MINIMUM DOWNSIDE RISK REPORT AND RECOMMENDATIONS

MODIFIED REPORT FOR PUBLIC RELEASE

Prepared for the Rhode Island Office of the Health Insurance Commissioner

bailit health

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1. Regulatory Requirement and Purpose of Study

Background

After studying the impact of the Rule 2 Affordability Standards and participating in a robust public process, the Rhode Island Office of the Health Insurance Commissioner (OHIC) amended Section 10 of Regulation 2, effective February 13, 2015, to include a payment reform requirement that insurers over time increase the percentage of insured covered lives that are attributed to provider total cost of care contracts that include risk sharing. Specifically, Regulation 2 requires that by the end of 2016 at least 10 percent of insured covered lives be attributed to either a Population-Based Contract[1] that includes risk sharing or a Global Capitation Contract, which places 100% of the risk on providers. For 2017 and thereafter, the Commissioner is to determine the appropriate insurer targets.[2]

Both contract types measure provider performance against the anticipated total cost of care for attributed members. They recognize savings when total costs fall below the expected costs, and (sometimes) losses when actual costs exceed expected costs. A Population-Based Contract continues to reimburse providers on a fee-for-service basis and determines savings, or losses, at the end of a designated time period, which is usually one year. These contracts create provider incentives to transform care delivery processes by sharing savings in a manner that ties savings distributions to performance on quality measures. Currently in Rhode Island these contracts much less frequently share financial losses.

Global Capitation Contracts[3] are a subset of Population-Based Contracts, and are characterized by periodic prospective payments to the provider organization that is inclusive of the total, or nearly total, cost of covered services. Because the provider entity is receiving prospective payments for services, any costs that exceed the amount of the prospective payment are typically the responsibility of the provider entity.

Population-Based Contracts with shared shavings between providers and insurers and which continue to reimburse providers on a fee-for-service basis are the predominant Population-Based Contract model in

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[1] Defined in OHIC Regulation 2, Section (3)(l) as: means a provider reimbursement contract with an Integrated System of Care that uses a reimbursement methodology that is inclusive of the total, or near total medical costs of an identified, covered-lives population. A Population-Based Contract may be a Shared Savings Contract, or a Risk Sharing Contract, or a Global Capitation Contract. A primary care or specialty service capitation reimbursement contract shall not be considered a Population-Based Contract for purposes of this Section. A Population-Based Contract may not transfer insurance risk or any health insurance regulatory obligations. A Health Insurer may request clarification from the Commissioner as to whether its proposed contract constitutes the transfer of insurance risk

[2] OHIC Regulation 2, Section 10(d)(1)(B) and (C).

[3] Defined in OHIC Regulation 2, Section (3)(f) as: "a Population-Based Contract with an Integrated System of Care that (i) holds the Integrated System of Care responsible for providing or arranging for all, or substantially all of the covered services provided to the Health Insurer's defined group of members in return for a monthly payment that is inclusive of the total, or near total costs of such covered services based on a negotiated percentage of the Health Insurer's premium or based on a negotiated fixed per member per month payment, and (ii) incorporates incentives and/or penalties for performance relative to quality targets."

Rhode Island in 2016. Very few providers have the infrastructure in place to manage prospective payments and full or near-full risk.

Policy experts who work with providers undergoing delivery system transformation have consistently found that while shared savings can motivate change, shared or delegated risk more powerfully captures providers' attention and generates broad commitment to undergo delivery system transformation. At the same time, there is recognition that too much risk can threaten providers' financial viability and early experience with provider risk delegation bore this out.[4]

Because there is currently so little risk assumption by Rhode Island providers under Population-Based Contracts, OHIC seeks to advance insurer (and indirectly, provider) movement in this direction. In order to do so, OHIC needs to determine the minimum downside risk that providers should assume to spark change in how care is delivered without imposing so much financial risk that it might place providers in jeopardy.

The 2016/2017 OHIC Alternative Payment Model Plan, adopted by the Commissioner on February 10, 2016, includes a requirement that OHIC study options for setting a minimum downside risk threshold for medical service provider or ACO contracts. OHIC is expected to issue a report and open a 30-day public comment window, after which the Commissioner may adopt standards in conjunction with the approval of insurer rate filings.[5]

OHIC engaged Bailit Health Purchasing, LLC to research current trends in levels of provider risk adoption in other states and develop recommendations for the Commissioner's consideration. This report presents the results of the research and recommendations.

