Risk Assessment of Emerging Payment Arrangements

Financial Solvency Standards Board (FSSB) Meeting

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Introduction

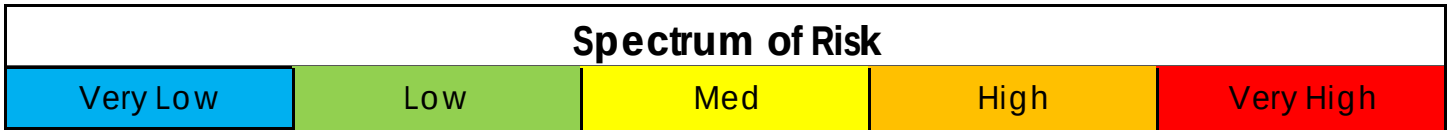
Over the years, healthcare payers and providers have developed and used a number of different reimbursement methodologies. Lately, there has been a renewed interest in developing additional types of payment methodologies. There has been a move away from the traditional "fee for service" model as a result of the desire to align incentives between payers and providers in order to achieve better overall outcomes, both financial and clinical. As the payment methodologies to providers move from fee for service to capitation, each of these different methodologies has the potential to shift risk from the payer to the provider. This document is intended to assess the level of risk of each of these methods for the healthcare provider.

Risk is the uncertainty of a future event. If the outcome of an event is known, we say that there is no risk; therefore, there is no potential for variability. Risk only comes into play when we are less than 100% certain of the outcome. As the number of events or the size of the covered population increases, the predictability of the outcome increases, and therefore the risk decreases, and this is referred to the "law of large numbers". When we talk about risk in healthcare insurance, it can be best described by splitting it into 2 types of risk:

1. **Clinical or Procedural Risk**
   Clinical risk is defined as the uncertainty of how much a particular medical event will cost. For example, if the cost to treat a heart attack patient varies greatly among patients we would say that the clinical risk would be high. On the other hand, an internal medicine physician seeing a patient for their annual checkup would have a very low clinical risk since annual checkups are routine and are very predictable. Key factors in determining the clinical risk are the volume of services provided as well as if the healthcare provider can provide services directly or if there is a need to subcontract services.

2. **Population or Insurance Risk**
   Population risk is defined as the uncertainty of how many medical events there may be for a given population. An example would be how many heart attack events there are for a given population over a given year. If statistics show that in some years there are very few heart attacks and in other years there are a lot we say that the population risk is high. On the other hand, an annual check-up would have a very low population or event risk since it is very likely that most people will have 1 check-up in a year. In other words, a low frequency of events and high cost per event introduces a high level of population risk, whereas a high frequency of events and low cost per event would have a lower level of population risk. Also, as the role of provider and insurer merge, the idea of population risk becomes even more important.

In assessing the risk level of each type of risk and total risk, we used a 5-category color coded system as follows:



While each payment methodology is assessed independently of the others, it is noted that a given contract may have multiple methodologies. The various payment methodologies are categorized into 4 major sections:

Section 1: Base Payment Methods (non-performance based)

Section 2: Non-Provider Organization entities

Section 3: Performance Based Payment Methods

Section 4: Percentage of Premium Arrangements

We have also included an overall summary of the different types of payments, a graph showing the range of risk and a detailed description with examples of each of the different payment methodologies.

Catalogue of Traditional and Emerging Payment Methodologies
Risk Level to the Contracting Organization

