



Examples of Health Care Payment Models Being Used in the Public and Private Sectors

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EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

PREAMBLE

This compilation was commissioned in January 2016 by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the US Department of Health and Human Services (HHS) as background information for ASPE and for the new Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC was created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

In addition to providing for new ways for the federal Medicare program to pay physicians for the care they provide to Medicare beneficiaries, MACRA also created the PTAC to make recommendations to the Secretary of HHS on proposals for physician-focused payment models (PFPMs) submitted by stakeholders in Medicare's physician payment programs. MACRA also charged ASPE with providing technical and operational support to the PTAC.

This document aims to compile information on payment approaches underway or under development by federal and state governments, as well as by payers of healthcare in the private sector. In addition to providing background information to ASPE and the PTAC, we hope this document may be a useful resource to stakeholders who, encouraged by MACRA, are working to develop new PFPMs. We hope these stakeholders will be able to use this document to:

- Identify models that are similar to those of interest to the stakeholder(s),
- Understand the extent to which a given model has been evaluated and has lessons to share, and
- Identify points of contacts to follow up on these models.

**EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING
USED IN THE PUBLIC AND PRIVATE SECTORS**

Table of Contents

PREAMBLE..... i

INTRODUCTION..... 1

1. PUBLIC AND PRIVATE SECTOR MODELS IN THE UNITED STATES..... 2

 1.1 CMS’s (Multi-payer) Comprehensive Primary Care Initiative 2

 1.2 CMS’s Financial Alignment Initiative for Medicare-Medicaid Enrollees..... 6

 1.3 Medicare’s Shared Savings Program..... 10

 1.4 Medicare’s Bundled Payments for Care Improvement (BPCI) Initiative..... 14

 1.5 Medicare’s Comprehensive Care for Joint Replacement..... 20

 1.6 Medicare’s Comprehensive ESRD Care Initiative..... 24

 1.7 Medicare’s Coordinated Care Demonstration..... 27

 1.8 Medicare’s Independence at Home Demonstration 30

 1.9 Medicare’s Oncology Care Model..... 33

 1.10 21st Century Oncology’s Radiation Oncology Bundled Payments..... 37

 1.11 Aetna PCMH Programs..... 40

 1.12 AmeriHealth Caritas’s “PerformPlus” Suite of Payment Incentive Programs 43

 1.13 Anthem Cancer Care 46

 1.14 Arkansas Health Care Payment Improvement Initiative (ACPHI) 48

 1.15 BirthBundle 54

 1.16 Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC) 56

 1.17 Blue Cross Blue Shield of Michigan Physician Group Incentive Program 60

 1.18 Blue Cross Blue Shield of Minnesota Aligned Incentive Contracts 65

 1.19 Boeing’s Preferred Partnership..... 69

 1.20 Bridges to Care Program in Aurora, CO 72

 1.21 CalPERS Reference Pricing 75

 1.22 CalPERS Sacramento ACO 78

 1.23 California Value-Based Pay-for-Performance (VBP4P) Program 82

 1.24 Capital District Physicians’ Health Plan (CDPHP)’s Enhanced Primary Care (EPC) Program..... 85

 1.25 CareFirst (of Maryland, DC, & Northern Virginia) Patient-Centered Medical Home Program... 89

 1.26 Cigna Collaborative Care..... 94

 1.27 City and County of San Francisco ACO Collaboration 97

 1.28 Community Health Choice’s Maternity and Newborn Care Bundled Payment Pilot 99

 1.29 Community Oncology Medical Home (COME HOME) 102

 1.30 Geisinger Health System’s Physician Compensation Model..... 105

 1.31 Geisinger Health System’s ProvenCare® Acute Episodes of Care..... 108

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.32 Horizon Blue Cross Blue Shield of New Jersey Episodes of Care Program 111

1.33 Horizon Blue Cross Blue Shield of New Jersey Patient-Centered Medical Home Program 113

1.34 Intel’s Connected Care 115

1.35 Intel’s Healthcare Marketplace Collaborative (HMC) 118

1.36 MDVIP 121

1.37 Presbyterian Health Plan’s Medicaid Multi-Specialty Sub-Capitation Payment Model 123

1.38 Priority Health’s Spine Centers of Excellence Program 126

1.39 Project Sonar 129

1.40 PROMETHEUS Payment Model 132

1.41 SMARTCare 135

1.42 Tufts Health Plan Coordinated Care Model 138

1.43 UnitedHealthcare Oncology Episode Pilot Program 140

1.44 Washington State Health Care Authority’s Accountable Care Program 144

1.45 WellPoint’s Patient-Centered Medical Home Pilot 148

2. INTERNATIONAL MODELS 151

2.1 Netherland’s Bundled Payments for Certain Chronic Conditions 151

2.2 Physician Payment in Denmark 155

The following members of the Support for the MACRA Physician-Focused Payment Model Technical Advisory Committee project assembled this Examples of Health Care Payment Models Being Used in the Public and Private Sectors document:

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EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

INTRODUCTION

Social & Scientific Systems, Inc. and its subcontractors, Actuarial Research Corporation, the University of Pennsylvania, and the Urban Institute (the SSS Team) are contractors to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) to provide administrative and logistical services, as well as technical and analytic support to the Medicare Access and CHIP Reauthorization Act (MACRA) Physician-Focused Payment Model Technical Advisory Committee (PTAC).

As part of this technical and analytic support, ASPE asked the SSS Team to help identify what approaches to payment (models) are currently in use in the public and private sectors. This paper presents 47 payment models in standardized templates, addressing the most salient aspects of the model, for ease of review and cross-comparison. Nine payment models are public sector payment models (Medicare and Medicaid models primarily involving the traditional fee-for-service (FFS) Medicare program), 36 are private sector models (reflecting a range of developers such as employers, insurers, health systems, and other stakeholders), and two are international models.

The models highlighted in this paper do not represent a complete representation of all payment models in use by all public and private payers in the United States. Rather, this document presents a subset of payment models:

- For which information was publicly available, including from the Center for Medicare and Medicaid Innovation’s website, and sufficient information was available to prepare a reasonably complete profile.
- That were submitted for inclusion in this document by organizations suggested by the PTAC and the Health Care Payment Learning and Action Network.
- That are currently or recently in use (i.e., not proposed models).

It is also important to note that a model’s inclusion in this document does not represent the preference, endorsement, or recommendation by the SSS Team, ASPE, or PTAC. Alternatively, we hope this document can be a resource to:

- Identify models of potential interest to stakeholders,
- Understand the extent to which a given model has been evaluated and for which lessons learned can be identified, and
- Provide points of contacts with whom to follow-up.

The description of the models in the following pages address a range of areas, including payment or care delivery model goals; how payments were calculated; how incentives operate in the model; services, patients, and providers involved; performance measures’ role in payment calculations; and whether the model layers on top of FFS or is an alternative to FFS. One of the template elements addresses whether the model has been evaluated, and this document only includes high-level summary information about evaluations (i.e., contractor, timeline, research question summary, links to evaluations and reports). The rest of this paper presents the 47 models.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1. PUBLIC AND PRIVATE SECTOR MODELS IN THE UNITED STATES

This section includes profiles for nine sample payment models.

1.1 CMS’s (Multi-payer) Comprehensive Primary Care Initiative

Model Name: Comprehensive Primary Care Initiative (CPCI)	
Brief Description: Through this multi-payer initiative, 445 primary care practices are receiving monthly care management fees from the Medicare fee-for-service (FFS) program, Medicaid FFS programs (both of which are paid for by CMS), as well as commercial plans, Medicare Advantage, Medicaid managed care plans, and self-insured employers in 7 regions. The monthly payment from Medicare averages \$20 per beneficiary per month during Years 1-2 of the initiative, and decreases to \$15 during Years 3-4. (Practices receive other payments from other payers.) Starting in the second year of the initiative, participating practices also have the opportunity to share in savings earned for Medicare and other payers. Practices are required to meet annual milestones associated with the patient-centered medical home model of care to maintain participation in the initiative, and receive data feedback and learning activities and technical assistance.	
Developer: CMS Innovation Center	
What is the goal of this payment model?	The goal of this payment model is to improving care coordination and primary care delivery to achieve better health care, better health outcomes, and lower total cost of care.
How long has this payment model been in operation? Where has it been implemented?	The model was launched in October 2012 and will run for 4 years. 445 primary care practices are participating in 7 regions, including 4 states (AR, CO, NJ, and OR) and regions of 3 other states (in NY, OH/KY, and OK).
Type(s) of health care services, medical conditions, and health care settings addressed?	For purposes of calculating shared savings, participating practices are held accountable for all spending generated by their attributed patients.
Types of patients included?	Patients insured by participating payers in each region and receiving care from practices selected by CMS to participate in this initiative are included.
Method of attributing patients to participating providers	Medicare FFS beneficiaries are attributed on a quarterly basis to CPC practices that either delivered the plurality of their primary care visits during the past 2 years OR billed the most recent Medicare Chronic Care Management visit. For purposes of calculating shared savings, a beneficiary must be attributed to a practice for at least one quarter of the performance year in question. Beneficiaries can cease to be attributed to a practice due to: death; enrollment in a Medicare Advantage or PACE plan; loss of Medicare Parts A or B; if Medicare becomes a secondary payer for the beneficiary; or the beneficiary moves to an institutional facility.
Types of providers participating in the payment model?	CMS competitively-selected primary care practices from a larger pool of applicant practices, giving preference to practices that were meaningful users of electronic health records, were recognized as a patient-centered medical home, and were experienced in quality improvement initiatives.
The entity accountable to the payer?	Participating primary care practices are accountable to CMS and other participating payers.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive Primary Care Initiative (CPCI)	
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>Participating practices that meet annual milestones receive a monthly risk-adjusted care management fee from CMS for each Medicare FFS beneficiary (and, in cases where the state Medicaid agency is participating, for each Medicaid FFS beneficiary) attributed to their practice based on prior claims data. The monthly payment from Medicare averages \$20 per beneficiary per month during Years 1-2 of the initiative, and decreases to \$15 during Years 3-4. Practices also receive monthly fees from other participating payers.</p> <p>In addition, after the first year, practices that meet minimum quality requirements have the opportunity to earn shared savings payments from Medicare and other payers. Shared savings are calculated by estimating what Medicare FFS expenditures would have been in the region, absent the CPCI initiative, and then comparing that target to actual expenditures (including monthly CPCI payments) in the region. CMS determines whether the savings generated fall into one of three savings corridors (1-2.3%, 2.3-3.5%, and 3.5% or greater). If a region's expenditures are 1-2.3% below their spending target, the region's practices receive 10% of the savings generated after the first 1 percentage point. If a region's expenditures are 2.3-3.5% below their spending target, practices receive 10% of the savings generated after the first percentage point and up to 2.3% below the target, plus 20% of the savings between 2.3% and 3.5%. If the region's expenditures are more than 3.5% below their spending target, practices receive 50% of the savings on a first-dollar basis.</p> <p>Medicare calculates savings at the regional level. The percentage of regional savings that a practice can earn is equal to the practice's total annual care management fees divided by the region's sum of total annual care management fees. Total care management fees reflect both the number of attributed beneficiaries and the risk-adjusted care management fees paid for those beneficiaries. In this way, the amount of savings earned by each practice is dependent upon the acuity and size of that practice's CPCI population.</p> <p>Other payers may use different patient attribution algorithms, risk-adjustment methods, monthly payment amounts, and shared savings methods.</p>
Are there any performance metrics? If so, what is being measured?	<p>Enhanced payments from CMS are contingent upon the primary care practices reporting on their implementation of a set of annual milestones set at the beginning of the performance year. For example, first-year milestones were:</p> <ol style="list-style-type: none"> 1) Estimate CPCI revenues and develop a plan for their reinvestment in the practice. 2) Stratify patients by risk status and provide care management to high-risk patients. 3) Ensure 24/7 access to the medical record for the practice's providers. 4) Assess and improve patient experience with care by conducting a patient survey or forming a patient and family advisory council (PFAC) that meets quarterly. 5) Use data to guide care improvement by selecting one quality and one utilization measure on which to focus. 6) Improve care coordination in the medical neighborhood by selecting one area for focus.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive Primary Care Initiative (CPCI)	
	<p>7) Improve patient shared decision-making capacity by selecting one decision aid. 8) Participate in the regional learning community. 9) Attest to Stage 1 meaningful use.</p> <p>To earn shared savings starting in the second year of the initiative, practices had to meet performance targets on five Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience measures and three claims-based quality measures. Practices had to also successfully report 9 out of 11 electronic clinical quality measures.</p>
Are there any performance incentives? If so, what is being incentivized?	Practices are incentivized to complete annual milestones, in order to continue to participate in the initiative and receive monthly care management fees. Practices are also incentivized to lower their attributed patients' total health care expenditures and perform highly on specified quality measures, in order to earn shared savings payments.
How do incentives operate?	See "How are providers paid under the payment model?" and prior row, above. To earn shared savings payments (which became available starting in 2014), practices had to earn at least 35 out of 70 possible quality points from any combination of measures and benchmark gates.
Is this a stand-alone payment model or is it used with other payment models?	This payment model is used with FFS payment systems. Monthly care management fees and shared savings opportunities are offered in addition to Medicare FFS payments.
Has the model been evaluated? Who funded this evaluation?	<p>Mathematica Policy Research is the current evaluation contractor, but CMS plans to competitively re-procure this contract under its Research, Measurement, Assessment, Design, and Analysis (RMADA) indefinite-delivery, indefinite-quantity task order contract in the 4th federal quarter (July-September) of 2016. Quarterly and annual evaluation reports are scheduled to be produced at the practice, regional, and initiative levels.</p> <p>The current evaluation is studying 7 research questions regarding: stakeholder participation (by region, payers, practices, and patients); patient experience, care quality, utilization, and costs; care delivery transformation; success factors; model results segmented by regions and subgroups of patients and practices; and implications for replication and spread of the model. Evaluation findings are available in the following publications: <i>Evaluation of the Comprehensive Primary Care Initiative: First Annual Report</i>, January 2015, https://innovation.cms.gov/files/reports/cpci-evalrpt1.pdf; and "Two-Year Costs and Quality in the Comprehensive Primary Care Initiative," <i>New England Journal of Medicine</i>, http://www.nejm.org/doi/pdf/10.1056/NEJMsa1414953.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive Primary Care Initiative (CPCI)	
Other pertinent information	<p>-Practices receive data feedback from CMS on cost, service use, quality of care, and patient, provider, and practice staff experience.</p> <p>-Practices that do not meet annual milestones can be placed on corrective action plans or terminated from the initiative by CMS.</p> <p>-In April 2016, CMS announced the “Comprehensive Primary Care Plus” model, which it expects will become the largest multi-payer effort to improve primary care in the US. CMS hopes to implement the model in 20 regions, involving 25 million patients. Practices will continue to receive new monthly care management fees, but will also be paid incentive payments at the start of the year, which they will have to pay back if they don’t meet quality measure and utilization targets. A new “Track 1” will continue to receive regular FFS payment for evaluation & management visits, while practices in a “Track 2” will agree to reduced FFS payment rates plus capitated payments for comprehensive primary care services. CMS is accepting applications from payers and practices this summer.</p>