Study Approach

To understand current market practice regarding levels of downside risk included in insurer/provider contracts, we collected risk assumption information from CMS-initiated payment reform models, including the Medicare Shared Savings Program (MSSP), the Medicare Next Generation ACO model, and the Medicare Pioneer ACO model. We also gathered information from commercial payers in Massachusetts. We selected these models for several reasons. CMS has been an important driver of payment reform nationally and has frequently set the direction for payment reform among commercial payers. In that manner, it sets a target level of risk assumption that it considers reasonable. The payment information is also available publicly. We selected Massachusetts because this neighboring state has significantly more shared risk contracting activity than Rhode Island – perhaps as much as any state in the country. Its providers are relatively mature

[4] A.B. Frakt and R. Mayes. "Beyond Capitation: How New Payment Experiments Seek to Find the 'Sweet Spot' in Amount of Risk Providers and Payers Bear." *Health Affairs* 31, No. 9 (2012); N. McCall and D. Peikes. "Tricky Problems with Small Numbers: Methodological Challenges and Possible Solutions for Measuring PCMH and ACO Performance." Robert Wood Johnson Foundation, April 2016.

[5] Rhode Island 2016-2017 Alternative Payment Methodology Plan Recommended to Health Insurance Commissioner Kathleen C. Hittner, Adopted February 10, 2015, Section IV(3).

in their risk assumption experience and their contracts therefore can be used to set a reasonable target for Rhode Island providers to adopt over time.

We also interviewed major Rhode Island provider organizations to understand how they view risk and what level of risk they would consider meaningful to motivate change. These discussions focused not only on levels of risk, but on how risk is measured.

Finally, we used the information collected to model different risk levels, expressed a) as a percentage of total cost of care and b) as a percentage of cash reserves and total reserves for two hospital-based ACOs and for one physician organization-based ACO.

From this work, we developed separate recommendations regarding minimum risk levels for physician-based and hospital-based Population-Based Contracts, with consideration given to the number of covered lives attributed to the risk contract.

2. Research Findings

Net Risk

When defining risk within the context of a payment model, it is most often defined as a percentage of the per-member-per-month (pmpm) total cost of care budget (or payment) that providers are given to cover all or almost all of an attributed patient population's service needs. For example, downside risk might be capped at 5% of the $400 pmpm total cost of care budget, or $20 pmpm. Risk assumption is often mitigated by risk sharing, e.g., the insurer and provider entity sharing losses on a 50%/50% (50/50) basis, which, assuming an actual loss of $20 pmpm, would limit the provider's risk to $10 pmpm.

Another mechanism used to define risk is a "Minimum Loss Rate" (MLR).[6] This establishes a minimum level of loss (or gain) that must be realized before risk sharing (or shared savings) is applied. Because MLRs are used to increase the statistical likelihood that calculated losses are actual losses, it is reasonable for insurers and providers to share the entire loss when losses exceed the MLR. Under federal programs, only the loss exceeding the MLR is shared. Using a federal program example with a 2% MLR with 50/50 risk sharing and a 5% cap on losses, a provider realizing a 5% pmpm loss ($20 pmpm), would be not be responsible for covering the first 2% or $8 pmpm, but would then share the remaining $12 pmpm loss 50/50 with the insurer. The provider's total liability would be $6 pmpm. Because of the variation in how risk arrangements are structured, when discussing downside risk, we will be speaking in terms of *net risk*, which is the amount of final risk a provider assumes after the application of any MLR or risk-sharing formula relative to the total cost of care. For the examples above, which assume a $20 pmpm actual loss, the net risk levels are calculated as depicted in the table below.

[6] The "upside" corollary of Minimum Loss Rate is Minimum Savings Rate (MSR). Commercial insurers often employ the term "risk corridor" rather than MLR and MSR

Risk Arrangement	Calculation of Maximum Possible Loss	Net Risk Assumption
Risk capped at 5% of $400 total cost of care pmpm	Loss: $400 x 0.05 = $20 pmpm, which is equal to the loss cap	5%
Risk capped at 5% of $400 total cost of care pmpm and shared 50/50 with insurer	Loss: $20 pmpm Loss After Risk Sharing: $20 x 0.5 = $10 pmpm, which is below the loss cap	2.5%
Risk capped at 5% of $400 total cost of care pmpm; risk beyond 2% is shared 50/50 with insurer	Loss: $20 pmpm Risk Corridor: $400 x 0.02 = $8 pmpm Total Provider Loss: ($20 - $8) x 0.5 = $6 pmpm, which is below the loss cap	1.5%

It is important to note that providers mitigate assumed risk in ways not accounted for in our modeling of net risk. These methods include, but are not limited to, reinsurance at the individual patient (i.e., high-cost outlier) level, reinsurance at the aggregate level (e.g., losses above 4% of total cost), delegation of risk (e.g., subcapitation) and carving out selected services (e.g., transplants, new high-cost pharmaceuticals).