Section 1: Base Payment Methods (non-performance based)	Payment per: Svc/Event/ Population	Type of Entity (Hosp/Phys)	Traditional/ Emerging	Level of Risk to Provider		
				Clinical Risk	Population Risk	Total Risk
Percent (%) of Billed Charges	Svc	Hosp or Phys	Traditional	Very Low	Very Low	Very Low
Fixed fee schedule, no bundling	Svc	Hosp or Phys	Traditional	Very Low	Very Low	Very Low
Level of Care Per Diem	Svc	Hosp	Traditional	Low	Very Low	Very Low
Single Per diem	Svc	Hosp	Traditional	Low	Very Low	Low
Case rate by Diagnosis-related Groups (DRG)	Svc/Event	Hosp	Traditional	Med	Very Low	Low
Bundled Case Rate – Hospital (IP or OP) Stay Only	Event	Hosp & Phys	Emerging	Med to High	Very Low	Low to Med
Episode Bundled Payment - Hospital (IP or OP) Stay plus Post-Acute Care	Event	Hosp & Phys	Emerging	Med to Very High	Very Low	Low to Med
Physician Specialist Capitation	Population	Phys	Traditional	Low	Med	Low to Med
Partial Capitation: Only for svcs provided by org, risk adjusted	Population	Hosp or Phys	Emerging	Med	Low	Low to Med
Partial Capitation: Only for svcs provided by org, age and gender adjusted	Population	Hosp or Phys	Traditional	Med	Med	Med
Total Cost of Care Risk Pool Arrangements (ACOs)	Population	Hosp & Phys	Emerging	Med to High	Med to High	Med to High
Total Capitation: For all services for a population, risk adjusted	Population	Hosp & Phys	Emerging	Very High	High	High to Very High
Total Capitation: For all services for a population, age and gender adjusted	Population	Hosp & Phys	Traditional	Very High	Very High	Very High

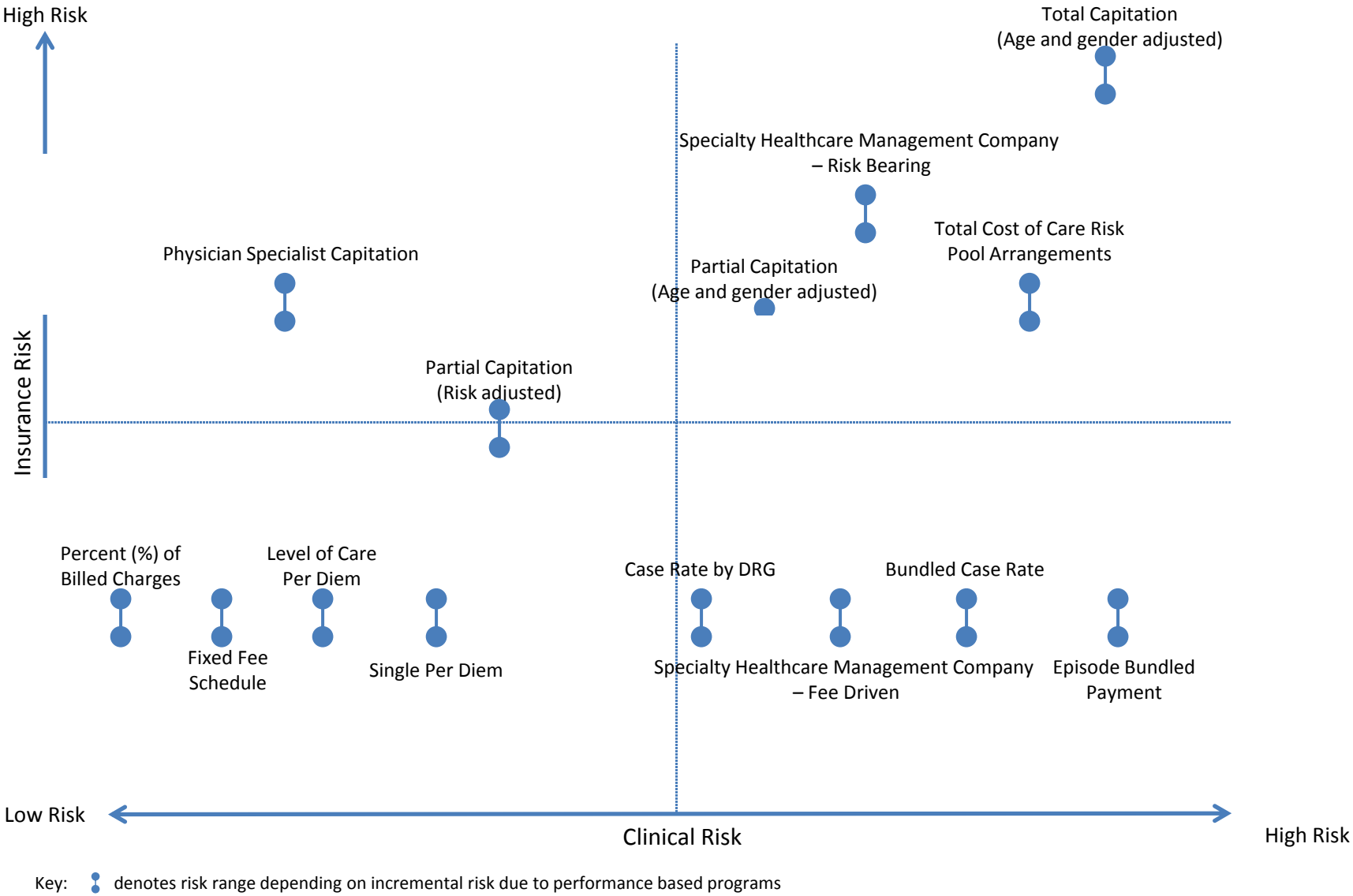
Section 2: Non-Provider Organization entities	Payment per: Svc/Event/ Population	Type of Entity	Traditional/ Emerging	Level of Risk to Organization		
				Clinical Risk	Population Risk	Total Risk
Specialty Healthcare Management Company - Fee Driven	Svc/Event	Non-Provider	Both	Med to High	Very Low	Very Low to Low
Specialty Healthcare Management Company - Risk Bearing	Population	Non-Provider	Both	Med to Very High	Med to Very High	Med to Very High