The above information was excerpted or summarized from these sources:

CMS. “Comprehensive Primary Care Initiative.” Available at: <https://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>; and other CMS documents linked from this webpage.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.2 CMS’s Financial Alignment Initiative for Medicare-Medicaid Enrollees

Model Name: Financial Alignment Initiative for Medicare-Medicaid Enrollees	
Brief Description: This gives state Medicaid agencies the opportunity to partner with Medicare to coordinate the financing of health insurance for individuals dually enrolled in Medicare and Medicaid through two CMS-proposed models, or to pursue a state-proposed model. Under the “Capitated Model,” which is being pursued by 10 states, a private health insurance plan receives a prospective, blended, capitated payment from Medicare and Medicaid to provide comprehensive, coordinated care to Medicare-Medicaid enrollees. Under the “Managed Fee-for-Service Model,” which 2 states are pursuing, Medicare and Medicaid continue to pay providers on a fee-for-service (FFS) basis but a state Medicaid agency is eligible to share in any annual savings generated for CMS. Minnesota is pursuing an alternative model, testing the integration of administrative functions without financial alignment to strengthen their existing Medicare-Medicaid plan, Minnesota Senior Health Options (MSHO).	
Developer: CMS Innovation Center and CMS Medicare-Medicaid Coordination Office	
What is the goal of this payment model?	The goals of this payment model are to: better align the financial incentives and financing of the Medicare and Medicaid programs, achieve savings for both states and CMS, and eliminate cost shifting between the two programs; better coordinate primary, acute, behavioral health, and long-term services and supports for Medicare-Medicaid enrollees; improve beneficiary experience in accessing care; and improve quality.
How long has this payment model been in operation? Where has it been implemented?	Rolling entry of states into this demonstration started in July 2013. State demonstrations can run for up to 5 years. The Capitated Model is being pursued by 10 states (CA, IL, MA, MI, NY, OH, RI, SC, TX, and VA). The Managed FFS Model is being pursued by 2 states (CO, WA). An alternative model is being pursued by 1 state (MN).
Type(s) of health care services, medical conditions, and health care settings addressed?	State demonstrations pursuing either the Capitated Model or the Managed FFS Model must ensure the provision of all necessary Medicare- and Medicaid-covered services, including primary, acute, prescription drug, behavioral health, and long-term supports and services. They must also ensure the provision of care coordination (e.g., comprehensive health assessments, development of individualized care plans, and management of care transitions). In the Capitated Model, plans must also cover all services included in their state’s Medicaid state plan and Medicare Part D benefits.
Types of patients included?	Participating states can enroll individuals dually enrolled in Medicare and full-benefit Medicaid who reside in the community or in institutional settings and are not cared for by a provider participating in a Medicare Shared Savings Program ACO, not insured through Medicare Advantage, and not in a Program of All-Inclusive Care for the Elderly (PACE) plan. As of Sept. 2015, approximately 400,000 individuals were enrolled in this demonstration.
Method of attributing patients to participating providers	Under the Managed FFS model, all Medicare-Medicaid enrollees eligible for a state’s demonstration will be attributed to the state’s demonstration, regardless of the enrollee’s level of engagement in the associated interventions, for purposes of calculating shared savings. Under the Capitated Model, states typically provide an opt-in enrollment period during which beneficiaries can select a plan, followed by a passive enrollment period whereby remaining beneficiaries are automatically assigned to a plan.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Financial Alignment Initiative for Medicare-Medicaid Enrollees	
Types of providers participating in the payment model?	Providers of primary, acute, prescription drug, behavioral health, and long-term supports and services who serve Medicare-Medicaid enrollees may be affected by this new financing approach.
The entity accountable to the payer?	In the Capitated Model, private health insurance plans are jointly accountable to state Medicaid agencies and CMS. In the Managed FFS Model, a state Medicaid agency is accountable to CMS.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>In the Capitated Model, private health insurance plans jointly contract with a state Medicaid agency and CMS to receive a blended, capitated, actuarially-developed rate for the full continuum of benefits provided to Medicare-Medicaid enrollees (including Part D benefits). Rates are developed to allow both states and CMS to achieve savings relative to their expected FFS or managed care spending (whichever is lower) for each service area. Typically, a portion (1%-3%) of the capitated payments are withheld, which plans can earn back if they meet certain quality thresholds. CMS does not require that plans use a particular payment method to pay providers.</p> <p>In the Managed FFS Model, providers are paid using existing Medicare and Medicaid FFS payment systems for services provided to Medicare-Medicaid enrollees. State Medicaid agencies make upfront investments in care coordination for this population, and are eligible for an annual retrospective performance payment from CMS if a targeted level of savings is achieved for CMS and quality targets are met. To receive a payment, states must generate savings for CMS that exceed a minimum savings rate relative to a spending target. A state's spending target is set by calculating historical spending for its eligible enrollees over a 2-year baseline period prior to the demonstration, then trending that amount forward based on the expenditure growth rate for a comparison group of Medicare-Medicaid enrollees in a statistically similar region. Separate Medicare and Medicaid savings targets are set, using separate rates of cost growth for Medicare and Medicaid comparison beneficiaries. States' minimum savings rates range from 2.0% to 4.5% below their spending target, depending on the number of beneficiaries eligible for states' demonstration. If savings to the Medicare program exceed the minimum savings rate, after deducting any increase in federal Medicaid spending, and if quality targets are met, the state is eligible to earn up to 50% of the net federal savings. (Note: Increases in the federal share of Medicaid spending are only deducted from Medicare savings if the increase in Medicaid spending exceeds the minimum savings rate; if it does, such increases in the federal share of Medicaid spending relative to the Medicaid spending target are deducted on a first-dollar basis.) Performance payments to states are capped at 6% of total Medicare Parts A and B expenditures for eligible Medicare-Medicaid enrollees. If a state fails to generate savings that exceed their minimum savings rate, the state does not owe CMS any money.</p> <p>13 state-specific demonstrations are described in Memoranda of Understanding on CMS's website.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Financial Alignment Initiative for Medicare-Medicaid Enrollees	
Are there any performance metrics? If so, what is being measured?	In the Capitated Model, some quality measures are consistent across all participating states (and include HEDIS measures, Health Outcomes Survey measures, CAHPS patient experience survey measures, and existing Part D measures) while others are state-specific (e.g., focusing on long-term services and supports, coordination, transitions, utilization). In the Managed FFS Model, measures assess spending, utilization, quality, and patient experience. States are primarily assessed on their ability to lower the growth in spending for Medicare-Medicaid enrollees. In addition, states are assessed on: core quality measures from the starter measure set outlined in the National Quality Forum’s June 2012 report, <i>Measuring Healthcare Quality for the Dual Eligible Beneficiary Population</i> (starting with 4 of these, and eventually increasing to 8 of these measures); state-specific process measures (including 2 mandatory measures and at least 1 additional state-selected measure from a CMS list of measures); and 3-5 state-selected demonstration measures (which do not need to be from CMS’s list). CMS will also sponsor a CAHPS patient experience survey for this demonstration.
Are there any performance incentives? If so, what is being incentivized?	In the Capitated Model, plans are incentivized to limit spending by Medicare-Medicaid enrollees to below their capitated rate, in order to generate profit for themselves. They are also incentivized to work with contracted providers to meet performance targets on quality measures specified in state-specific contracts. In the Managed FFS Model, states are incentivized to reduce spending on Medicare-Medicaid enrollees beyond their minimum savings rates for Medicare and Medicaid. States are also incentivized to work with providers to meet performance targets on specified quality measures.
How do incentives operate?	In the Capitated Model, plans are required to meet established quality thresholds. In the Managed FFS Model, a state is incentivized to meet spending and quality targets to become eligible to receive a retrospective performance payment. In the first year of the demonstration, states can receive shared savings payments if they report on required quality measures. Starting in the second year, states can only receive such payments if they meet performance targets on those measures. (See specific states’ MOUs for more on quality measurement requirements.)
Is this a stand-alone payment model or is it used with other payment models?	The Capitated Model is a stand-alone payment model used instead of FFS Medicare and Medicaid. The Managed FFS Model is used with FFS Medicare and Medicaid: If savings are generated for CMS relative to a spending target, the state Medicaid agency may qualify to receive an additional annual shared savings payment.
Has the model been evaluated? Who funded this evaluation?	CMS hired RTI International to evaluate this initiative in 2013; the evaluation will run through 2017. Evaluation findings reports are scheduled to be produced quarterly and annually. The evaluation’s 9 research questions ask the evaluator to: compare states’ demonstration designs; study the extent to which demonstration policies and strategies are being replicated; beneficiary experience and perception of performance improvement efforts; impact on healthcare cost savings, utilization, access, and the quality of care for acute, long-term, and behavioral health services.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Financial Alignment Initiative for Medicare-Medicaid Enrollees	
	<p>Official evaluation reports are available at: <i>Report on Early Implementation of the Demonstrations under the Medicare-Medicaid Financial Alignment Initiative</i>, October 15, 2015, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf;</p> <p><i>Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals Aggregate Evaluation Plan: Executive Summary</i>, December 16, 2013, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanExecSumm.pdf;</p> <p><i>Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals Aggregate Evaluation Plan</i>, December 16, 2013,</p> <p>https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/EvalPlanFullReport.pdf;</p> <p><i>Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Preliminary Findings from the Washington MFFS Demonstration</i>, January 4, 2016, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf;</p> <p>State-specific evaluation design plans are available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html.</p>
Other pertinent information	<ul style="list-style-type: none"> -A state can pursue both the Capitated Model and the Managed FFS Model at the same time, for different patient populations. -Under the Capitated Model, health plans can be given administrative, benefit, and enrollment flexibilities (e.g., can offer supplemental benefits). -States pursuing either of the two models must establish an ombudsman program, and inform beneficiaries of changes related to this initiative. -States must identify protections to ensure beneficiaries' health, safety, and access to high-quality health and supportive services (e.g., enrollment and disenrollment procedures, grievances and appeals, process for ensuring access to and continuity of care). -States must provide CMS with data, including beneficiary-level expenditure data and covered benefits for the last 3 years. -CMS is offering technical assistance to support states' planning activities.

The above information was excerpted or summarized from these sources:

CMS. "Financial Alignment Initiative." Available at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html>; other CMS documents linked from this webpage; MACPAC. "Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare." Available at: <https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.3 Medicare’s Shared Savings Program