Net Risk Assumption under CMS Payment Reform Initiatives. We looked at four key CMS payment reform initiatives designed to encourage ACO development. They are:

- the Medicare Pioneer ACO Model, CMS' first ACO initiative, which was targeted at mature provider systems;
- the Medicare Shared Savings Program, which was designed to appeal to a broader group of physician and hospital organizations and called for a transition to downside risk assumption over time;
- the Medicare Next Generation ACO Model, which is the most recent ACO-based payment reform initiative and introduces prospective payment and expanded risk assumption; and
- the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which established requirements for Alternative Payment Model (APM) adoption by Medicare-participating providers, and requires that participants bear a minimum amount of financial risk to meet the requirement of participating in an "Advanced APM."

To understand the levels of risk embedded in each program's risk formula, we calculated a net risk level by assuming a $400 total cost of care pmpm. In performing these calculations, we assumed that the provider accepted the maximum possible risk when, for example, the risk sharing options are "up to 60%" or the risk corridors "range between 0.5% and 4.5%." The calculations are detailed in Appendix A.

When analyzing the risk arrangements and the resulting net risk assumption levels for these initiatives, several relevant observations can be made. The Pioneer ACO program offered risk arrangements that resulted in net risk levels ranging from a low of 2% to a high of 10.5%, which indicates a recognition that

even among the most mature provider organizations there was a range of readiness to assume risk. This program also built in increased risk assumption over time, as providers built their risk management infrastructure. The Medicare Shared Savings Program, which was designed to include all levels of readiness and started with shared savings options initially, includes risk sharing arrangements that result in net risk levels ranging between a low of 1.8% and a high of 4.8%. This is a much narrower and lower range of risk assumption, which is consistent with the goal of providing a program that enabled providers to ease into risk assumption arrangements. Again, the initiative built in increasing levels of risk assumption over time. Finally, the newest ACO initiative, Next Generation, has relatively high levels of risk assumption, ranging from a low of 8.4% to a high of 15%, with the option of 100% risk assumption, with losses capped at 15% of the total cost of care pmpm. Again, the program has built in increased risk assumption over time. The relatively high level of risk assumption apparently reflects a belief by CMS that there is a group of providers that is currently capable of assuming significant levels of risk.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). CMS' proposed rules set minimum risk assumption, risk sharing and MLR requirements. To meet the MACRA requirements, the maximum amount of losses possible under an Advanced APM for ACOs must be at least 4% of the APM spending target.[7] A separate standard is proposed for CMS-recognized PCMHs, expressed as a percentage of the participating providers' Medicare Parts A and B revenue. The minimum net risk assumption begins at 2.5% for 2017 and increases to 5% by 2020.

Commercial Health Plan Risk Arrangements with ACOs. When we looked at the risk arrangements in place for two major health plans in Massachusetts, we found a different picture. First, the plans do not generally use risk MLRs (risk corridors). Second, there is a bifurcated distribution of levels of risk assumption among contracted provider organizations. On the high end, there are a few very mature provider organizations that assume 100% of the risk with no loss cap. Most other provider organizations have risk sharing arrangements with net risk levels of between 5% and 8% of total cost of care pmpm. These levels of risk assumption have been in place for at least 5 years and plan staff report that they do not anticipate that they will be changing much. One plan noted that providers consider 5% net risk substantial, particularly when framed as a percentage of their revenue. He also noted that providers typically do not hit the cap, and that losses, when they occur, are substantially below the cap. This pattern of risk assumption suggests that a net risk level between 5% and 8% provides sufficient incentive to provider organizations to motivate delivery system redesign in order to manage risk. The Massachusetts experience suggests that once a provider organization has infrastructure in place and a proven track record at managing risk, some may be interested in assuming 100% risk to maximize earning potential, while still meeting quality performance requirements. Gradually assuming risk beyond 5 to 8% does not appear to be considered necessary by these health plans or by a large cohort of mature provider organizations.