Section 3: Performance Based Payment Methods	Payment per: Svc/Event/ Population	Type of Entity (Hosp/Phys)	Traditional/ Emerging	Incremental Risk to Base Payment Method		
				Clinical Risk	Population Risk	Total Risk
Bonus payments, upside only	Any	Hosp or Phys	Both	No Change	No Change	No Change
Risk share arrangements, upside and downside	Any	Hosp or Phys	Both	1 to 2 Levels	1 to 2 Levels	1 to 2 Levels

Section 4: Percentage of Premium Arrangements	Payment per: Svc/Event/ Population	Type of Entity	Traditional/ Emerging	Level of Risk to Provider		
				Clinical Risk	Population Risk	Total Risk
Percentage of Premium - risk-adjusted premium	Population	Hosp or Phys	Both	Med to Very High	Low to High	Med to High
Percentage of Premium - non risk-adjusted premium	Population	Hosp or Phys	Both	Med to Very High	Med to Very High	Med to Very High

Definitions
1)Capitation: Payment made to provider regardless of patient utilizing svcs
2)Fee for Svc (FFS): Payment made to provider contingent upon patient utilizing svcs. Definition of svc can vary from the most granular itemization of svcs to a full event.
3)Clinical Risk: Risk within a given medical event
4)Population Risk: Risk of events occuring for a given population
5)Total Risk: Combined clinical and population risk

Catalogue of Traditional and Emerging Payment Methodologies
Risk Level to Contracting Organization



Key: ⋮ denotes risk range depending on incremental risk due to performance based programs

Section 1: Base Payment Methods (non-performance based)

Percent (%) of Billed Charges

Overview:
Reimbursement is based on a percentage of a provider's billed charges, per individual service provided.

Nature of Financial Risk
The provider has complete control over price as the basis of payment is a pre-determined percentage of the fees on their charge master.

Example of use of the Arrangement
Many hospital contracts utilize percent of billed charges for services provided, most often for outpatient services. Also, a percentage of billed charge arrangement is often capped with a maximum allowable payment.