Model Name: Medicare’s Shared Savings Program (MSSP)	
Brief Description: This is the original Medicare program that created “accountable care organizations” (ACOs). Groups of health care providers who voluntarily join together to form ACOs are eligible for annual “shared savings” bonus payments if they generate enough savings, relative to the total Medicare expenditures their attributed patients were expected to generate, while meeting performance targets. Of the 400+ MSSP ACOs that have formed in nearly every state in the US, the vast majority (99%) have opted to participate as a “one-sided risk” ACO – meaning they are only eligible to earn shared savings, and do not have to pay shared losses to Medicare if they generate more spending than expected. ACOs can also take on “two-sided risk” – meaning they agree to pay CMS a share of the losses generated if they spend more than they were expected to (such ACOs are also eligible to receive larger shares of any savings generated). A third MSSP ACO track was announced in mid-2015, which will allow ACOs to take on greater two-sided risk.	
Developer: Congress authorized this program in a dedicated section of the Affordable Care Act (Sec. 3022); it is being implemented by the CMS Innovation Center.	
What is the goal of this payment model?	The goals of this payment model are to: encourage providers to better coordinate care for Medicare patients; avoid unnecessary duplication of services; prevent medical errors; deliver evidence-based health care; eliminate waste; and reduce excessive costs through improved care delivery.
How long has this payment model been in operation? Where has it been implemented?	April 1, 2012 is when the first set of MSSP ACOs’ operational periods began. 404 MSSP ACOs are located in 49 states, DC, and Puerto Rico.
Type(s) of health care services, medical conditions, and health care settings addressed?	ACOs are responsible for all services covered under Medicare Parts A and B.
Types of patients included?	Medicare fee-for-service beneficiaries whose primary care providers opt to join an ACO are attributed to that ACO are included.
Method of attributing patients to participating providers	Beneficiaries are considered attributed to an ACO if the beneficiary receives a plurality of their primary care services from a provider in the ACO; beneficiaries are attributed to an ACO’s providers using preliminary prospective beneficiary assignment, based on past claims, with final retrospective beneficiary assignment later on.
Types of providers participating in the payment model?	ACOs can include: physicians, physician assistants, nurse practitioners, or clinical nurse specialists in group practice arrangements, in networks of individual practices, in a joint venture with a hospital, or employed by a hospital; certain critical access hospitals, federally-qualified health centers, and rural health clinics; plus any other type of Medicare-enrolled provider in good standing that wishes to join an ACO (e.g., hospitals, long-term care facilities), although beneficiaries cannot be attributed to this last set of providers. Providers cannot concurrently participate in another Medicare fee-for-service shared savings initiative.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Medicare’s Shared Savings Program (MSSP)	
The entity accountable to the payer?	The MSSP ACO (a group of health care providers who come together to form this new organization) is accountable to CMS.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>Providers that participate in an ACO continue to be paid on a fee-for-service basis, but are eligible to receive (or pay) an annual bonus (or penalty) if they generate lower (or higher) expenditures than an ACO-specific spending “benchmark” set by CMS. Since the specific approach that ACOs use to distribute shared savings payments (or divide up liability for paying shared loss penalties) among its providers is not specified by Medicare – and therefore unknown to us – this row focuses on describing how CMS pays ACOs.</p> <p>Step 1: Setting an ACO’s spending benchmark. The benchmark is an estimate of what the total Medicare expenditures for an ACO’s beneficiaries would have been in the absence of the ACO. Each ACO’s unique benchmark is set using their patients’ most recent available 3 years of Medicare Parts A and B expenditures, trended forward using the projected absolute amount of growth in national per capita Parts A and B spending, and is risk-adjusted. (Beneficiaries are considered attributed to an ACO if the beneficiary receives a plurality of their primary care services from a provider in the ACO; beneficiaries are attributed to an ACO’s providers using preliminary prospective beneficiary assignment, based on past claims, with final retrospective beneficiary assignment later on.)</p> <p>Step 2: Determining eligibility for shared savings (or losses). If expenditures generated by an ACO are at least 2.0%-3.9% lower than their benchmark, the ACO is eligible to receive shared savings. Conversely, if the expenditures generated by an ACO are at least 2% (or whatever their selected rate is) higher than the benchmark, and if they opted to take on two-sided risk, they must pay a share of these cost over-runs to Medicare. (For ACOs choosing one-sided risk, their threshold savings rate ranges from 2.0-3.9%, with larger ACOs having to meet a smaller minimum savings rate; two-sided ACOs can select a symmetric shared savings/loss rate ranging from 0%-3.9% starting in 2016 – previously it was 2% in all cases.)</p> <p>Step 3a: Determining payment amounts. If they exceed their benchmark by this minimum percentage, one-sided ACOs can receive up to 50% of the savings generated below their benchmark. Meanwhile, two-sided ACOs can receive up to 60% of the savings generated (or must pay up to 60% of the cost over-run generated in excess of their benchmark). ACOs share in all savings or losses below or above their benchmark on a “first dollar” basis (receiving or owing not just the amount of savings or losses that exceeds the minimum percentage identified above). The maximum payment an ACO can receive is capped at 10% of their benchmark if they are a one-sided ACO, and 15% if they are a two-sided ACO. The maximum payment a two-sided ACO can owe is capped at 5% of their benchmark in the 1st year, 7.5% in the 2nd year, and 10% in the 3rd year. Starting in 2016, MSSP ACOs can participate in “Track 3,” which features a higher shared savings / loss rate (of up to 75% of an ACO’s benchmark, with shared savings capped at 20% of their benchmark, and shared losses capped at 15% of their benchmark) and <i>prospective</i> beneficiary assignment to ACOs (with no retrospective reconciliation).</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Medicare’s Shared Savings Program (MSSP)	
	Step 3b: Adjusting amounts based on quality. The amount of an ACO’s shared savings payment or shared losses penalty is then adjusted based on the ACO’s performance on 33 quality measures.
Are there any performance metrics? If so, what is being measured?	MSSP ACOs are required to report on (in their 1 st year) and meet performance targets for (in subsequent years) 33 quality measures in four domains: 1) patient/caregiver experience; 2) care coordination/patient safety; 3) at-risk population (including measures re: Diabetes, Hypertension, and other chronic conditions); and 4) preventive care. Measures are derived from patient experience survey data, claims data, and measure data reported by ACOs.
Are there any performance incentives? If so, what is being incentivized?	ACOs create incentives for health care providers who belong to an ACO to work together to treat a patient across care settings – including both ambulatory and hospital settings. ACOs that lower their growth in health care costs while meeting performance standards on quality and patient experience measures are eligible to receive annual bonuses, which are distributed to member providers.
How do incentives operate?	ACOs are eligible to receive annual shared savings payments if they generate lower expenditures than a spending benchmark. An ACO’s performance on measures determines the percentage of an ACO’s eligible shared savings (or losses) that they get to keep (or must pay back to CMS). In the 1 st year of an ACO’s 3-year agreement with CMS, they are eligible for the full amount of any shared savings earned if they report on all 33 quality measures; in their 2 nd year, pay-for-performance applies to 25 of the 33 measures, and pay-for-reporting applies to the remaining 8 measures; in their 3 rd year, pay-for-performance applies to 32 of the 33 measures, and pay-for-reporting applies to the remaining 1 measure. CMS may terminate an agreement if an ACO avoids at-risk beneficiaries, fails to meet quality performance standards, etc.
Is this a stand-alone payment model or is it used with other payment models?	MSSP ACO participants continue to bill Medicare on a fee-for-service basis.
Has the model been evaluated? Who funded this evaluation?	CMS hired L&M Policy Research to evaluate this model as well as the Pioneer ACO model in Fall 2012; the evaluation is expected to run through Spring 2016. Evaluation reports were scheduled to be released on a quarterly, semi-annual, and annual basis. The evaluation’s 20 research questions explore the program’s impact on: care coordination; expenditures; utilization patterns; access to care; quality of care; patient health outcomes; patient experience; beneficiary selection bias; organizational, administrative, and structural changes influencing ACO success; impact of the receipt of advance payments to ACOs; effectiveness of shared learning; and unintended consequences. Official evaluation reports for the first two years of the program are available: <i>Effect of Pioneer ACOs on Medicare Spending in the First Year</i> , November 3, 2013, https://innovation.cms.gov/Files/reports/PioneerACOEvalReport1.pdf ; <i>Pioneer ACO Evaluation Findings from Performance Years One and Two</i> , March 10, 2015, https://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf . A group of Harvard researchers have also released a claim-based analysis of quality and costs: “Early Performance of Accountable Care Organizations in Medicare,” <i>New England Journal of Medicine</i> , April 13, 2016, http://www.nejm.org/doi/full/10.1056/NEJMSa1600142 .

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Medicare’s Shared Savings Program (MSSP)	
Other pertinent information	<p>-ACOs must: agree to accept responsibility for the expenditures and quality of care of at least 5,000 Medicare fee-for-service beneficiaries who receive their primary care from the ACO’s providers; establish a governing body representing providers and beneficiaries; submit a detailed application describing how they plan to deliver high-quality care and lower the growth in their expenditures (among other things); have the application approved by CMS (since entrance into the program is not granted automatically); and sign a 3-year agreement with CMS.</p> <p>-ACOs are required to notify beneficiaries that their primary care provider is participating in an ACO, and beneficiaries can choose not to continue seeing this provider, since beneficiaries retain the ability to choose which providers they see and services they receive.</p> <p>-ACOs are required to notify beneficiaries that their claims data may be shared with the ACO, and beneficiaries can choose not to allow this data to be shared.</p>

The above information was excerpted or summarized from these sources:

CMS. “Shared Savings Program.” Available at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html>; and other CMS documents linked from this webpage.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.4 Medicare’s Bundled Payments for Care Improvement (BPCI) Initiative

Model Name: Bundled Payments for Care Improvement (BPCI) Initiative – Models 2 and 36	
<p>Brief Description: This profile focuses on Models 2 and 3 of Medicare’s BPCI Initiative, the models that the vast majority of provider organizations participating in the BPCI Initiative have chosen to participate in. Both Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against an awardee-specific, CMS-set spending target for episodes of care lasting 30, 60, or 90 days, and shared savings payments or losses are then calculated. Episodes are triggered by an inpatient stay for one of 48 common procedures or conditions (e.g., acute myocardial infarction, coronary artery bypass graft, diabetes, major lower extremity joint replacement, renal failure, pneumonia, urinary tract infection). Only a handful of organizations are participating in BPCI Models 1 and 4, in which episodes last only the duration of an inpatient stay – these models are briefly described in the “Other pertinent information” row at the end of this profile.</p> <p>Models 2 and 3 differ along one very important dimension. Model 2 episodes include an inpatient stay (plus post-acute care and all related services received after a hospital discharge), whereas Model 3 episodes do <u>not</u> include an inpatient stay (and instead begin at the initiation of post-acute care services within 30 days of an acute care hospital stay for a triggering inpatient stay).</p> <p>As of Jan. 1, 2016, 337 organizations were participating in the BPCI Initiative under one of the 4 models as “awardees” (e.g., hospitals in Model 2, or organizations that provide post-acute care in Model 3) – meaning they contracted with CMS to take on financial risk for episodes. 1,237 organizations were participating as “episode initiators” (e.g., the organizations described above, or physician group practices) – meaning qualifying inpatient stays at these facilities trigger an episode, or qualifying inpatient stays led by operating or attending physicians that belong to these physician group practices trigger an episode. Organizations can be both “awardees” and “episode initiators.” Organizations that are only “episode initiators” enter into agreements with “awardees” to participate in episodes and share in any savings or losses.</p> <p>Provider organizations participating in the BPCI Initiative include: 409 acute care hospitals; 700 skilled nursing facilities; 100 home health agencies; 9 inpatient rehabilitation facilities; 1 long-term care hospital; and 288 physician group practices. These organizations are spread across the US.</p>	
Developer: CMS Innovation Center	
What is the goal of this payment model?	The goal of the BPCI Initiative is to align payment incentives among providers and suppliers with the health care experience of the Medicare beneficiary who is undergoing a period of treatment for a clinical condition. The four BPCI models attempt to achieve efficiency gains in health care delivery, primarily through care redesign. (Participants must submit care redesign plans to CMS to enter the initiative, before they are selected as “awardees.”)
How long has this payment model been in operation? Where has it been implemented?	Participation in Models 2 and 3 began in October 2013. Awardees enter into agreements with CMS lasting 3 years, although either CMS or the awardee may terminate the agreement at any time (though any shared savings or losses would still be owed). See “Brief description” above for information on the magnitude of participation in this model.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Bundled Payments for Care Improvement (BPCI) Initiative – Models 2 and 36	
Type(s) of health care services, medical conditions, and health care settings addressed	<p>Episodes include most services covered under Medicare Parts A and B that are provided to a beneficiary throughout the duration of one of the 48 clinical episodes defined by CMS. (Participating provider organizations pick which clinical episodes they will participate in.) Episodes under both Models 2 and 3 are triggered by an “anchor DRG” for an inpatient stay, which is included in the Model 2 bundle of services but not the Model 3 bundles of services (instead, Model 3 episodes begin when post-acute care is sought following this anchor inpatient stay). Episodes include physicians’ services, inpatient hospital readmission services, long-term care hospital services, inpatient rehabilitation facility services, skilled nursing facility services, home health agency services, clinical laboratory services, durable medical equipment, and Part B drugs. In addition, Model 2 episodes also include: inpatient hospital services, hospital outpatient services, and independent outpatient therapy services. Model 3 episode also include: inpatient post-acute care services.</p> <p>Episodes do not include: a list of CMS-identified, unrelated Parts A and B services that can be provided during an episode without counting towards an awardee’s episode expenditures (e.g., hemophilia clotting factors): indirect medical education (IME), disproportionate share hospital (DSH), and capital payments.</p>
Types of patients included	Beneficiaries must be eligible for Medicare Part A and enrolled in Medicare Part B, receive inpatient hospital care at an episode initiator (defined below), not have end-stage renal disease, not be enrolled in a managed care plan (e.g., Medicare Advantage), not be covered under United Mine Workers, and Medicare must be their primary payer.
Method of attributing patient to participating providers	<p>Under Model 2, an episode is triggered for an awardee (defined below) when an eligible patient has an inpatient admission at a participating acute care hospital for one of the eligible DRGs.</p> <p>Under Model 3, an episode is triggered for an awardee when an eligible patient is admitted to or initiates services with an “episode initiator” (defined below) within 30 days of being discharged from an acute care hospital for a qualifying DRG.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Bundled Payments for Care Improvement (BPCI) Initiative – Models 2 and 36	
Types of providers participating in the payment model	<p>The BPCI Initiative uses unique terminology to refer to different types of entities involved in this model:</p> <ul style="list-style-type: none"> • An “awardee” is an entity that signs an agreement with CMS to assume financial liability for clinical episode spending. <ul style="list-style-type: none"> ○ An awardee can be a single Medicare provider or supplier or a convening organization that coordinates multiple health care providers’ participation. • An “episode initiator” is a health care provider that can trigger a BPCI episode of care. Episode initiators who also serve as awardees enter into agreements with CMS to bear financial risk directly. Episode initiators who do not also serve as awardees enter into agreements with awardees to participate in episodes and share any savings or losses. <ul style="list-style-type: none"> ○ In Model 2, “episode initiators” are acute care hospitals and physician group practices. Health systems, physician hospital organizations, and conveners of health care providers may also participate in this model as partnering organizations. ○ In Model 3, “episode initiators” are skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, home health agencies, and physician group practices. Health systems and conveners of health care providers can also participate in this model as partnering organizations. ○ Under both Model 2 and 3, physician group practices are considered “episode initiators” if they were the operating or admitting physician for the qualifying inpatient stay. • A “convener” is an entity that brings together multiple health care providers to participate in the BPCI Initiative. Conveners can (but do not have to) also serve as awardees – meaning they can (but do not have to) bear financial risk to CMS. <ul style="list-style-type: none"> ○ Conveners are not required to be health care providers.
The entity accountable to the payer	“Awardee” entities (defined above) enter into agreements with CMS to bear financial risk for episodes.
The entity receiving payment from the payer (if different from above)	Same as above.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Bundled Payments for Care Improvement (BPCI) Initiative – Models 2 and 36	
How are providers paid under the payment model?	<p>In both Models 2 and 3, providers continue to bill Medicare for fee-for-service payments during the episode. At the end of the episode, CMS compares the total expenditures for all related services to the spending target for that awardee for that type of episode. If actual expenditures are below the spending target, CMS shares those savings with the awardee; if expenditures are above the target, the awardee pays a share of these losses back to CMS.</p> <p>The spending target for an episode is set by CMS using 3 years of historical claims data for the episode initiator (and additional regional data, if needed). The spending target is then trended forward to the current year using national episode-specific growth rates, and a discount is then applied. In Model 2, a 3% discount is applied to 30- or 60-day episodes, and a 2% discount is applied to 90-day episodes. In Model 3, all episodes are discounted by 3%.</p> <p>Awardees may choose to bear up-side and down-side risk up to the 75th, 95th, or 99th percentile of their actual expenditures. Awardees bear 100% of the risk up to one of these thresholds, then 20% of the risk beyond that. Awardees can change risk tracks on a quarterly basis.</p> <p>CMS monitors Medicare Parts A and B spending in the 30 days following an episode; if spending in the post-episode period increases due to cost-shifting, awardees are responsible for paying CMS any amount that exceeds a threshold of spending in this post-episode period.</p> <p>Awardees are permitted to share savings with partnering providers. However, CMS does not specify how awardees must distribute shared savings payments (or share liability for paying CMS penalties).</p>
Are there any performance metrics, if so, what is being measured?	<p>No quality measures are tied to payment, but awardees must: 1) get CMS approval for provider-led care redesign and enhancements (e.g., re-engineered care pathways, standardized operating protocols, improved care transitions, care coordination) to enter the initiative; 2) comply with CMS’s information requests in support of monitoring and evaluation activities; and 3) collect a subset of measures included in the BPCI Continuity Assessment Record and Evaluation (B-CARE) tool to evaluate beneficiary condition at discharge from the hospital.</p>
Are there any performance incentives, if so, what is being incentivized?	<p>Participating providers have an incentive to deliver care during an eligible patient’s clinical episode at a total cost that is below their spending target, in order to generate a reconciliation payment from CMS.</p>
How do incentives operate?	<p>See prior row.</p>
Is this a stand-alone payment model or is it used with other payment models?	<p>The BPCI Initiative relies on the fee-for-service payment system to calculate spending targets for clinical episodes and to identify whether participating providers’ actual expenditures were below or above this target, which is in turn used to determine the size of awardees’ reconciliation payments or penalties.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Bundled Payments for Care Improvement (BPCI) Initiative – Models 2 and 36	
<p>Has the model been evaluated? Who funded this evaluation?</p>	<p>CMS hired The Lewin Group to evaluate Models 2, 3, and 4 of this initiative in 2013; the evaluation will run through 2018. Evaluation findings reports are scheduled to be produced quarterly and annually. The evaluation’s 3 main research questions are: 1) What are the characteristics of the program and participants at baseline and how have they changed during the course of the initiative? 2) What is the impact of the BPCI initiative on the costs of episodes, the Medicare program, and the quality of care for Medicare beneficiaries? 3) What program, provider, beneficiary, and environmental factors contributed to the various results of the BPCI initiative? Early evaluation results are available: <i>Bundled Payments for Care Improvement – First Evaluation Report</i>, Feb. 2015, https://innovation.cms.gov/Files/reports/BPCI-EvalRpt1.pdf.</p>
<p>Other pertinent information</p>	<p>-CMS has issued waivers of certain fraud and abuse authorities to allow gainsharing, incentive payments, and patient engagement incentive arrangements under Models 2 and 3.</p> <p>-CMS has also issued waivers of certain Medicare payment policies. Provided certain circumstances are met, CMS waives the direct-supervision requirement for post-discharge home visits, and the geographic area requirement for coverage of telehealth services. For Model 2 participants, CMS also waives the requirement for a 3-day inpatient hospital stay prior to the provision of Medicare-covered post-hospital extended care services by a skilled nursing facility (instead, the inpatient stay can be of a shorter duration).</p> <p>-Awardee agreements specify provider-led care redesign and enhancements (e.g., re-engineered care pathways, standardized operating protocols, improved care transitions, care coordination) and may also specify gainsharing that will occur among participating providers.</p> <p>-Participating providers must notify Medicare beneficiaries of their involvement in the BPCI Initiative.</p> <p>-Implementation of Models 2, 3, and 4 is divided into two phases. To enter the first phase, participants have to be selected by CMS after a review of their proposed care redesign plans and a preliminary program integrity screening. In this first (“preparation”) phase, awardees receive monthly beneficiary-level claims data for episodes of care, their target prices for the 48 available episodes (to help them pick which episodes to pursue), and they engage in education and shared learning activities with other participants. This is followed by the second (“risk-bearing”) phase, when participants formally enter into agreements with CMS and begin participation in the payment model.</p> <p><u>Other BPCI models are described below:</u></p> <p>-Model 1: Acute care hospitals receive a payment based on their usual DRG payment rate for any inpatient stay payable under the Medicare Inpatient Prospective Payment System. Similarly, physicians treating patients as part of this inpatient stay continue to be paid on a fee-for-service basis under the Medicare Physician Fee Schedule. However, the hospital is permitted to offer physicians’ gain-sharing payments out of their DRG payment if the hospital’s costs end up being lower than the DRG payment received for the inpatient stay. 11 organizations are participating in this model, which began in April 2013, and will run for 3 years (and is set to then terminate, per CMS).</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Bundled Payments for Care Improvement (BPCI) Initiative – Models 2 and 36	
	-Model 4: Hospitals receive a prospective bundled payment to cover the cost of all services furnished by both the hospital and physicians and other practitioners during an inpatient stay for one of the 48 clinical episodes mentioned above plus any related hospital readmissions. Physicians and other practitioners submit “no-pay” claims for services furnished, and are paid by the hospital out of the bundled payment amount. 9 organizations are pursuing this model, which began in October 2013.