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[7] Quality Payment Program: Delivery System Reform, Medicare Payment Reform, & MACRA: The Merit-based Incentive Payment System (MIPS) & Alternative Payment Models (APM). Accessed June 15, 2016. Available at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

Rhode Island Providers' View of Risk

Both the Rhode Island physician organization-based ACO and the Rhode Island hospital-based ACO with which we spoke found it most relevant to think of risk in terms of the percentage of revenue each participating organization earned for services delivered under an ACO contract. This is significantly different from the predominant industry view of risk as a percentage of the total cost of care budget. As a result of our discussions, we believe that this view reflects the fact that the physicians sponsoring medical group and hospital-based ACOs in Rhode Island capture a very small percentage of the total cost of care budget through their own service delivery. A PCP-based ACO can expect to capture approximately 10 to 11% of the total cost of care spending. A hospital system in Rhode Island can expect to capture between 30% and 40% of the total cost of care funds because it has so few employed or affiliated PCPs and so does not routinely keep referrals within the sponsoring hospital system.[8] In the last year each of two primary care physician-dominated organizations has begun to align with one of the two major hospital-based ACOs through risk sharing contracting, which will lead to a larger percentage of revenue capture by the hospital-based ACOs, as the provider-based groups standardize their referrals to their partner hospital system.[9]

Assessment

We conducted a number of financial analyses with provider-level data shared with OHIC. These results are not presented here due to the confidential nature of some of the provider financial data. However, the results of these analyses and the data collected from Massachusetts payers suggest several important guideposts in developing meaningful downside risk recommendations. First, Rhode Island ACOs, both hospital- and provider-based, currently express lower risk tolerance than their Massachusetts counterparts which have more experience in assuming and successfully managing risk. This suggests that recommendations should consider setting relatively low risk levels initially. Second, the Massachusetts experience also indicates that over time providers can successfully manage increasing levels of risk. However, the level of risk may not need to be as high as the CMS initiatives have adopted to provide strong incentives to generate practice transformation based on the successful evaluation findings for BCBSMA's risk contracts.[10] Third, it appears that once ACOs have experience managing risk under a shared risk arrangement, some are willing to move to a fully capitated payment model.

3. Recommendations

[8] We obtained the 10-11% and 30-40% estimates from Rhode Island provider interviews.
[9] Coastal Medical recently joined Lifespan in a risk-sharing arrangement with BCBSRI. RIPCPC joined Integra Community Care Network, which includes Care New England hospitals and providers, in a risk-sharing arrangement with BCBSRI.
[10] Z. Song et al. "Changes in Health Care Spending and Quality 4 Years into Global Payment." *The New England Journal of Medicine*. 371:1704-1714 October 30, 2014.

Based on our research, interviews and financial modeling, we recommend the following framework for defining OHIC meaningful downside risk assumption requirements for insurers. We have created separate risk assumption requirements for ACOs including hospital system-involved ACOs and physician organization-based ACOs, because of the different levels of cash reserves available to the organizations and the different percentage of total cost of care revenue hospital-based entities and physician-based entities can expect to capture from an ACO contract.

We recommend that the risk assumption expectation for ACOs including hospital systems be expressed as *net risk as a percentage of total cost of care*. We further recommend that risk assumption expectation for physician-based entities be expressed as *net risk as percentage of the physician organization ACO contract revenue*. We also recommend that risk assumption expectations increase over time to the levels witnessed in Massachusetts.

Finally, we recommend that expectations for insurer risk contracts be modified for insurer ACO contracts for relatively small populations. This recommendation is informed by the growing appreciation of the difficulty in assessing total cost of care financial performance when covered lives are small due to the effect of random variation in service utilization. This consideration is important because under risk-sharing models, both providers and insurers want to receive or make payments to which they are actually entitled. While the risk of false positives and false negatives can be mitigated by several statistical techniques[11], it can also be mitigated by requiring a minimum number of covered lives before assuming risk and by adopting lower risk assumption levels for ACO agreements below a specified number of covered lives, which our recommendations reflect.

Our specific recommended minimum risk requirements follow below.

ACOs including Hospital Systems. An insurer contract with an ACO that includes a hospital system must have a minimum of 10,000 covered lives before it is subject to an OHIC Population-Based Contract downside risk provision.

- Contracts covering between 10,000 and 20,000 commercial lives must include **net risk of at least 1% as a percentage of projected <u>total cost of care</u> in year 1 of a risk contract[12], and at least 4% within five years of the date the parties entered into their first risk contract.**
  Consistent with our recommendations above, this approach calls for increasing risk over time, and reduced risk for smaller populations.