Rating of Risk Level

Clinical Risk	Very Low
Population Risk	Very Low
Total Risk	Very Low

Fixed Fee Schedule, no bundling

Overview:
Reimbursement is based on a pre-determined fixed fee for each individual service provided.

Nature of Financial Risk:
Provider has control over the individual services and amount of services being provided, and will be reimbursed for each and every individual service.

Example of use of the Arrangement:
Professional providers are often reimbursed based on a fixed fee schedule.

Rating of Risk Level

Clinical Risk	Very Low
Population Risk	Very Low
Total Risk	Very Low

Level of Care Per Diem

Overview:
Reimbursement is based on a pre-determined fee for inpatient services provided in a day; bundling all services provided into one daily rate dependent on the level of care required such as medical/surgical or intensive care unit (ICU).

Nature of Financial Risk:
The cost to the provider for services provided to a patient for a day could vary depending on patient severity mix and the per diem fee may or may not cover expected costs. Risk could be mitigated by the inclusion of an outlier provision such as "stoploss" where a provider is reimbursed on a % of billed charges for longer stay cases. The outlier provision would provide additional payment for those occurrences in which the patient care provided far exceeded the expected amount of care anticipated.

Example of use of the Arrangement:
Hospital contracts typically utilize level of care per diems for inpatient (IP) services provided. Typically having differentiated rates dependent on the level of care required, e.g. Med/Surg, ICU, NICU etc.

Rating of Risk Level

Clinical Risk	Low
Population Risk	Very Low
Total Risk	Very Low

Single Per Diem

Overview:
Reimbursement is based on a pre-determined fee for inpatient services provided in a day; essentially bundling all services provided into one single daily rate, regardless of the level of care required.

Nature of Financial Risk:
The cost to the provider for services provided to a patient for a day could vary depending on patient severity mix and the per diem fee may or may not cover expected costs. Since there is no variation in per diem by level of care, the clinical risk level is slightly higher than that of a level of care per diem. Risk could be mitigated by the inclusion of an outlier provision such as "stoploss" where a provider is reimbursed on a % of billed charges for longer stay cases. The outlier provision would provide additional payment for those occurrences in which the patient care provided far exceeded the expected amount of care anticipated.

Example of use of the Arrangement:
Hospital contracts typically utilize level of care per diems for inpatient services provided when they don't expect to handle overly complex cases.

Rating of Risk Level:

Clinical Risk	Low
Population Risk	Very Low
Total Risk	Low

Case Rate by Diagnosis-related Groups (DRG)

Overview:
Reimbursement is made to a hospital for inpatient services on a per admission basis, independent of length of stay. Hospitalizations are categorized into diagnosis-related groups (DRG), based on the diagnosis, age and procedures performed on the patient.

Nature of Financial Risk:
Since the level of reimbursement is fixed for the entire patient admission, the hospital bears the severity risk for each type of admission (DRG). The severity risk could be a combination of the patient needing to stay in the hospital longer than expected and/or a higher level care provided on a daily basis.

Risk could be mitigated by the inclusion of an outlier provision. The outlier provision would provide additional payment for those occurrences in which the patient care provided far exceeded the expected amount of care anticipated.

Example of use of the Arrangement:
Hospitals are reimbursed on a case rate DRG basis mainly from government sponsored payers, such as Medicare and MediCal. However, many commercial payers are reimbursing hospitals on a DRG basis as well for their under 65, non-MediCal population.

Rating of Risk Level:

Clinical Risk	Med
Population Risk	Very Low
Total Risk	Low

Bundled Case Rate – Hospital (IP or OP) Stay Only

Overview:
Reimbursement is based on a prospective, pre-determined fee for all services related to one procedure provided by the hospital, the physicians and other practitioners; exclusive of related services provided pre and post procedure. Payment is usually made to 1 provider entity which then pays the other providers involved in the procedure.

