out the clinical transformation steps necessary to meet improvement targets or maintain ongoing high performance.

Internal Benchmarks: A robust quality measurement and improvement strategy also includes a focus on internal targets and measurement. Externally derived benchmarks introduce an element of relative performance and historical lag. They are also subject to revision and change by decision-makers outside of your organization, which can introduce uncertainty into your strategy. An accountable entity that aims to drive extensive transformation should also identify internal priorities and standards that are revisited annually and selected by your organizational leadership. These measures should be captured in internal dashboard and performance assessment tools, and should be based on real-time or close-to-real-time data. As with external benchmarks, a clearly identified clinical champion should set out the clinical transformation steps necessary to meet improvement targets or maintain ongoing high performance for each metric.

Develop a Process for Engaging Clinical and Administrative Leadership

Your organization needs a strong internal quality strategy and culture led by a clinical champion who understands the methods behind the measures and model, and who can serve as a respected change agent within your clinical practice. Depending on requirements and opportunities under the specific model, your strategy may include working to tie the internal distribution of incentives to program performance at the site or service level. Your clinical champion should receive support in developing a process to regularly review dashboards and performance, and should consult with internal clinical leaders on changing practice standards. This individual should be effective in the following key activities:

- Providing leadership in setting benchmarks and prioritizing measures
- Working with clinical stakeholders to understand whether poor performance on a metric is a clinical care problem or related to documentation practices

- Working with clinical and administrative leaders to align clinical transformation and quality strategy.

Recommendations to Enhance Quality Performance

1. **Develop a proactive data and reporting strategy** that incorporates real-time quality performance reports and effectively measures outcomes at an actionable level. Quality data without a meaningful way to improve outcomes will not aid in improving performance measurement.
2. **Select internal and external standards of performance** that align with your clinical strategy and provider knowledge of high-quality clinical care delivery. Incorporating both internal and external benchmarks into your quality strategy helps ensure successful quality performance within the model and continued improvement.
3. **Develop a process for engaging clinical and administrative leadership**. Having buy-in from both clinical and administrative leadership enables your organization to perform well on quality measures and to adjust clinical practice as necessary when evaluating quality data measures.

Financial Management

To varying degrees, these models enable providers to begin to move away from a reliance on FFS payments and toward alternative strategies that can better align payment across payer types, create incentives for population health throughout the care team, and form stronger relationships and care management across the continuum of care.

Key Model Characteristics

- Managing spend against benchmarks
- Potential ability to vary FFS payments across your network

Determining and Implementing Downstream Payments

Some of the models, like Next Gen and DC, offer the ability to restructure traditional Medicare payments to participant and preferred providers in the ACO or DC network.

DCEs have the option of deploying FFS, population-based payments (reduced claims paid to the participant or preferred provider) or another downstream payment arrangement. DCEs should determine how they will to pay those providers and create funds flow methodology to process payments and adjustments to those providers.

Managing Against a Benchmark

In accountable care models, CMS establishes a benchmark or target against which the entity's financial performance is assessed. Accountable care entities have different tools available to them to try to outperform their benchmark and accrue shared savings. ACOs and DCEs need financial management capabilities to evaluate their performance against the CMS-established benchmark.

When making model selections, entities should evaluate factors that may contribute to benchmark differentials, such as the regional component of a benchmark and other technical factors that may make an ACO or DCE option more or less attractive.

Benchmark in Initial Agreement Period

Attribute	MSSP	Next Gen	Standard DCE Professional	Standard DCE Global
Historical Baseline Expenditures	Part A and B expenditures for three years prior to PY1 (weighted 10%, 30% and 60%); averaged subsequent years	Continuously updated equally weighted 2-year baseline (17–18 for PY2020)	Part A and B expenditures for 2017, 2018 and 2019 (weighted 10%, 30% and 60%);	
Risk Adjustment	Risk scores are normalized and subject to a 3% cap over the	Risk scores are normalized and subject to 3% cap; 0% floor.	Normalized risk scores are subject to a symmetrical 3% cap and then to a retrospective coding intensity factor (CIF) adjustment to prevent growth in risk	

	entire 5-year agreement period.		scores. The 3% cap is on a 2-year rolling baseline. Certain voluntarily aligned beneficiaries are excluded from the CIF and the cap for a period of time.	
Discount	N/A	1.25% or 0.5% depending on risk arrangement selected	N/A (shared savings rate of 50%)	PY 1–2: 2% PY 3–5: 3%–5% PY 6: 5%
Quality Withhold*	N/A	PY 2019: 2% PY 2020: 3% PY 2021: 2%	5% benchmark withhold PY 1-2: 1% based on performance (readmissions) and 4% based on reporting only (patient experience) PY 3–6: All 5% based on performance	5% benchmark withhold PY 1-2: 1% based on performance (readmissions) and 4% based on reporting only (patient experience) PY 3–6: All 5% based on performance

**The quality withhold applies to the benchmark and is not a reduction of savings achieved. This significantly impacts the importance of quality performance across models. Poor quality performance in MSSP would reduce savings, whereas in DC it could eliminate savings altogether.*

Managing Shared Savings Payments

DCEs may wish to design incentive programs to distribute shared savings and quality incentive payments to ensure that provider payments align to the program's goals. DCEs should assess their ability to form robust funds flow contracts with providers incurring claims reductions. DCEs also should determine who is responsible for shared losses and who is eligible to share in savings.

Key decisions may include what amount of the payment to retain for investment in technology and resources for the DCE to function.

Recommendations to Manage Financial Performance

1. **Make strategic decisions about financial engagement of network providers** using financial levers available in the model to tie payment to performance.
2. **Determine how to structure and distribute surplus** if the DCE is successful against its savings targets.

Conclusion and Recommendations

Successful transition to value-based care models, especially those with the highest levels of financial risk, requires data and technology capabilities beyond those used in a FFS environment. This toolkit outlines considerations for model participants. We additionally recommend that payers, including CMS, take steps to accelerate this transformation.

- ✓ Accelerate the transformation to two-sided, total cost of care models by making more options available to entities that want to participate.
- ✓ Make additional data and information publicly accessible.
- ✓ Continuously improve attribution and risk adjustment models, including by exploring use of advanced analytics and a robust data infrastructure that moves beyond claims data to build and deploy algorithms.
- ✓ Streamline requirements across models as much as possible.
- ✓ Create a stronger feedback loop between model participants and the government as payment models are being designed. For example, provide the opportunity to comment on financial models before they are finalized.
- ✓ Incentivize private payers to become more active participants in driving the transformation to total cost of care payment models.

For more information please contact Mara McDermott at mmcdermott@mcdermottplus.com. Additional resources are available on our website: techdriveshealth.org