The above information was excerpted or summarized from these sources:

CMS. “Bundled Payments for Care Improvement (BPCI) Initiative.” Available at:

<https://innovation.cms.gov/initiatives/bundled-payments/>; and other CMS documents linked from this webpage.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.5 Medicare’s Comprehensive Care for Joint Replacement

Model Name: Comprehensive Care for Joint Replacement Model	
Brief Description: This retrospective bundled payment model is a new mandatory program for acute care hospitals in 67 CMS-selected metropolitan statistical areas (MSAs). Hospitals that are not already receiving bundled payments for lower extremity (hip or knee) joint replacements through CMS’s Bundled Payments for Care Improvement initiative are required to participate in this 5-year model. Starting April 1, 2016, these hospitals are financially accountable for the quality and cost of a 90-day lower extremity joint replacement episode of care. If actual Medicare Parts A and B expenditures related to these episodes are <i>below</i> CMS-set, hospital-specific episode target prices, and if hospitals achieve minimum quality composite scores, they are eligible to receive a reconciliation payment from Medicare for this difference (up to a cap); if actual episode expenditures are <i>above</i> the target price, hospitals are financially responsible to Medicare for this difference (up to a cap).	
Developer: CMS Innovation Center	
What is the goal of this payment model?	The goal of this payment model is to give hospitals a financial incentive to work with physicians, home health agencies, skilled nursing facilities, and other providers to improve the quality, care coordination, and efficiency of the most common inpatient surgeries Medicare beneficiaries receive – hip and knee replacements.
How long has this payment model been in operation? Where has it been implemented?	Model start date is April 1, 2016. 67 MSAs (which are counties associated with a core urban area with a population of at least 50,000) selected by CMS for participation in this model, located in AL, AR, CA, CO, CT, FL, GA, IL, IN, KS, KY, LA, MI, MO, MS, NC, ND, NE, NJ, NM, NV, NY, OK, OH, OR, PA, SC, TN, TX, VA, UT, WA, and WI.
Type(s) of health care services, medical conditions, and health care settings addressed?	Inpatient surgeries for lower extremity joint replacements or reattachments, with or without complications, plus all related Medicare Parts A and B services delivered by any provider in the 90 days following discharge (with certain exclusions). Does <u>not</u> include unrelated services for acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of a lower extremity joint replacement surgery, and for chronic conditions that are generally not affected by the lower extremity joint replacement procedure or post-surgical care.
Types of patients included?	Medicare fee-for-service beneficiaries undergoing lower extremity joint replacements at a participating hospital in one of the 67 CMS-selected MSAs.
Method of attributing patients to participating providers	Patients are attributed to the hospital where they underwent their lower extremity joint replacement procedure.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive Care for Joint Replacement Model	
Types of providers participating in the payment model?	<p>Acute care hospitals are required to participate in this model if they are paid under the Inpatient Prospective Payment System (IPPS), are located within one of the 67 CMS-selected MSAs, and are not already receiving bundled payments for lower extremity joint replacements as a participant in CMS’s Bundled Payments for Care Improvement initiative. As of Nov. 16, 2015, approximately 800 hospitals were required to participate in this model.</p> <p>Hospitals can enter into financial arrangements with certain types of providers and suppliers (skilled nursing facilities, long-term care hospitals, home health agencies, inpatient rehabilitation facilities, physician and non-physician practitioners, and outpatient therapy providers) who also furnish services during an episode, allowing these other providers to share in reconciliation payments, internal cost savings, and the responsibility for repayment to Medicare. Hospitals may also enter into financial arrangements with ACOs, to have the ACO coordinate care for patients.</p>
The entity accountable to the payer?	Participating hospitals are accountable to CMS.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>During each of the 5 performance years of this model, CMS sets 4 hospital-specific target prices for lower extremity joint replacements, with or without complications, performed on patients with or without a hip fracture. (Target prices will generally include a discount over expected episode spending and incorporate a blend of historical hospital-specific spending and regional spending for lower extremity joint replacement episodes, with the regional component increasing over time.)</p> <p>At the end of each year, actual Medicare Parts A and B spending for an episode is compared to the hospital’s target price for that type of episode.</p> <ul style="list-style-type: none"> • If actual episode spending is <i>lower</i> than the target price, and the hospital achieves the minimum composite quality score, the hospital is eligible to receive a reconciliation payment from Medicare for the difference between the target price and the actual spending, up to a cap. These payments are capped at up to 5% of a hospital’s target episode price in Years 1 and 2, 10% in Year 3, and 20% in Years 4 and 5 (with amounts dependent on the hospital’s composite quality score). • If actual episode spending is <i>higher</i> than the target price, the hospital may be financially responsible to Medicare for the difference, up to a cap. In Year 1, no penalties are owed to Medicare. After that, penalties for rural hospitals, Medicare-dependent hospitals, rural referral centers, and sole community hospitals are capped at 3% of the target price in Year 2, then 5% in Years 3-5. Penalties for all other hospitals are capped at 5% of the target price in Year 2, 10% in Year 3, and 20% in Years 4 and 5. (In Years 2 and 3, the amount owed will be discounted.) <p>As noted above, hospitals can enter into financial arrangements with certain types of providers and suppliers who also furnish services during an episode or with ACOs.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive Care for Joint Replacement Model	
Are there any performance metrics? If so, what is being measured?	<p>Performance metrics assess cost and quality:</p> <p>Hospitals are measured on their ability to limit Medicare spending within a 90-day episode following a lower extremity joint replacement.</p> <p>Hospitals are also assessed using a composite quality score, initially reflecting performance on only 2 quality measures: 1) 90-day complication rates following elective hip and knee arthroplasties over the past 3 years; and 2) patient experience as measured by the HCAHPS survey over the past year. Hospitals are also required to report data on pre- and post-operative patient-reported functional outcomes and 11 patient risk variables (e.g., race, BMI, presence of live-in support at home, pre-operative use of narcotics, health literacy); these data are being used by CMS to create a 3rd performance measure (of hospital-level risk-adjusted patient-reported outcomes) to be included in composite quality score calculations in Years 4 and 5.</p>
Are there any performance incentives? If so, what is being incentivized?	<p>Hospitals are incentivized to try to lower total Medicare Parts A and B spending on hip and knee replacements and follow-up care by working with physicians and post-acute care providers. They are also incentivized to achieve low rates of complications from these surgeries, and high rates of patient satisfaction.</p>
How do incentives operate?	<p>See “How are providers paid under the payment model?” above. Payment and penalty amounts are adjusted based on a hospital’s quality composite score, with better quality yielding hospitals larger payments or smaller penalties.</p>
Is this a stand-alone payment model or is it used with other payment models?	<p>This payment model is used with fee-for-service Medicare payment. Providers and suppliers are paid under the usual Medicare fee-for-service system throughout the year; at the end of the year, actual spending for an episode is compared to the hospital’s target price for that type of episode and, depending on the hospital’s performance, the hospital may receive an additional payment from Medicare or be required to make a payment to Medicare.</p> <p>This payment model can also be used with Medicare ACO payment models. Hospitals participating in the Comprehensive Care for Joint Replacement model may enter into financial arrangements with ACOs to have the ACO coordinate the care of CJR hospitals’ patients, and to share in reconciliation payments, internal cost savings, and the responsibility for repayment to Medicare.</p>
Has the model been evaluated? Who funded this evaluation?	<p>CMS plans to competitively procure an evaluation contractor through its Research, Measurement, Assessment, Design, and Analysis (RMADA) indefinite-delivery, indefinite-quantity task order contract in the 4th federal quarter (July-September) of 2016.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive Care for Joint Replacement Model	
Other pertinent information	<ul style="list-style-type: none"> -There is no application process. -Beneficiaries retain freedom of choice to choose services and providers. -Beneficiaries cannot opt out of CMS sharing their claims data with hospitals (unlike the Medicare Shared Savings Program). -HHS’s OIG & CMS have jointly issued waivers of certain fraud and abuse laws for purposes of testing this model (e.g., prohibitions on hospitals distributing gainsharing payments to other providers, or paying incentives to patients). -CMS will monitor claims data to ensure hospitals continue to provide all necessary services. -CMS will give hospitals spending and utilization data and facilitate the sharing of best practices between participating hospitals through a learning and diffusion program.

The above information was excerpted or summarized from these sources:

CMS. “Comprehensive Care for Joint Replacement Model.” Available at: <https://innovation.cms.gov/initiatives/cjr>; and other CMS documents linked from this webpage. Date of estimated evaluation contractor procurement was obtained from CMS’s April 11, 2016 Wave Chart.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.6 Medicare’s Comprehensive ESRD Care Initiative