Nature of Financial Risk:
Bundled case rates require coordination of care and the risk is either borne by 1 provider entity or is potentially shared among the different providers involved with the procedure. Also, care is limited to services directly related to one procedure, exclusive of related services provided pre and post procedure, and may or may not include a warranty period. Risk can be mitigated by excluding high risk patients, such as those with a high BMI or with other current clinical conditions such as cancer, HIV/AIDS, or ESRD.

Example of use of the Arrangement:
Recently, the Center for Medicare and Medicaid Innovation (CMMI) put forward the Bundled Payments for Care Improvement (BPCI) initiative and this type of payment is referred to as "Model 4". This bundled case rate payment is determined prospectively and a lump sum payment is made to a provider for the acute care hospital stay.

A wide range of medical conditions can be used for a bundled case rate such as hip & knee replacement, bariatric services, and maternity and some are used by commercial payers today.

Rating of Risk Level

Clinical Risk	Med to High
Population Risk	Very Low
Total Risk	Low to Med

Episode Bundled Payment – Hospital (IP or OP) Stay plus Post-Acute Care

Overview:
Reimbursement is based on a pre-determined fee for all services related to one procedure provided by the hospital, and all related services during the episode for a given time period, usually 30, 60, or 90 days after discharge. Payment is usually made to 1 provider entity which then pays the other providers involved in the procedure.

Nature of Financial Risk:
Episode Bundled Payment requires coordination of care and a sharing of risk between the providers of hospital, physician and other services. The level of risk is determined by several factors such as:

- the volume of procedures,
- the number of types of procedures,
- what is included or excluded in the bundled payment, and
- whether the payment is calculated retrospectively or prospectively.

Risk can be mitigated by excluding high risk patients, such as those with a high BMI or with other current clinical conditions such as cancer, HIV/AIDS, or ESRD.

Example of use of the Arrangement:
Recently, the Center for Medicare and Medicaid Innovation (CMMI) put forward the Bundled Payments for Care Improvement (BPCI) initiative and this type of payment is referred to as "Model 2". This episode bundled case rate payment is determined retrospectively against a target price for acute care hospital stays plus post-acute care. Many providers have agreed to this pilot nationwide which is an indication of the upside business opportunity seen by this type of payment arrangement.

A wide range of medical conditions can be used for a bundled case rate such as hip & knee replacement, bariatric services, transplant services and maternity and some are used by commercial payers today.

Some other examples:

IHA Bundled Episode Payment Program Experience
IHA has participated in two bundled episode payment projects, through an Agency for Healthcare Research and Quality (AHRQ) grant (Bundled Episode Payment Gainsharing Demonstration), and the Center for Medicare and Medicaid Innovation's Bundled Payments for Care Improvement (BPCI) initiative.

Arkansas Episode-Based Payment Model
Arkansas is launching an episode-based payment model that is moving away from a single prospective "bundled-payment" to one that is built on the current FFS payment methodology. For each episode, the payer will automatically identify a principal accountable provider (PAP), who is the provider with the most influence and responsibility over an episode, based on the claims data. The determination of a share in savings or excess in costs will be determined by benchmarking the PAPs average cost for all episodes against the predetermined cost thresholds for gain and risk sharing within the performance period.

Rating of Risk Level

Clinical Risk	Med to Very High
Population Risk	Very Low
Total Risk	Low to Med

Physician Specialist Capitation

Overview:
Reimbursement is based on a pre-determined monthly fee per enrolled member for services. The payment is made to a physician specialty group to provided specialty care (such as an oncology practice) and the contractual rates may be adjusted for age and gender.

Nature of Financial Risk:
A physician specialty practice agrees to a monthly fee per member in exchange for professional specialty services provided to enrolled members, where the cost of care could vary per member and may not necessarily be proportional to the age and gender adjustments which are related to a moderate level of population risk. However, the clinical risk is fairly low since the services provided are highly specialized.

Example of use of the Arrangement:
IPAs sometimes use this arrangement to sub-contract with specialty providers.