- Contracts with over 20,000 commercial lives must include **net risk of at least 2% as a percentage of projected <u>total cost of care</u> in year 1 of a risk contract, and at least 6% within five years of the date the parties entered into their first risk contract.**

[11] N. McCall and D. Peikes. "Tricky Problems with Small Numbers: Methodological Challenges and Possible Solutions for Measuring PCMH and ACO Performance." Robert Wood Johnson Foundation, April 2016.
[12] "Risk contract" is defined here as a contract in which the provider organization assumes some financial responsibility for total cost of care spending above a targeted pmpm level.

These levels of risk assumption are effectively significantly above the 2.75% of cash reserves that interviewed Rhode Island providers considered reasonable, but markedly below the 8% total cost of care budgets currently in effect in Massachusetts.

Physician-based ACOs. An insurer contract with a physician-based ACO must have a minimum of 10,000 covered lives before it is subject to an OHIC Population-Based Contract downside risk provision.

- Contracts covering between 10,000 and 20,000 commercial lives must include **net risk of at least 3% of the physician organization's ACO contract revenue in year 1 of the risk contract, and at least 10% within five years of the date the parties entered into their first risk contract.**
  This level of risk assumption eventually reaches the 10% thought to be reasonable by the interviewed Rhode Island providers.

- Contracts covering more than 20,000 commercial lives must include **net risk of 10% of the physician organization's ACO contract revenue in year 1 of the risk contract, and at least 20% within five years of the date the parties entered into their first risk contract.**
  This range of risk assumption starts at the bottom end of the range in use in Massachusetts and extends by year 5 to the mid-point of the range for physician organization contracts.

Provider-Hospital ACO Collaborations. As discussed previously, two of the largest provider-based ACOs have recently joined with one of the two major Rhode Island hospital systems in an ACO contract with BCBSRI. Coastal has joined Lifespan in contracting with BCBSRI, covering only Coastal's attributed lives. RIPCPC has joined with Integra, which includes CNE hospitals, their employed physicians and some community physicians, in an ACO contract with BCBSRI. In considering which risk assumption guidelines should apply, we recommend that the risk assumption requirements be those outlined above for ACOs with hospital systems participating, since the new entities can access the resources of the hospital system partners.

4. Conclusion

These meaningful downside risk recommendations build off of the research, interviews and modeling we performed and encompass the four overarching recommendations that grew out of our assessment:

- treat minimum risk assumption requirements in contracts with ACOs involving hospital systems differently than in contracts with physician organization-based ACOs;
- start with an insurer requirement for a relatively low ACO risk assumption minimum requirement, and increase the minimum required level over time, and
- recognize the problem of small numbers by treating populations with smaller populations differently than those with larger populations when setting minimum risk requirements.

The levels of risk that we recommended reflect these principles and recognize that Rhode Island is in the early stages of ACO development, and insurer-contracted ACOs will be capable of assuming more risk over time with the benefit of experience.

Appendix A

Risk Arrangements and Net Risk Calculations for Four Medicare ACO Initiatives: Pioneer ACO Model, Shared Savings Program and Next Generation ACO Model and MACRA Alternative Payment Models

In each of the examples below, it is assumed that the total cost of care pmpm is $400 and the actual loss is equal to the risk cap. This loss is referred to as the "Maximum Loss."

Risk Arrangement	Risk Calculation	Net Risk Assumption
Medicare Pioneer		
Core Arrangement Year 1 • Risk sharing: 60/40 (provider/Medicare) • Minimum Loss Rate: 1% • Risk cap: 10%	Maximum Loss: $400 x 0.1 = $40 Minimum Loss Value: $4 Total Provider Risk with Risk Sharing:: ($40 - $4) x 0.6 = $21.60	5.4%
Core Arrangement Year 2+ • Risk sharing: 70/30 • Minimum Loss Rate: 1% • Risk cap: 15%	Maximum Loss: $400 x 0.15 = $60 Minimum Loss Value: $4 Total Provider Risk with Risk Sharing: ($60 - $4) x 0.7 = $39.20	9.8%
Core Option A Year 1 • Risk sharing: 50/50 • Minimum Loss Rate: 1% • Risk cap: 5%	Maximum Loss: $400 x 0.05 = $20 Minimum Loss Value: $4 Total Provider Risk with Risk Sharing: ($20 - $4) x 0.5 = $8	2%
Core Option A Year 2+ • Risk sharing: 60/40 • Minimum Loss Rate: 1% • Risk cap: 10% year 2 • Risk cap: 15% year 3	Maximum Loss Year 2: $400 x 0.1 = $40 Minimum Loss Value: $4 Total Provider Risk with Risk Sharing: ($40 - $4) x 0.6 = $21.60 Maximum Loss Year 3: $400 x 0.15 = $60 Minimum Loss Value: $4 Total Provider Risk with Risk Sharing: ($60 - $4) x 0.6 = $33.60	Year 2: 5.4% Year 3: 8.4%
Core Option B Year 1 • Risk sharing: 70/30 • Minimum Loss Rate: 1% • Risk cap: 15%	Maximum Loss: $400 x 0.15 = $60 Minimum Loss Value: $4 Total Provider Risk with Risk Sharing: ($60 - $4) x 0.7 = $39.20	9.8%