Model Name: Comprehensive End-Stage Renal Disease (ESRD) Care Initiative	
Brief Description: This is the first disease-specific ACO model being tested by CMS. The ACOs in this model are called ESRD Seamless Care Organizations (ESCOs). ESCOs are comprised of dialysis clinics, nephrologists, and other providers who come together to form an entity that offers coordinated care to Medicare fee-for-service beneficiaries with End-Stage Renal Disease (ESRD). ESCOs agree to be held accountable for clinical quality outcomes and all Medicare Parts A and B spending, not just spending on dialysis services, for beneficiaries attributed to their ESCO. ESCOs that include the participation of at least one dialysis facility owned by a large dialysis organization (LDO), defined as an organization that owns more than 200 dialysis centers, will face two-sided risk – meaning they will be eligible to share in total Medicare savings generated but will also be responsible repayment of shared losses if spending increases. ESCOs that only include facilities owned by smaller dialysis organizations (non-LDOs) will only face one-sided risk – meaning they will be eligible to share in savings, but will not be required to share in losses. Of the 13 participating ESCOs located in cities across the US, 12 have LDOs as partners and face two-sided risk.	
Developer: CMS Innovation Center	
What is the goal of this payment model?	The goal of this payment model is to identify ways to improve care coordination, quality of care, and health outcomes of Medicare beneficiaries living with ESRD, while reducing Medicare expenditures.
How long has this payment model been in operation? Where has it been implemented?	Model started October 1, 2015, and the initial agreement period lasts 3 years. CMS and ESCOs then have the option of extending this agreement for an additional 2 years, based on the ESCO’s performance. Of the 13 participating ESCOs, 12 have LDOs as partners which means they are subject to two-sided payment risk. The 13 ESCOs are located in cities in: AZ, CA, FL, IL, NC, NJ, NY (the only one-sided ESCO), PA, SC, TN, and TX.
Type(s) of health care services, medical conditions, and health care settings addressed?	ESCOs are responsible for coordinating care and attempting to lower the total cost of all Medicare Parts A and B services received by eligible beneficiaries, including care unrelated to ESRD.
Types of patients included?	Medicare fee-for-service beneficiaries living with ESRD and who are receiving maintenance dialysis services, are at least 18 years of age, residing in the US, not aligned to another existing Medicare Shared Savings Program ACO (unless otherwise determined by CMS) and not a recipient of a kidney transplant in the last 12 months. Patients also must have Medicare as the primary payer.
Method of attributing patients to participating providers	CMS will match beneficiaries to an ESCO based on claims data showing dialysis utilization using a “first touch” approach—meaning that an eligible beneficiary’s first visit to a participating dialysis facility will prospectively match that beneficiary to that dialysis facility’s ESCO, unless the beneficiary loses eligibility to be attributed to the ESCO (e.g., ceases dialysis treatment, joins Medicare Advantage, receives a functioning transplant). This patient alignment process identifies the Medicare beneficiaries for whom CMS will hold an ESCO clinically and financially accountable.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive End-Stage Renal Disease (ESRD) Care Initiative	
Types of providers participating in the payment model?	ESCOs are comprised of dialysis clinics, nephrologists and other providers who come together to form a new entity. ESCOs are required to have participant owners that include at least one nephrologist or nephrology group practice and at least one dialysis facility. ESCOs must be led by care professionals experienced in providing care to beneficiaries with ESRD, and must have a minimum of 350 Medicare fee-for-service beneficiaries attributed to their organization.
The entity accountable to the payer?	The ESCO is accountable to CMS for meeting spending and quality targets.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>ESCOs with dialysis facilities owned by an LDO will face two-sided risk, and ESCOs with dialysis facilities owned by non-LDOs will face one-sided risk.</p> <p>CMS calculates an ESCO’s shared savings or losses based on a comparison of their spending benchmark to their actual Medicare Part A and B expenditures for the patients attributed to them in a given year. CMS will develop an ESCO’s spending benchmark based on historical Medicare Parts A and B expenditures incurred for beneficiaries who would have been attributed to the ESCO. CMS will then trend the benchmark forward using national data. Savings will be adjusted based on quality performance on broad quality measure domains listed in “Are there any performance metrics? If so, what is being measured?”</p> <p>An LDO ESCO whose beneficiaries’ expenditures are below the ESCO’s spending benchmark by at least a certain percentage will receive up to 70% of these savings in Year 1 (and 75% in subsequent years), or owe 70% (and later, 75%) of losses, up to a cap. Savings or losses are capped at 10% of savings or losses relative to the spending benchmark (rising to 15% in Year 3). LDO ESCOs’ spending benchmarks will be reduced (i.e., made more ambitious) to reflect a discount applied to non-dialysis Medicare Part A and Part B costs (starting at a 1.0% discount in Year 2, and steadily rising to a 3.0% discount from Year 4-on). Savings or losses for two-sided LDO ESCOs will be measured relative to the resulting discounted benchmark.</p> <p>A non-LDO ESCO with expenditures below their spending benchmark by at least a certain percentage will receive up to 50% of the savings generated, up to a cap of 5% of the updated benchmark.</p> <p>To receive shared savings payments, an ESCO must meet a minimum quality score. In Year 1, ESCOs only have to <i>report</i> on specified quality measures to be eligible to receive shared savings payments. In subsequent years, ESCOs performance points are earned based on an ESCO’s performance relative to a national benchmark or improvement over the prior year on the specific measures. Total points earned for each measure are multiplied by the measure weight and summed to produce a Total Quality Score, which is used to determine an ESCO’s eligibility for shared savings and the size of the shared savings payment. ESCOs that do not perform highly on the quality measures may be terminated from the initiative.</p> <p>ESCOs must also receive a minimum Total Performance Score from the ESRD Quality Incentive Program for that ESCO to be eligible for shared savings.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Comprehensive End-Stage Renal Disease (ESRD) Care Initiative	
Are there any performance metrics? If so, what is being measured?	See “How are providers paid under the payment model?” above. In addition to spending targets, ESCOs are accountable for quality. ESCO quality measure domains include: Preventive health; Chronic disease management; Care Coordination/Patient Safety; Patient/Caregiver Experience; Patient Quality of Life. These measures assess: outcomes (including mortality rates), utilization, clinical quality, and patient experience, using claims data, claims-and-medical records (“hybrid measures”), ESRD QIP results, and patient surveys.
Are there any performance incentives? If so, what is being incentivized?	ESCOs are incentivized to try to lower total Medicare spending by attributed Medicare fee-for-service beneficiaries, in order to generate shared savings payments. They are also incentivized to perform highly on specified quality measures, to allow them to receive and maximize the size of such payments.
How do incentives operate?	See “How are providers paid under the payment model?” above.
Is this a stand-alone payment model or is it used with other payment models?	This payment model is used with fee-for-service Medicare. Providers participating in an ESCO continue to bill Medicare for fee-for-service payments, and then qualify for shared savings payments or shared loss penalties at the end of the year, when actual fee-for-service expenditures are compared to their spending target.
Has the model been evaluated? Who funded this evaluation?	CMS hired The Lewin Group to evaluate this model in 2015, and this evaluation will conclude by 2020, with the potential for the evaluation period to be extended to 2021. Quarterly and annual evaluation reports are scheduled to be produced. The evaluation will explore 16 research questions, focusing on: care quality (i.e., impacts on clinical process measures, access, care coordination, “meaningful use” of health IT, patient-provider communications, unintended consequences); health outcomes (i.e., clinical outcomes, patient experience and quality of life, health status, unintended consequences); and cost (i.e., changes in utilization under Medicare Part A, physician and pharmacy services under Medicare Part B, unintended consequences, factors associated with lower costs). We are unaware of any publicly available evaluation reports at this time.
Other pertinent information	-Providers can participate in both this payment model and the Medicare Shared Savings Program. -Beneficiaries retain the right to see any Medicare provider and obtain any Medicare-covered services. -Each ESCO’s governing body must include at least one patient representative or independent consumer advocate.

The above information was excerpted or summarized from these sources:

CMS. “Comprehensive ESRD Care Model.” Available at: <https://innovation.cms.gov/initiatives/comprehensive-ESRD-care/>; and other CMS documents linked from this webpage.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.7 Medicare’s Coordinated Care Demonstration

Model Name: Medicare Coordinated Care Demonstration	
Brief Description: This 15-site randomized trial, which is now over, tested whether nurse-led “coordinated care services” (disease management or case management) could improve the quality of care or lower the cost of care for fee-for-service (FFS) Medicare beneficiaries with chronic conditions. Participating organizations were located in urban and rural areas across the US. Services were primarily offered by phone, focused on patient education, and nurses were not employed by primary care practices. An evaluation found that none of the 15 demonstrations were ultimately effective.	
Developer: Congress authorized this demonstration in a dedicated section of the Balanced Budget Act of 1997; CMS implemented it.	
What is the goal of this payment model?	The goal of this payment model was to support a specific change in care delivery: the use of private-sector “coordinated care services” used by HMOs, insurers, and academic medical centers targeted to beneficiaries with high-cost chronic conditions. This demonstration tested whether offering such services could reduce Medicare spending, and whether these services could: prevent avoidable, costly medical complications and hospitalizations; improve health status, clinical outcomes, satisfaction, and quality of life; and lead to more appropriate use of Medicare-covered services by targeted Medicare beneficiaries.
How long has this payment model been in operation? Where has it been implemented?	The 15 competitively-selected sites began implementing projects between April-Sept. 2002, and all ran through at least 2006. A subset was extended to 2008 and then 2010 (to allow for further data analyses), and then 1 site, Health Quality Partners (HQP) was extended to 2014 (because it generated favorable results for a small subset of its high-risk beneficiaries). After this last site’s extension population failed to generate favorable results, it was terminated as well. The 15 sites were organizations located in urban and rural areas of AZ, CA, DC, FL, IA, IL, IN, MD, ME, MN, MO, NE, NY, PA, SD, TX, and VA.
Type(s) of health care services, medical conditions, and health care settings addressed?	Site-defined “coordinated care services” consisted of disease management (serving patients with a particular condition) or case management (serving patients with a mix of problems and concurrent conditions). Care coordinators worked with 36-200 patients at a time, and primarily implemented this demonstration’s intervention over the phone. They did initial assessments of patients’ needs and conditions, and developed care plans with patients (but not other providers). They called patients 1-3 times per month to monitor them between doctor visits. They emphasized patient education, and sought to improve communication between patients and providers by training patients (e.g., telling them to go to visits with lists of questions) and sending physicians regular written reports on patients. Care coordinators referred patients to needed support services (e.g., home-delivered meals, transportation assistance), and some sites used devices for home tele-monitoring or engaged in other care coordination activities.
Types of patients included?	Site-defined subsets of Medicare FFS beneficiaries with one or more chronic conditions that represent high costs to the Medicare program, live in the site’s catchment area, and were covered by Medicare Parts A and B FFS coverage are included. Enrolled beneficiaries ended up mainly suffering from congestive heart failure, coronary artery disease, chronic pulmonary disease, and/or diabetes. They also tended to be substantially more highly educated, with higher incomes, and more likely to be white than Medicare beneficiaries overall.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Medicare Coordinated Care Demonstration	
Method of attributing patients to participating providers	Participating sites recruited Medicare FFS beneficiaries interested in participating in the initiative. CMS's hired contractor, Mathematica Policy Research, then randomly assigned eligible beneficiaries at each site to either a treatment group (which received the site's intervention) or a control group (which did not).
Types of providers participating in the payment model?	To be eligible for this demonstration, organizations had to have experience operating a disease management or case management program that had been shown to reduce hospitalizations or costs in some population or setting. Competitively-selected organizations ultimately included commercial disease management vendors, hospitals, academic medical centers, an integrated delivery system, a hospice, a long-term care facility, and a retirement community. Most participating organizations used care coordinators who were registered nurses to deliver care coordination services to patients.
The entity accountable to the payer?	Participating organizations (i.e., commercial disease management vendors, hospitals, academic medical centers, an integrated delivery system, a hospice, a long-term care facility, and a retirement community).
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	Participating organizations receive a monthly all-inclusive rate for proposed coordinated care services, negotiated with CMS on a site-by-site basis. Payments ranged from \$50-\$437 per month. The one site that briefly generated favorable results was paid \$281 per month for high-risk beneficiaries. Participating organizations may bill Medicare for this payment for each month that a beneficiary is enrolled in and receiving coordinated care services. Payments were considered administrative fees and not subject to beneficiary co-insurance or deductible liability.
Are there any performance metrics? If so, what is being measured?	No performance measures incorporated into the payment model.
Are there any performance incentives? If so, what is being incentivized?	Participating organizations were primarily incentivized to deliver coordinated care services at a cost that was lower than the capitated care coordination monthly payment amount they negotiated with CMS, to generate profit for themselves. They were also incentivized to lower total Medicare expenditures for enrolled beneficiaries or improve the quality of their care without raising costs, since such criteria would allow CMS to extend or expand their demonstration (under special authority granted to CMS as part of the Balanced Budget Act section that authorized this demonstration).
How do incentives operate?	See previous row.
Is this a stand-alone payment model or is it used with other payment models?	This payment model is used with fee-for-service Medicare. Beneficiaries continue to obtain Medicare-covered services from fee-for-service providers.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Medicare Coordinated Care Demonstration	
<p>Has the model been evaluated? Who funded this evaluation?</p>	<p>CMS hired Mathematica Policy Research to evaluate this model in 2002, and publicly available information suggests several re-awards were granted through 2015.</p> <p>The Demonstration progressed in two phases. The first phase of the program spanned 2002-2010. The second phase ran from October 2010-2014, when CMS extended the Demonstration for one program, HQPs. The Demonstration ended in 2014 and a final evaluation report focusing solely on the HQP was prepared in October 2015. Evaluation reports were scheduled to be released bi-annually.</p> <p>The evaluation’s 3 key research questions addressed in the most current version of the evaluation explore: the impact of HQP’s intervention on high-risk Medicare beneficiaries (in terms of mortality, health care utilization, and expenditures) during a 2010-2014 extension; new interventions provided after the 2010-2014 extension; explanations for observed differences in impacts before and after the extension (focusing on impacts on patients, and changes and disruptions in interventions).</p> <p>Official findings from this evaluation are available in the following publications: <i>Evaluation of the Medicare Coordinated Care Demonstration: Final Report for the Health Quality Partners’ Program</i>, October 2015, https://innovation.cms.gov/Files/reports/mccd-hqp-finaleval.pdf; <i>Fifth Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration: Findings over 10 Years</i>, 2014 https://innovation.cms.gov/Files/reports/MedicareCoordinatedCareDemoRTC.pdf; <i>Evaluation of the Medicare Coordinated Care Demonstration: Interim Impact Estimates for the Health Quality Partners’ Program</i>, November 2014, https://innovation.cms.gov/Files/reports/MedicareCoordinatedCareDemoHQP.pdf; <i>The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years</i>, March 2007, https://innovation.cms.gov/Files/x/Evaluation-of-Medicare-Coordinated-Care.pdf; <i>Second Report to Congress on the Evaluation of the Medicare Coordinated Care Demonstration</i>, December 2006, available upon request; <i>Coordinating Care for Medicare Beneficiaries: Early Experiences of 15 Demonstration Programs, Their Patients, and Providers</i>, May 2004, https://innovation.cms.gov/Files/reports/Best-Prac-Congressional-Report.pdf.</p>
<p>Other pertinent information</p>	<p>This rigorous demonstration randomly assigned interested beneficiaries into treatment and control groups, to allow <i>causal</i> impacts to be determined. (Most demonstrations do not use this approach and can therefore only identify <i>correlations</i> between interventions and impacts.) The one site with briefly favorable results later failed to repeat those favorable results when its extension-period control group experienced a lower rate of hospitalizations than its earlier control group.</p>

The above information was excerpted or summarized from these sources:

CMS. “Medicare Coordinated Care Demonstration.” Available at: <https://innovation.cms.gov/initiatives/Medicare-Coordinated-Care>; and other CMS documents linked from this webpage; Randall S. Brown, Deborah Peikes, Greg Peterson, et al. “Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients.” *Health Affairs*, 2012;31(6):1156-1166.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.8 Medicare’s Independence at Home Demonstration

Model Name: Independence at Home Demonstration	
Brief Description: Under this model, primary care practices that deliver home-based primary care and care coordination to Medicare fee-for-service beneficiaries with multiple chronic conditions and functional impairments are eligible to receive shared savings payments if they generate a sufficient amount of savings for the Medicare program while meeting quality requirements. The 16 participating organizations are located in cities across the US and are independent practices or consortia of practices.	
Developer: Congress authorized this demonstration in a dedicated section of the Affordable Care Act (Sec. 3024); it is being implemented by the CMS Innovation Center.	
What is the goal of this payment model?	The goal of this payment model is to support a specific change in care delivery: house-calls by primary care practice staff to Medicare beneficiaries with multiple chronic conditions and functional impairments. Additional aims of this demonstration are to: improve overall quality of care, quality of life, health outcomes, and care satisfaction for these patients; lower health care costs for Medicare by forestalling the need for care in institutional settings such as hospitals; and provide comprehensive, continuous, accessible care to high-need patients and to coordinate care across all treatment settings.
How long has this payment model been in operation? Where has it been implemented?	This demonstration will run from June 2012 to September 2017 (5 years). The 16 participating sites (e.g., independent practices, or consortia of practices) are located in cities in DC, DE, FL, MA, MI, NC, NY, OH, OR, PA, TX, VA, and WI.
Type(s) of health care services, medical conditions, and health care settings addressed?	Participating practices are expected to provide a complete range of primary care services delivered in the home setting. They must also: be available 24/7 to carry out care plans; use EHRs, remote monitoring, and mobile diagnostic technology; and coordinate care with other health and social service professionals.
Types of patients included?	Practices can enroll Medicare fee-for-service beneficiaries who: are not long-term residents of nursing facilities; are not enrolled in a PACE (Program of All-inclusive Care for the Elderly) program; have at least 2 chronic conditions and at least 2 functional impairments that require assistance from another person; had a non-elective hospital admission and received acute or sub-acute rehabilitation services in the year prior to their enrollment; and are not enrolled in a practice participating in a Medicare shared savings initiative.
Method of attributing patients to participating providers	Participating practices must inform eligible beneficiaries that their practice is participating in this demonstration, and that the patient will automatically be enrolled in the demonstration if they agree to continue to participate in home visits by the practice. Practices submit a list of enrolled beneficiaries to CMS, which in turn analyzes claims data to verify: that Medicare home visits are being conducted by these practices to these beneficiaries; and that these beneficiaries meet demonstration eligibility criteria.
Types of providers participating in the payment model?	Eligible practices must be led by physicians or nurse practitioners and: be organized for the purpose of providing physician services; have experience providing home-based primary care to patients with multiple chronic conditions; serve at least 200 eligible beneficiaries; and not be participating in a Medicare shared savings initiative. (Home health agencies do not qualify unless they provide in-home medical care as a primary medical care provider.)