Rating of Risk Level

Clinical Risk	Low
Population Risk	Med
Total Risk	Low to Med

Partial Capitation - for services that are directly provided by the organization – Risk Adjusted

Overview:
Reimbursement is based on a pre-determined monthly fee per enrolled member for services that are directly provided by the organization, typically professional services, where the contractual rates are risk adjusted by the health status of the enrolled members.

There is growing interest within the health care industry and health policy world in the concept of risk assessment and risk adjustment payments; to establish capitation payments that are aligned with the health status, anticipated cost and utilization of medical services of a provider's enrolled member population.

Nature of Financial Risk:
A provider organization agrees to a monthly fee per member in exchange for professional services provided to enrolled members, where the cost of care could vary by member. Since payment is dependent on a risk score, the accuracy of the risk score assessment is important.

As compared to capitation payments adjusted only by age & gender (see following page for description), adjusting for health status mitigates the risk to a provider since the expected costs of the covered population more closely aligns with payments received.

Risk can be mitigated for the provider by carving out (i.e. cap deduct) services that are hard to predict whether due to infrequency, high cost or both.

Example of use of the Arrangement:
Commercial payers have begun to incorporate clinical risk-score adjustments to their capitation payments with IPAs, in addition to the traditional demographic adjustments of age/gender factors. Some large purchasers of healthcare, such as CalPERS, are now beginning to risk-adjust premiums which is encouraging more of these types of contracts between payers and providers.

Providers contracted to serve Medicare Advantage members sometimes have a payment which is often tied to a percentage of the risk adjusted revenue that the carrier receives from CMS.

Rating of Risk Level

Clinical Risk	Med
Population Risk	Low
Total Risk	Low to Med

Partial Capitation - for services that are directly provided by the organization – Age and Gender Adjusted

Overview:
Reimbursement is based on a pre-determined monthly fee per enrolled member for services that are directly provided by the organization, typically professional services, where the contractual rates are usually adjusted for age & gender.

Nature of Financial Risk:
A provider organization agrees to a monthly fee per member in exchange for professional services provided to enrolled members, where the cost of care could vary per member and may not necessarily be proportional to the age and gender adjustments.

Example of use of the Arrangement:
Within the payers' HMO networks, professional capitation is utilized with the majority of IPAs and medical groups.

Rating of Risk Level

Clinical Risk	Med
Population Risk	Med
Total Risk	Med

Total Cost of Care Risk Pool Arrangements (ACOs)

Overview:
A global budget is set for the total cost of care (TCC). The TCC budget is allocated for hospital, physician, pharmacy and ancillary services. Several entities, such as the hospital, medical group and the insurer, may share in the risk of meeting the allocated TCC budget targets.

Nature of Financial Risk:
This financial arrangement makes the provider entities accountable for care provided and can add a significant level of risk to the providers, depending upon the specifics of the contract.

Example of use of the Arrangement:
A number of ACOs (particularly those on an HMO platform) use this type or reimbursement arrangement.

Rating of Risk Level

Clinical Risk	Med to High
Population Risk	Med to High
Total Risk	Med to High

Total Capitation - for all services provided to a population – Risk Adjusted

Overview:
Reimbursement is based on a pre-determined monthly fee per enrolled member for all services provided to a population, where the contractual rates are risk adjusted by the health status of the enrolled members.

There is growing interest within the health care industry and health policy world in the concept of risk assessment and risk adjustment payments; to establish capitation payments that are aligned with the health status, anticipated cost and utilization of medical services of a provider's enrolled member population.

Nature of Financial Risk:
Total capitation requires coordination of care and a sharing of risk between the providers of facility, professional and other services. A provider organization agrees to a monthly fee per member in exchange for professional and facility services provided to that enrolled member, where the cost of care could vary per member. Since payment is dependent on a risk score, the accuracy of the risk score assessment is important.

As compared to capitation payments adjusted only by age & gender (see following page for description), adjusting for health status mitigates the risk to a provider since the expected costs of the covered population more closely aligns with payments received.