Risk Arrangement	Risk Calculation	Net Risk Assumption
Core Option B Year 2+ • Risk sharing: 75/25 • Minimum Loss Rate: 1% • Risk cap: 15%	Maximum Loss: $400 x 0.15 = $60 Minimum Loss Value: $4 Total Provider Risk with Risk Sharing: ($60 - $4) x 0.75 = $42	10.5%
Medicare Shared Saving Program		
Year 1 • Risk sharing: 60/40 • Minimum Loss Rate: 2% • Risk cap: 5%	Maximum Loss: $400 x 0.05 = $20 Minimum Loss Value: $8 Total Provider Risk with Risk Sharing: ($20 - $8) x 0.6 = $7.20	1.8%
Year 2 • Risk sharing: 60/40 • Minimum Loss Rate: 2% • Risk cap: 7.5%	Maximum Loss: $400 x 0.075 = $30 Minimum Loss Value: $8 Total Provider Risk with Risk Sharing: ($30 - $8) x 0.6 = $13.20	3.3%
Year 3 • Risk sharing: 60/40 • Minimum Loss Rate: 2% • Risk cap: 10%	Maximum Loss: $400 x 0.1 = $40 Minimum Loss Value: $8 Total Provider Risk with Risk Sharing: ($40 - $8) x 0.6 = $19.20	4.8%
Medicare Next Generation		
Zero Risk-sharing option • Risk sharing: none • Minimum Loss Rate: none • Risk cap: 15%	Maximum Loss: $400 x 0.15 = $60 Total Provider Risk with Risk Sharing: $60	15%
Risk Sharing Option: Years 1-3 • Risk sharing: 80/20 • Minimum Loss Rate 1: 0.05% • Minimum Loss Rate 2: 4.5% • Risk cap: 15%	Maximum Loss: $400 x 0.15 = $60 Minimum Loss Value 1: $0.2 Total Provider Risk with Risk Sharing 1: ($60 - $0.2) x 0.8 = $47.84 Maximum Loss: $400 x 0.15 = $60 Minimum Loss Value 2: $18 Total Provider Risk with Risk Sharing 2: ($60 - $18) x 0.8 = $33.60	#1: 12% #2: 8.4%
Risk Sharing Option: Years 1-3 • Risk sharing: 85/15 • Minimum Loss Rate: 4.5% • Risk cap: 15%	Maximum Loss: $400 x 0.15 = $60 Minimum Loss Value: $18 Total Provider Risk with Risk Sharing: ($60 - $18) x 0.85 = $35.70	8.9%

Risk Arrangement	Risk Calculation	Net Risk Assumption
Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)		
Total potential risk must be at least 4% of expected expenditures	Minimum loss: $400 x 0.04 = $16.00	4%
Medical Home Model Standard At least the following amounts: • In 2017, 2.5 percent of the APM Entity's total Medicare Parts A and B revenue	Calculations assume the PCMH receives 10% of total cost of care budget of $400pmpm Minimum Loss: $400 x 0.1 x 0.025 = $1.00	0.25%
• In 2018, 3 percent of the APM Entity's total Medicare Parts A and B revenue.	Minimum Loss: $400 x 0.1 x 0.03 = $1.20	0.3%
• In 2019, 4 percent of the APM Entity's total Medicare Parts A and B revenue.	Minimum Loss: $400 x 0.1 x 0.04 = $1.60	0.4%
• In 2020 and later, 5 percent of the APM Entity's total Medicare Parts A and B revenue.	Minimum Loss: $400 x 0.1 x 0.05 = $2.00	0.5%