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Independence at Home Demonstration	
The entity accountable to the payer?	Participating practices, a consortia of practices (treated as one practice, for purposes of calculating savings under this demonstration), or a national pool of practices (again, treated as one practice for purposes of this demonstration – though no practices signed up for this option) are accountable to CMS.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>Practices that succeed in generating a sufficient level of savings for the Medicare program while meeting quality measure performance targets are eligible to receive an annual incentive payment.</p> <p>Savings are calculated relative to a practice’s target expenditure, which represents the expected Medicare spending that would have been generated in the absence of the demonstration. Practice-specific target expenditures are equal to average Medicare Parts A and B expenditures in a base period, trended forward (using the expected average increase in per beneficiary per month Medicare Parts A and B expenditures) and risk adjusted and frailty adjusted.</p> <p>Each practice must meet a minimum savings rate (MSR) relative to this target expenditure to be eligible to share in savings. MSRs range from 2.2%-14.1%, depending on the number of beneficiaries in a practice’s panel. If a practice’s actual expenditures are lower than their target expenditure by at least their applicable MSR, and if the practice meets quality requirements, they are eligible to receive 25%-80% of the savings beyond the first 5 percentage points of savings generated, depending on the amount of savings generated and the number of quality measure targets they met.</p>
Are there any performance metrics? If so, what is being measured?	Primary care practices are assessed based on their ability to reduce Medicare spending and meet performance targets on 6 quality measures. The six quality measures assess whether beneficiaries have higher-than-average rates of <i>inpatient admissions</i> and <i>ED visits</i> for ambulatory-sensitive conditions and <i>hospital readmissions</i> , and whether a high proportion are <i>contacted within 48 hours of a hospital admission and discharge</i> , have their <i>medications reconciled at home</i> , and have <i>patient preferences documented</i> in their medical record.
Are there any performance incentives? If so, what is being incentivized?	Primary care practices are incentivized to reduce total Medicare spending by participating Medicare beneficiaries, and to perform highly on the 6 quality measures mentioned in the previous row.
How do incentives operate?	Practices that succeed in generating a sufficient level of savings for the Medicare program while meeting quality measure performance targets are eligible to receive an annual incentive payment. The size of incentive payments depends on the amount of savings achieved and the number of quality measures for which performance targets are met; practices must meet performance targets on at least 3 of 6 measures to receive incentive payments. Practices that do not meet quality standards during any year of the demonstration or fail to achieve savings two years in a row will be terminated from the demonstration.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Independence at Home Demonstration	
Is this a stand-alone payment model or is it used with other payment models?	This payment model is used with traditional fee-for-service Medicare. Participating providers continue to bill fee-for-service Medicare using existing Medicare Part B Evaluation & Management codes or FQHC/RHC revenue codes. At the end of a year, Medicare compares actual expenditures to a practice’s target expenditure, and determines if a practice has generated a sufficient level of savings for the Medicare program to receive an incentive payment.
Has the model been evaluated? Who funded this evaluation?	ASPE hired Mathematica Policy Research to evaluate this demonstration in 2012, and their evaluation will run through 2017. Evaluation reports are scheduled to be released quarterly and annually. The evaluation’s 3 key research questions will address: the effect of the demonstration on care processes; the effect of the demonstration on outcomes (including patient health status, utilization, costs incurred and savings earned, and patient and caregivers’ experiences with the program); and features of the demonstration interventions that are most important predictors of positive outcomes.
Other pertinent information	<p>-Practices are required to notify beneficiaries that they are participating in the demonstration. Beneficiary participation in the demonstration is automatic when they agree to be seen in their homes, but beneficiaries can opt out of this program, and they retain freedom to see any provider and obtain any covered service.</p> <p>-Practices must report their patients’ chronic conditions and functional impairments on a monthly basis, and their patients’ inpatient utilization on a quarterly basis.</p> <p>-CMS’s design and implementation contractor is providing technical assistance on how to report data to CMS, and on a learning collaborative to help practices meet quality requirements.</p> <p>-CMS monitors performance using 8 quality measures (which assess utilization of recommended care coordination services and outcomes such as patient symptom management and caregiver stress).</p>

The above information was excerpted or summarized from these sources:

CMS. “Independence at Home Demonstration.” Available at: <https://innovation.cms.gov/initiatives/independence-at-home/>; and other CMS documents linked from this webpage.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.9 Medicare’s Oncology Care Model

Model Name: Oncology Care Model	
Brief Description: Participating oncology practices will receive care management fees of \$160 per Medicare fee-for-service beneficiary per month during a 6-month period starting when chemotherapy is first administered. If they can lower the total cost of their patients’ care while meeting quality requirements during this 6-month period, practices can also receive a performance-based payment equal to 100% of savings generated relative to a spending target. CMS is soliciting participation from other payers, who will have the flexibility to design their own payment models.	
Developer: CMS Innovation Center	
What is the goal of this payment model?	The goal of this payment model is to: transform care delivery for patients undergoing chemotherapy; improve the quality of cancer care; reduce spending for cancer treatment; improve health outcomes for patients with cancer; improve care coordination; improve appropriateness of care; and improve access for beneficiaries undergoing chemotherapy.
How long has this payment model been in operation? Where has it been implemented?	The model is expected to begin in Spring 2016 and run for 5 years. Oncology practices have not yet been selected.
Type(s) of health care services, medical conditions, and health care settings addressed?	Participating practices are paid monthly fees for care management and coordination services provided to chemotherapy patients in the 6 months following an initial administration of chemotherapy (initiated by an initial chemotherapy administration claim or a Part D chemotherapy claim). Practices also have the opportunity to earn a performance-based payment if they reduce total Medicare Parts A and B (and certain Part D) spending for these chemotherapy patients during this 6-month period. Examples of services other than chemotherapy that are included in these 6-month episodes include: inpatient costs; post-acute care services; drugs; labs; imaging; surgery; radiation therapy; and clinical trials.
Types of patients included?	Medicare fee-for-service beneficiaries receiving chemotherapy for “nearly all” cancer types from participating oncology practices, who do not have end-stage renal disease, whose primary insurer is Medicare, and are not covered under United Mine Workers are included.
Method of attributing patients to participating providers	Patients who are administered chemotherapy by a participating practice are attributed to that practice for the next 6 months. Beneficiaries who receive chemotherapy after the end of this 6-month period from a participating practice will trigger a new 6-month round of monthly care management fees and eligibility for shared savings for the practice.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Oncology Care Model	
Types of providers participating in the payment model?	<p>Physician group practices, multi-specialty practices, and solo practitioners that prescribe cancer chemotherapies and are currently enrolled in Medicare may apply to participate in this model. In addition, hospital-owned practices (including on- and off-campus, provider-based departments) may apply to participate if the hospital is paid by Medicare under the inpatient and outpatient Prospective Payment Systems (PPS), but preference will be given to non-hospital based entities.</p> <p>Practices must meet following six requirements:</p> <ol style="list-style-type: none"> 1) Provide and attest to 24 hours a day, 7 days a week patient access to an appropriate clinician who has real-time access to the practice’s medical records. 2) Attestation and use of ONC-certified EHRs. 3) Utilize data for continuous quality improvement. 4) Provide core functions of patient navigation through patient navigators that can perform the 10 basic National Cancer Institute patient navigation activities to help coordinate care. 5) Document a care plan that contains the 13 components in the Institute of Medicine’s <i>Delivering High-Quality Cancer Care</i> report. 6) Treat patients with therapies consistent with nationally-recognized clinical guidelines from the American Society of Clinical Oncology or the National Comprehensive Cancer Network.
The entity accountable to the payer?	Participating practices are accountable to CMS and any other payers that ultimately join the initiative.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>During the 6-month chemotherapy episode, participating practices bill Medicare for monthly \$160 care management payments per beneficiary using a new fee-for-service G-code created for this model. They also continue to bill fee-for-service Medicare for all other services delivered to beneficiaries.</p> <p>At the end of the 6 months, practices are eligible to receive a performance-based payment if they have reduced total Medicare expenditures below a spending target while meeting quality requirements. Spending targets will be calculated by first establishing a spending benchmark based on historical Medicare expenditure data (which could include both practice expenditures and regional or national expenditures), which would then be risk adjusted, adjusted for geographic variation, and trended forward to the applicable performance period using the growth rate in national expenditures. A 4% discount will likely then be applied to the benchmark to determine a spending target (e.g., Benchmark = \$100; Discount = -4%; Target Price = \$96). Then, if actual Medicare expenditures during the 6-month period are below the target price, the practice could receive a performance-based payment (e.g., Actual = \$90; Performance-based payment = up to \$6). The receipt and amount of the performance-based payment will be discounted based on the participant’s achievement and improvement on a set of quality measures.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Oncology Care Model	
	All participants in Years 1 and 2 will be subject to one-sided risk, meaning they will not owe Medicare money if their patients' expenditures during the 6-month episode exceed their spending target. In Year 3, participants can elect to face two-sided risk, meaning they will owe Medicare a penalty payment if their patients' Medicare expenditures exceed their spending target; in exchange for taking on downside risk, participating practices will have an easier time earning shared savings – they will be eligible for shared savings if their patients' expenditures are 2.75% below their spending benchmark (instead of 4%).
Are there any performance metrics? If so, what is being measured?	Performance measures will be used to determine receipt and amount of performance-based payments. A preliminary list of the measures that will be used for this purpose include: utilization measures (both during the 6-month episode and in the 6 months after); clinical quality measures; patient experience survey measures; and outcomes (including risk-adjusted mortality rates).
Are there any performance incentives? If so, what is being incentivized?	Practices will have an incentive to deliver care management and care coordination services to their fee-for-service Medicare beneficiaries, now that they can obtain payment for such services. They will also have an incentive to keep patients out of hospice, since monthly care management fees are discontinued when a beneficiary enters hospice. Participating practices will have an incentive to lower patients' total Medicare expenditures, in order to qualify for performance-based payments. Practices will also have an incentive to perform highly on quality measures in order to qualify for and maximize the size of such payments.
How do incentives operate?	See "How are providers paid under the payment model?" above. Performance-based payments will be adjusted based on the participating practice's performance on a range of quality measures. Practice performance will be measured based on achievement and improvement relative to other participants or national benchmarks on quality measures, which will be transformed into weighted scores and summed to calculate a performance multiplier. A practice must exceed a minimum quality threshold for the practice to be eligible to receive a performance-based payment.
Is this a stand-alone payment model or is it used with other payment models?	This payment model is used with fee-for-service payment systems. During 6-month chemotherapy episodes, participating practices continue to bill Medicare for fee-for-service payments. Monthly care management payments and any shared savings payments are paid in addition to fee-for-service payments.
Has the model been evaluated? Who funded this evaluation?	CMS hired Abt Associates to evaluate this model in January 2016; their evaluation will run at least through 2021, and possibly through 2023. Evaluation findings reports are scheduled to be released quarterly and annually. The evaluation's 22 research questions will assess: implementation effectiveness (measured by participants' patient case mix, services delivered, practice characteristics, and approach to care delivery); program effectiveness (measured by care quality, patient health outcomes, utilization, costs); and stakeholder engagement and scalability (measured by provider/staff satisfaction, impact of various factors on participants' success, market share changes, unintended consequences, scalability).

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Oncology Care Model	
Other pertinent information	<p>-Participating practices can also participate in other Medicare shared savings initiatives, but CMS will adjust shared savings payments to ensure performance-based payments are not paid twice for the same savings for the same beneficiary. Participating practices cannot participate in the Transforming Clinical Practice Initiative.</p> <p>-Beneficiaries who receive chemotherapy after the end of the 6-month episode will begin a new 6-month episode.</p> <p>-If a beneficiary enters hospice, monthly care management fees to the practice will be discontinued.</p>

The above information was excerpted or summarized from these sources:

CMS. "Oncology Care Model." Available at: <https://innovation.cms.gov/initiatives/oncology-care/>; and other CMS documents linked from this webpage.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

This section includes profiles for 36 sample payment models.