Risk is high, as the provider is assuming risk for a member for a large proportion of medical services but some of the risk can be mitigated by having the payer contractually responsible for certain services outside of the control of the provider such as out-of-network services.

Risk can be mitigated for the provider by carving out (i.e. cap deduct) services that are hard to predict whether due to infrequency, high cost or both.

Example of use of the Arrangement:
Commercial payers have begun to incorporate clinical risk-score adjustments to their capitation payments with IPAs, in addition to the traditional demographic adjustments of age/gender factors. Some large purchasers of healthcare, such as CalPERS, are now beginning to risk-adjust premiums which is encouraging more of these types of contracts between payers and providers.

Providers contracted to serve Medicare Advantage members sometimes have a payment which is often tied to a percentage of the risk adjusted revenue that the carrier receives from CMS.

Rating of Risk Level

Clinical Risk	Very High
Population Risk	High
Total Risk	High to Very High

Total Capitation - for all services provided to a population – Age and Gender Adjusted

Overview:
Reimbursement is based on a pre-determined monthly fee per enrolled member for all services provided to a population, where the contractual rates are adjusted for age and gender.

Nature of Financial Risk:
Total capitation requires coordination of care and a sharing of risk between the providers of facility, professional and other services. A provider organization agrees to a monthly fee per member in exchange for professional and facility services provided to that enrolled member, where the cost of care could vary per member and may not necessarily be proportional to the age & gender adjustments.

Risk is high, as the provider is assuming risk for a member for a large proportion of medical services but some of the risk can be mitigated by having the payer contractually responsible for certain services outside of the control of the provider such as out-of-network services.

Risk can be mitigated for the provider by carving out (i.e. cap deduct) services that are hard to predict whether due to infrequency, high cost or both.

Example of use of the Arrangement:
Within the payers' HMO networks, total capitation is utilized with a growing number of IPAs and medical groups.

Rating of Risk Level

Clinical Risk	Very High
Population Risk	Very High
Total Risk	Very High

Section 2: Non-Provider Organization entities

Specialty Healthcare Management Company – Fee Driven

Overview:

There are a growing number of organizations within the health care industry who specialize in managing care for specific types of services or for populations with particular medical conditions. Value is added to the healthcare delivery system by developing and managing specialty networks that will ensure cost-efficient and quality care. A fee driven Specialty Healthcare Management Company contracts with a payer and will typically charge on a fee for service basis for services rendered, typically with some sort of performance guarantees.

Nature of Financial Risk:

A fee driven Specialty Healthcare Management Company typically has a portion of their fee for service reimbursement based on clinical and financial outcomes so the Specialty Healthcare Management Company can be taking on a wide range of clinical risk, depending upon the terms of their agreement with a payer.

Example use of the Arrangement:

Alere Care Management

A company whose services include specialized case management, focused on the specific clinical needs of a population.

Rating of Risk Level

Clinical Risk	Med to High
Population Risk	Very Low
Total Risk	

Specialty Healthcare Management Company – Risk Bearing

Overview:

There are a growing number of organizations within the health care industry who specialize in managing care for specific types of services or for populations with particular medical conditions. Value is added to the healthcare delivery system by developing and managing specialty networks that will ensure cost-efficient and quality care. A risk bearing Specialty Healthcare Management Company contracts with a payer and is typically reimbursed on a capitated basis to provide care for either the specific type of service or for the population with particular medical conditions.

Nature of Financial Risk:

A Specialty Healthcare Management Company will bear the risk for the entire spectrum of care required for either a specific type of service or for a particular medical condition in exchange for a pre-determined per-member monthly payment. This requires coordination of care and a sharing of risk between the providers of hospital, professional and other services. Since the Specialty Healthcare Management Company agrees to a pre-determined fee per member in exchange for professional and facility services provided to that enrolled member, the risk to the Specialty Healthcare Management Company, depending on the specifics of the contract, can be medium to very high.

Example use of the Arrangement:

There is a growing number of companies that offer full-risk services for a targeted population, to develop and manage specialty networks that will cater to this population's health needs that will ensure cost-efficiency and quality care. Some examples of vendors in this are Optum Behavioral Health and Magellan Health Services.

Rating of Risk Level

Clinical Risk	Med to Very High
Population Risk	Med to Very High
Total Risk	Med to Very High

Section 3: Performance Based Payment Methods

Bonus Payments, upside only

Overview:
There is growing interest within the health care industry and health policy to align reimbursement to a provider's quality and cost-efficiency measures, allowing a provider to earn additional payments by meeting pre-determined target measures.

Nature of Financial Risk:
There is no additional risk to providers since the bonus payments are on an upside-only basis.

Example use of the Arrangement:
IHA California Value Based P4P
The IHA VB P4P program is the largest non-governmental physician incentive program in the United States, with nearly 200 physician groups – representing approximately 35,000 physicians who provide care for about 10 million Commercial HMO/POS members which focuses on the measurement of Quality, Total Cost of Care and Appropriate Resource Use.

Upside only bonus payments also exist in agreements between payers and hospitals. A typical arrangement may involve targets related to average length of stay (ALOS) and readmission rates.

Rating of Risk Level
No incremental risk to providers.

Risk Share Arrangements, upside and downside

Overview:
There is growing interest within the health care industry and health policy in the sharing of risk between hospitals, physician groups and payers to help align incentives and to improve outcomes. In a risk share agreement, the provider has the potential to either lose part of its compensation or to earn a bonus, dependent upon performance of risk share arrangements. Metrics used are typically based on some or all of the following: 1)cost measures (e.g. PMPM), 2)efficiency measures (e.g. hospital day per population), or 3)quality measures (e.g. HEDIS quality scores).

Nature of Financial Risk:
Risk share agreements require the coordination of care and sharing of risk between hospitals, physician groups and payers. The risk that each entity takes depends on the terms of the agreement among the parties and can vary greatly. Another consideration is the amount of risk an entity may take relative to its size and its capital position

Example use of the Arrangement:
Accountable care organizations (ACOs) and patient centered medical homes (PCMHs) typically utilize risk share agreements by setting targets for 1 or more of the following: cost, efficiency, and quality measures.

Performance based contracting is a relatively new concept that puts part of a provider's budgeted annual increase at risk and depends upon the performance of the provider group.

Rating of Risk Level
The amount of incremental risk can raise the risk associated with the base payment by 1 or 2 levels, depending upon the aggressiveness of the risk arrangement.

Section 4: Percentage of Payment Arrangements

Percentage of Premium - risk-adjusted premium

Overview:
This is a "top down" payment approach where a percentage of the premium received from the customer goes to 1 or more of the provider entities such as a medical group or a hospital. The starting premium has been risk-adjusted to account for the health of the underlying population.

Nature of Financial Risk:
The nature of the financial risk is very similar to that of capitation with the additional risk of potential fluctuations of the premium. The risk can vary depending upon the scope of services the provider takes responsibility for.

Example use of the Arrangement:
Providers that serve Medicare Advantage members often use a methodology similar to this.

Rating of Risk Level

Clinical Risk	Med to Very High
Population Risk	Low to High
Total Risk	Med to High

Percentage of Premium – non risk-adjusted premium

Overview:
This is a "top down" payment approach where a percentage of the premium received from the customer goes to 1 or more of the provider entities such as a medical group or a hospital.

Nature of Financial Risk:
The nature of the financial risk is very similar to that of capitation with the additional risk of potential fluctuations of the premium. The risk can vary depending upon the scope of services the provider takes responsibility for.

Example use of the Arrangement:
This is a methodology that has been used in past by commercial payers and may see renewed interest as the payer and insurer roles begin to merge.

Rating of Risk Level

Clinical Risk	Med to Very High
Population Risk	Med to Very High
Total Risk	Med to Very High

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