1.10 21st Century Oncology’s Radiation Oncology Bundled Payments

Model Name: 21st Century Oncology’s Radiation Oncology Bundled Payments	
Brief Description: Since 2012, 21st Century Oncology (the largest radiation therapy provider in the US) has been receiving a prospective bundled episode payment from Humana for professional and technical services delivered in its facilities for external beam radiation therapy services for 13 common cancer diagnoses. Episodes begin at consultation and end 90 days after treatment, do not cover indirect treatment expenses such as medications, laboratory tests, and diagnostic imaging, and are not risk adjusted. No quality measures are used to calculate eligibility for, or size of, payments, but 21 st Century Oncology submits data to Humana on technology and service utilization..	
Developer: 21st Century Oncology	
What is the goal of this payment model?	The goal of 21 st Century Oncology’s bundled payment program is to improve patient satisfaction, reduce care costs (both medical and administrative), and preserve their high rate of compliance to the best clinical practice standards.
How long has this payment model been in operation? Where has it been implemented?	21 st Century Oncology entered into this agreement with Humana in August 2012. 21 st Century operates 180 facilities (50 of which are hospital-based) in 17 U.S. states.
Type(s) of health care services, medical conditions, and health care settings addressed?	Bundled payments are available for external beam radiation therapy services for 13 common cancer diagnoses. The bundled payments cover professional and technical services delivered in 21 st Century’s facilities during an episode that begins at consultation and ends 90 days after treatment. Bundled payments do not cover indirect treatment expenses such as medications, laboratory tests, and diagnostic imaging.
Types of patients included?	Patients with one of 13 common cancer diagnoses who are insured by Humana (through a commercial or Medicare Advantage plan) and consult with a 21 st Century Oncology radiation oncologist.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	<i>Information is not currently publicly available.</i>
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: 21st Century Oncology’s Radiation Oncology Bundled Payments	
How are providers paid under the payment model?	<p>Payment is triggered when a radiation oncologist submits a claim for a consultation that includes an ICD-10 diagnosis code covered under the agreement. The claim is processed in full immediately -- i.e., it is a prospective or up-front bundled payment. There are no provisions for outlier payments or risk adjustment.</p> <p>If a patient does not complete their treatment, pro-rated refunds are made to Humana.</p> <p>If a patient requires treatment for a diagnosis previously treated and reimbursed within the prior 90 days, then Humana does not make another payment to the provider. That being said, separate bundled payments are available for multiple episodes (for different diagnoses).</p> <p>21st Century is no longer required to obtain prior authorization from Humana before providing services; instead, they now only “pre-notify” Humana.</p> <p>To determine the price of each cancer-specific bundled episode payment, 21st Century aggregated their fee schedule payments for all clinically appropriate radiation therapy services for each treatment option available for that diagnosis and then weight-averaged the data according to the observed distribution of each such treatment – meaning the bundled payment price for a particular diagnosis does not vary depending on which treatment option is selected, but is instead set at a price that essentially represents 21st Century’s average historical costs for treating that diagnosis. Service unit counts for each treatment option were compared with consensus group guidelines and other relevant data to validate clinical appropriateness.</p>
Are there any performance metrics? If so, what is being measured?	No quality measures are used to calculate eligibility for, or size of, payments, but 21 st Century Oncology submits data to Humana on technology and service utilization.
Are there any performance incentives? If so, what is being incentivized?	21 st Century Oncology has an incentive to deliver the least possible amount of technical and professional services (since they are paid out of the bundled payment), and no incentive to try to limit the amount of medications, laboratory tests, and diagnostic imaging (since these services are not included in the bundled payment). That being said, 21 st Century Oncology also has an incentive to treat patients’ cancers effectively enough that they do not require additional services within the 90 day period following treatment.
How do incentives operate?	See above.
Is this a stand-alone payment model or is it used with other payment models?	This is a stand-alone payment model used in lieu of fee-for-service payments for radiation oncology professional and technical services. However, fee-for-service payments are still used for indirect treatment expenses such as medications, laboratory tests, and diagnostic imaging, and the prices of bundles were determined by analyzing prior fee-for-service claims.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: 21st Century Oncology’s Radiation Oncology Bundled Payments	
Has the model been evaluated? Who funded this evaluation?	No formal evaluations are available but an editorial in a peer-reviewed journal, co-authored by the organization’s CMO, highlighted briefly the initial findings from the first 12-month contract between 21 st Century Oncology and Humana: “21st Century Oncology observed a few positive outcomes. Resource utilization and physician prescribing habits for the Humana population remained greater than 98% compliant to the recommended types and number of services modeled in each diagnosis group. Clinically appropriate hypofractionation increased, particularly for breast cancer, and 21st Century Oncology modeled substantial savings associated with reduced administrative burden. Finally, Press Ganey patient satisfaction surveys administered to Humana patients before and after implementation of the bundle revealed a consistently high level of overall satisfaction, with a statistically significant increase in perceived ease of insurance approval.”
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Falit, BP, Chernew, ME and Mantz, CA, “Design and implementation of bundled payment systems for cancer care and radiation therapy”, Int J Radiat Oncol Biol Phys. 2014 Aug 1;89(5):950-3 available at: [http://www.redjournal.org/article/S0360-3016\(14\)00494-5/abstract](http://www.redjournal.org/article/S0360-3016(14)00494-5/abstract) ; Mantz C. Presentation: “Bundled Payments In Radiation Oncology: Case Studies In Innovative Specialist Value-Based Payment Initiatives: Specialty Payment Reforms That Reduce The Costs Of Procedures,” available at: http://www.p4psummitportal.com/assets/494/resources/mantz_ms17.pdf; and Minich-Pourshadi K, “Dive into Bundled Payments or Wait?”, HealthLeaders Media, October 15, 2012, available at: <http://www.healthleadersmedia.com/finance/dive-bundled-payments-or-wait>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.11 Aetna PCMH Programs

Model Name: Aetna PCMH Programs	
Brief Description: Aetna is offering supplemental payments to primary care practices that become recognized as patient-centered medical homes (PCMHs) by the National Committee for Quality Assurance (NCQA) through two programs: (1) Aetna’s “PCMH Recognition Program,” in which a quarterly prospective care coordination fee of \$2-\$3 per member per month (PMPM) is provided to physicians in addition to traditional fee-for-service (FFS) payments; and (2) a “PCMH Savings Sharing Program,” through which larger PCMH practices can qualify to receive annual bonuses worth up to 50% of the savings they generate for Aetna if they meet performance targets on 7 efficiency measures and 17 clinical measures. In this second program, the value of any PMPM care coordination fees already paid are deducted from shared savings bonuses that practices receive (e.g., if the practice earns a \$300,000 bonus, but was already paid \$100,000 in PMPM care coordination fees, the size of their shared savings bonus will be \$200,000).	
Developer: Aetna	
What is the goal of this payment model?	The goal of these PCMH programs is to improve the quality and cost of care that Aetna’s members receive, and to help reduce the risks of poor care coordination and improve patient quality-of-care – both of which should reduce overall medical costs over time.
How long has this payment model been in operation? Where has it been implemented?	This program was launched in Connecticut and New Jersey in January 2012, in 29 practices in North Carolina in July 2012, in Oregon in April 2013, in New York in May 2013, and in Massachusetts in July 2013.
Type(s) of health care services, medical conditions, and health care settings addressed?	Care management fees are expected to cover the cost of improved care management, increased patient engagement, data sharing, and clinical integration by primary care practices. Aetna’s PCMH programs include: <ul style="list-style-type: none"> - the use of health information technology, including electronic medical records - comprehensive disease management program - improved patient access to health services through the hiring of physician extenders, such as nurse practitioners and physician assistants - improved care coordination through case management and patient health education classes
Types of patients included?	Non-Medicare Aetna members receiving care from primary care physicians participating in Aetna’s PCMH programs.
Method of attributing patients to participating providers	For the “PCMH Savings Sharing Program”: Patients are attributed to: 1) the primary care physician (PCP) the patient saw the most frequently during a 12 month period; or, 2) if there were several single visits to multiple PCP practices, the PCP that the patient most recently visited.
Types of providers participating in the payment model?	Primary care physicians who participate in Aetna’s networks, who have been recognized by NCQA as a PCMH, and who are not participating in other quality incentive programs with Aetna are considered for the Aetna’s PCMH programs.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Aetna PCMH Programs	
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	<p>In the “PCMH Recognition Program,” recognized physicians receive a prospective payment of \$2-\$3 per member per month on a quarterly basis for each non-Medicare Aetna member in their care.</p> <p>In the “PCMH Savings Sharing Program,” at the end of an annual period, the physician group is eligible to receive up to 50% of the savings they helped generate, after deducting the value of any \$2-\$3 per member per month payments already paid to the practice (e.g., if the practice earns a \$300,000 bonus, but was already paid \$100,000 in PMPM care coordination fees, the size of their shared savings bonus will be \$200,000).</p>
Are there any performance metrics? If so, what is being measured?	Under the “PCMH Savings Sharing Program,” physician groups must meet performance targets on 7 efficiency measures (including efficiency in inpatient services, outpatient services, prescription services, and behavioral health – and specifically: reduction of non-emergent ER visits and inpatient hospital stays) and 17 clinical measures (including “quality reporting, particularly in Diabetes, Cardiovascular and Preventive Screening”).
Are there any performance incentives? If so, what is being incentivized?	Physician groups have an incentive to meet performance targets on measures in order to qualify for shared savings bonus payments.
How do incentives operate?	Savings calculations are based upon the evaluation of the 7 efficiency and 17 clinical measures identified above.
Is this a stand-alone payment model or is it used with other payment models?	This payment is layered on top of traditional FFS payments.
Has the model been evaluated? Who funded this evaluation?	No formal evaluations are available, but Aetna’s website has press releases of internal analyses of the implementation of the program at different sites.
Other pertinent information	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

The above information was excerpted or summarized from these sources:

The Patient-Centered Primary Care Collaborative's profile of Aetna Patient-Centered Medical Home Program: available at: <https://www.pcpcc.org/initiative/aetna-patient-centered-medical-home-program> and Aetna, "Payers and Physicians Combining Resources to Create Innovative Approaches to Care" –Information on Aetna's PCMH program, November, 2012, available at: <http://www.aetna.com/consultant/newsletter/2012/november/pcmh-special-edition.html>; Aetna, "Aetna launches patient-centered medical home program in Massachusetts," July 15, 2013, available at: <https://news.aetna.com/news-releases/aetna-launches-patient-centered-medical-home-program-in-massachusetts/>; Aetna, "Cornerstone Health Care will participate in Aetna's patient-centered medical home program," July 11, 2012, available at: <https://news.aetna.com/news-releases/cornerstone-health-care-will-participate-in-aetnas-patient-centered-medical-home-program/>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.12 AmeriHealth Caritas’s “PerformPlus” Suite of Payment Incentive Programs

Model Name: AmeriHealth Caritas’s “PerformPlus” Suite of Payment Incentive Programs	
Brief Description: Since 2010, AmeriHealth Caritas, a Medicaid managed care organization operating in 19 states, has been offering pay-for-performance bonuses to participating primary care and specialist physicians, hospitals and integrated delivery systems, and Federally-Qualified Health Centers. In some markets, AmeriHealth also offers one-sided shared savings bonus programs to integrated delivery systems. Very few additional details on these payment models appear to be publicly available.	
Developer: AmeriHealth Caritas	
What is the goal of this payment model?	PerformPlus payment models are designed to reward providers for timely, appropriate care and positive patient outcomes. AmeriHealth believes that primary care excellence and data sharing can reduce unnecessary emergency room treatment, unnecessary inpatient admissions and clinically inappropriate readmissions while improving outcomes and achieving financial savings. In the PerformPlus Shared Savings program, specifically, the needs of patients are intended to be effectively addressed across multiple care settings, with the aim of reducing fragmentation and duplicative services, and ultimately improving clinical outcomes.
How long has this payment model been in operation? Where has it been implemented?	This set of payment models has been offered to providers since 2010. As of May 2016, about 40% of AmeriHealth’s members were “touched in some way” by one of these payment models, and the insurer planned to reach 50% of their members by the end of 2016.
Type(s) of health care services, medical conditions, and health care settings addressed?	<i>Information is not currently publicly available.</i>
Types of patients included?	The focus appears to be Medicaid enrollees in AmeriHealth Caritas health plans, but the company also operates some Medicare Advantage plans.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	PerformPlus payment models are available to physicians (including primary care providers and specialists), hospitals and integrated delivery systems, and federally-qualified health centers.
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: AmeriHealth Caritas’s “PerformPlus” Suite of Payment Incentive Programs	
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	<p>AmeriHealth offers pay-for-performance bonuses to participating primary care and specialist physicians, hospitals and integrated delivery systems, and Federally-Qualified Health Centers. In some markets, AmeriHealth also offers one-sided shared savings bonus programs to integrated delivery systems.</p> <p>Payment models for primary care physicians include “semi-annual capitation adjustments, upside only, based upon peer-based percentile performance guardrails built upon quality and total cost of care results.”</p> <p>Shared savings payment models for integrated delivery systems include “trend and peer based measurement based upon quality scorecard and efficiency measures such as preventable admissions, readmissions and emergency room usage.”</p> <p>The approach used for assessing costs is “baselined to historical benchmarks and risk adjusted peer targets.”</p> <p>AmeriHealth uses “annual settlement parameters with interim payment stream.”</p>
Are there any performance metrics? If so, what is being measured?	<p>The quality measures that provide the foundation for each PerformPlus payment model are designed to incentivize necessary and preventive care and discourage preventable resource utilization.</p> <p>AmeriHealth’s one-sided shared savings programs for integrated delivery systems involve trend- and peer-based measurement based on AmeriHealth’s quality scorecard and efficiency measures such as preventable admissions, readmissions and emergency room usage. The shared savings bonus pool is “based on a percentage of total volume of claims payment and allocated across six potential domains”:</p> <ul style="list-style-type: none"> • Potentially preventable admissions • Potentially preventable emergency room visits • Potentially preventable readmissions • Neonatal intensive care metrics • Obstetric (OB) and primary care quality measures • Appropriate care measures <p>Providers participating in the PerformPlus model can access a secure, web-based dashboard to track their progress for each metric, and produce self-service reports with drill-down data mining capabilities. The dashboard also allows the identification of frequent emergency department utilizers, readmissions, HEDIS results, care gaps, clinical risk, and other member centric data to foster collaboration and meaningful member outreach. Data reports are updated monthly. Dashboards have been deployed to approximately 300 PCP groups, including FQHC and large IDS partnerships.</p>
Are there any performance incentives? If so, what is being incentivized?	<i>Information is not currently publicly available.</i>
How do incentives operate?	AmeriHealth’s pay-for-performance programs employ “quality gates.”

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: AmeriHealth Caritas’s “PerformPlus” Suite of Payment Incentive Programs	
Is this a stand-alone payment model or is it used with other payment models?	The PerformPlus payment models are layered on top of fee-for-service payments.
Has the model been evaluated? Who funded this evaluation?	No formal evaluations are available.
Other pertinent information	Headquartered in Philadelphia and operating in 18 states and the District of Columbia, AmeriHealth Caritas serves more than 5.9 million Medicaid, Medicare, and CHIP members through its integrated managed care products, pharmaceutical benefit management, specialty pharmacy services, behavioral health services, and other administrative services.

The above information was excerpted or summarized from these sources:

AmeriHealth Caritas, Our Company, available at: <http://www.amerhealthcaritas.com/corporate/>; Health Care Payment Learning and Action Network, Developing APMs to Better Serve Populations Most in Need,- May 31, 2016, available at: <https://hcp-lan.org/2016/05/developing-apms-to-better-serve-populations-most-in-need/#1458050697199-8a1c375d-9abe>; Health Care Payment Learning and Action Network, Addendum to the Alternative Payment Model (APM) Framework White Paper, January 12, 2016, available at: <https://hcp-lan.org/workproducts/apm-whitepaper-addendum.pdf>; AmeriHealth Caritas, AmeriHealth Caritas: Leading the Way in Payment Transformation, available at: <http://becomeaprovider.amerhealthcaritas.com/pdf/georgia/payment-acga.pdf>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.13 Anthem Cancer Care

Model Name: Anthem’s Cancer Care Quality Program	
Brief Description: Anthem providers participating in various states’ Anthem plans are eligible to submit a claim to receive a monthly payment of \$350 per eligible patient for treatment planning and care coordination when they prescribe cancer treatments that adhere to Anthem’s Cancer Treatment Pathways (clinical guidelines) or the patient enrolls in a nationally recognized precision medicine genomic clinical trial.	
Developer: AIM Specialty Health (a specialty benefits management company); Anthem, Inc.	
What is the goal of this payment model?	Anthem’s \$350 monthly fees are meant to offset lower provider revenues that may result from choosing a less costly cancer treatment regimen.
How long has this payment model been in operation? Where has it been implemented?	<p>This program has been in operation since July 1, 2014. As of June 2015, providers could use this payment model for approximately 14 million eligible Anthem members insured by various states’ Anthem plans.</p> <p>As of June 2015, 5,345 unique patients had received cancer treatment that made their provider eligible for the \$350 monthly payments.</p> <p>As of March, 2016, Anthem expanded this program to provide \$350 monthly payments when individuals with advanced cancer enroll in key nationally recognized precision medicine genomic clinical trials.</p>
Type(s) of health care services, medical conditions, and health care settings addressed?	The \$350 monthly payment covers managing treatment planning and care coordination management when a cancer treatment regimen is prescribed that adheres to one of Anthem’s Cancer Treatment Pathways (clinical guidelines). These guidelines have been developed for several types of cancer, including breast, colon, lung, lymphoma, ovarian, myeloma, rectal, pancreatic, lymphoma, prostate, leukemia, melanoma and brain cancer. The \$350 monthly payment is also available when patients who have failed standard treatments for their cancer enroll in nationally recognized clinical trials testing novel therapies.
Types of patients included?	Patient insured by various participating states’ Anthem plans.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Participating ordering providers who are in-network for the Anthem member’s benefit plan.
The entity accountable to the payer?	Same as above.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Practice staff initiate a request to AIM Specialty Health (through the AIM Provider Portal or the AIM Call Center) when a cancer treatment regimen is prescribed for an eligible Anthem patient. They provide clinical information such as tumor type and stage, histology, key biomarkers and line of therapy. AIM compares the planned cancer treatment regimen against the Cancer Treatment Pathways clinical guidelines. AIM then informs the provider of other recommended treatment options, if the treatment course is not recommended.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Anthem’s Cancer Care Quality Program	
	<p>If a recommended treatment course is ultimately chosen, the practice is eligible to submit S-code claims to Anthem to receive the following supplemental payments:</p> <ol style="list-style-type: none"> 1) S0353 – \$350 paid once, at the onset of treatment planning and care coordination management. 2) S0354 – \$350 paid monthly while managing treatment planning and care coordination management for an established cancer patient. <p>In March 2016, Anthem began offering these supplemental payments when eligible individuals with advanced cancer enroll in key nationally recognized precision medicine genomic clinical trials.</p>
Are there any performance metrics? If so, what is being measured?	<i>Information is not currently publicly available.</i>
Are there any performance incentives? If so, what is being incentivized?	Providers have an incentive to prescribe a cancer treatment regimen endorsed in one of Anthem’s Cancer Treatment Pathways clinical guidelines.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This is a supplemental fee paid in addition to usual fee-for-service payments.
Has the model been evaluated? Who funded this evaluation?	<i>Information is not currently publicly available.</i>
Other pertinent information	<p>Anthem’s Cancer Treatment Pathways (clinical guidelines) are developed using evidence-based medicine and updated quarterly to reflect new treatment options. Pathways are selected from therapies recommended by national guidelines based on:</p> <ul style="list-style-type: none"> - clinical benefit (efficacy), - safety/side effects (especially those leading to hospitalizations & impacting quality of life), - strength of national guideline recommendations, and - cost of regimens.

The above information was excerpted or summarized from these sources:

AIM Specialty Health, Cancer Care Quality Program, available at: <https://anthem.aimoncology.com/index.html>; AIM Specialty Health, Cancer Care Quality Program: Supporting Value in Oncology, Sept. 2015, , available at: https://www.anthem.com/provider/wi/f5/s1/t1/pw_e237115.pdf?refer=ahpprovider; AIM Specialty Health, Cancer Treatment Pathways: reviewed by oncologists, 2016, available at: <https://anthem.aimoncology.com/CancerTreatmentPathways.html>; AIM Specialty Health, Anthem Cancer Care Quality Program: Supporting oncology practices and your patients, 2015, available at: <https://anthem.aimoncology.com/pdf/ProgramOverview.pdf>; AIM Specialty Health, Precision Medicine, 2016, available at: <https://anthem.aimoncology.com/FAQ-PrecisionMedicine.html#>; AIM Specialty Health, Anthem Cancer Care Quality Program: Reimbursement FAQs, 2014, available at: <https://anthem.aimoncology.com/pdf/EnhancedReimbursementFAQ.pdf>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.14 Arkansas Health Care Payment Improvement Initiative (ACPHII)

Model Name: Arkansas Health Care Payment Improvement Initiative (ACPHII)	
<p>Brief Description: This Medicaid-led, multi-payer, multi-part payment model includes:</p> <p>Care coordination payments – paid per member per month (PMPM) to practices. To continue to receive these payments, practices must attest to having completed certain PCMH practice transformation activities each quarter. Currently, Medicaid pays \$1-\$30 PMPM, depending on patients’ “Risk Utilization Band”; certain commercial insurers must pay at least \$5 PMPM per state law.</p> <p>One-sided shared savings payments – available to PCMH practices that voluntarily meet cost and quality targets. Practices may keep up to 50% of the savings they generate for Medicaid; commercial insurers may use their own methodology for calculating these payments. In the first year of this program (2014), qualifying PCMH practices received shared savings payments that ranged from \$9,000 to \$900,000. <i>(In this profile we sometimes refer to care coordination payments and shared savings payments as “PCMH payments.”)</i></p> <p>Two-sided episode of care (EOC) payment – Medicaid and two commercial insurers are paying for 14 different medical, procedural/surgical, and behavioral health EOCs. This program is <u>mandatory</u> for providers, who can either receive retrospective bonuses if patients’ expenditures are lower than a target, neither receive nor owe money, or can owe money to payers if expenditures exceed a target. Medicaid began paying for certain EOCs in July 2012, Blue Cross began paying for EOCs in Jan. 2013, and Qualchoice (another private insurer) began paying for certain EOCs in Jan. 2014.</p> <p>As part of this broader payment reform initiative, the state is also weighing whether to pursue a Medicaid State Plan Amendment to offer supplemental payments to practices that qualify as Health Homes.</p>	
<p>Developer: Arkansas Department of Human Services’ Medicaid Program, with substantial input from technical development workgroups, stakeholders, and the two largest private payers in the state (Arkansas Blue Cross and Blue Shield and QualChoice of Arkansas). The Arkansas Center for Health Improvement has also been a partner in developing this model.</p>	
<p>What is the goal of this payment model?</p>	<p>The initiative is part of a larger effort to increase health care quality and reduce costs of care in Arkansas. It is designed to transition Arkansas to a “patient-centered” health care system that embraces the triple aim of (1) improving the health of the population; (2) enhancing the patient experience of care, including quality, access, and reliability; and (3) reducing, or at least controlling, the cost of health care. AHCPII is designed to reward physicians, hospitals, and other providers who give patients high-quality care at an appropriate cost.</p>
<p>How long has this payment model been in operation? Where has it been implemented?</p>	<p>PCMH payments: Medicaid began paying PCMH practices care coordination payments and shared savings bonuses in 2014. Starting in 2015, commercial insurers that sold: 1) qualified health plans in Arkansas’s health insurance marketplace, and 2) Medicare Advantage special need plans to individuals dually eligible for Medicare and Medicaid were also required to pay PCMH practices care coordination payments PMPM. Starting in 2016, these commercial payers were also required to pay PCMH practices shared savings bonuses.</p> <p>In the PCMH program’s first year (2014), 123 practices or groups participated, employing 659 primary care physicians, and providing care to 295,000 Medicaid beneficiaries. 37 of these practices or groups were potentially eligible for shared savings payments as a result of having at least 5,000 Medicaid beneficiaries attributed to them; 19 of these received shared savings payments as a result of meeting quality and cost targets.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Arkansas Health Care Payment Improvement Initiative (ACPHI)	
	<p>By Jan. 2016, 136 practices employing 870 providers were participating in the PCMH program, representing 52% eligible of eligible practices in the state. Participating payers include: Arkansas Medicaid (331,000 attributed beneficiaries); Arkansas Blue Cross and Blue Shield (157,000); Qualchoice (4,300); Centene/Ambetter (44,000); United Healthcare (TBD); Walmart (21,000); Arkansas State Employees and Public School Employees (30,000).</p> <p>EOC payments: Medicaid began paying for certain EOCs in July 2012; Blue Cross began paying for certain EOCs in Jan. 2013; and Qualchoice began paying for certain EOCs in Jan. 2014. Each of these payers has added payments for additional EOCs on a rolling basis. Providers that meet the criteria to serve as a Principal Accountable Provider (PAP) are required to participating in this payment model.</p>
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>Care coordination payments: These payments are intended to support ongoing operational expenses associated with care coordination and PCMH practice transformation tools, technology, and services.</p> <p>Shared savings payments: These payments are calculated based on the total cost of all care received by attributed beneficiaries – not just the care provided by PCMH practices.</p> <p>EOC payments: These payments cover bundles of services associated with 14 episodes, which fall into three categories: (1) “medical” episodes (Asthma, Chronic Obstructive Pulmonary Disease, Heart Failure, and Upper Respiratory Infection); (2) “procedural/surgical” episodes (Cholecystectomy, Colonoscopy, Coronary Artery Bypass Graft, Perinatal (described below), Tonsillectomy, Total Joint Replacement, Percutaneous Coronary Intervention); and (3) “behavioral health” episodes (Attention Deficit / Hyperactivity Disorder, Oppositional Defiant Disorder, and ADHD/ODD comorbidity). Arkansas Medicaid is currently proposing four more episodes: Appendectomy, Hysterectomy, Uncomplicated Pediatric Pneumonia, and Urinary Tract Infection. Bundles are expected to cover the cost of all services needed during a designated clinical episode (e.g., the Perinatal episode covers all treatments and prenatal visits, labor and delivery, and 60 days of follow up care). Bundles often cover a 1-year period. Specific services covered under each EOC are identified in the algorithm summaries available at: http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx.</p>
Types of patients included?	<p>Medicaid beneficiaries enrolled in ConnectCare, Arkansas’s Primary Care Case Management (PCCM) program, and not dually enrolled in Medicare and Medicaid; individuals insured by participating commercial insurers; and employees insured by participating self-insured employers.</p>
Method of attributing patients to participating providers	<p>PCMH payments: PCMH practices’ attributed Medicaid beneficiaries are determined by the ConnectCare Primary Care Case Management (PCCM) program. Attributed beneficiaries do not include individuals dually enrolled in Medicare and Medicaid.</p> <p>EOC payments: Medicaid and participating commercial insurers use claims data to determine which physician practice, hospital, or other provider is most responsible for the quality and cost of care for a given EOC; that provider is designated the Principal Accountable Provider (PAP). Different criteria are used to identify the PAP for each type of EOC; criteria for each type of EOC are available in algorithm summaries available at http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Arkansas Health Care Payment Improvement Initiative (ACPHI)	
Types of providers participating in the payment model?	<p>Care coordination payments: To be eligible to receive care coordination payments, providers must be: an individual primary care physician; a physician group of primary care providers who are affiliated with a common group identification number; a rural health clinic; or an area health education center. In addition, the practice must include primary care providers enrolled in the ConnectCare Primary Care Case Management (PCCM) program, but may not be participating in a separate PCCM shared savings pilot authorized under state law. The practice must also have at least 300 attributed Medicaid beneficiaries at the time of enrollment into the PCMH program, and meet Arkansas Medicaid’s PCMH practice recognition requirements.</p> <p>Shared savings payments: To be eligible to receive shared savings payments in 2014, PCMH practices must meet the above requirements, and must also have at least 5,000 Medicaid beneficiaries attributed to them (on their own, or jointly with <i>one other</i> practice) for at least 6 months. Starting in 2015, practices could meet the 5,000 beneficiary minimum by joining with <i>multiple</i> practices, or be placed in a state-wide “default pool.”</p> <p>EOC payments: Providers that meet the criteria to serve as a PAP and receive EOC bonuses or penalties include physician practices, hospitals, providers of rehabilitative services for persons with mental illness, or other qualifying providers. (See EOC algorithm summaries available at http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx)</p>
The entity accountable to the payer?	<p>Care coordination payments: PCMH practices are accountable for meeting PCMH practice transformation milestones in order to receive care coordination payments PMPM.</p> <p>Shared savings payments: Shared savings entities (either a practice, or a set of practices) are accountable for meeting PCMH practice transformation milestones, quality measure targets, and spending targets in order to qualify for shared savings payments.</p> <p>EOC payments: The PAP is accountable to the payer for EOC bonuses or penalties.</p>
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>Care coordination payments: Since 2014, Medicaid has paid PCMH practices care coordination payments PMPM on a quarterly basis. As of 2016, Medicaid payments ranged from \$1-\$30 PMPM (depending on a patient’s “Risk Utilization Band”). Since 2015, certain commercial insurers were also required to participate, by paying at least \$5 PMPM to practices recognized by Medicaid as PCMHs.</p> <p>Shared savings payments: Since 2014, Medicaid has offered PCMH practices shared savings payments if their average annual cost per member is lower than (1) a state-wide “medium” cost level; or (2) their own custom benchmark cost (set by projecting forward their historical costs). If practices have generated savings relative to both of these spending benchmarks, Medicaid uses whichever benchmark will yield the largest shared savings bonus for the practice. Practices are eligible to keep up to 50% of the savings they generate for Medicaid. Practices must achieve PCMH transformation</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Arkansas Health Care Payment Improvement Initiative (ACPHI)	
	<p>milestones and meet at least two-thirds of the shared-savings quality measure targets (e.g., measuring the rates of pediatric wellness visits, hemoglobin A1c testing for diabetes, breast cancer screenings, improved ADHD management, thyroid medication management). Practices face no downside financial risk (i.e., no risk of paying Medicaid a financial penalty if their actual spending exceeds their spending target). In the first year of this program (2014), practices that qualified to receive shared savings payments received payments that ranged from \$9,000 to \$900,000 per practice, and averaged \$278,000.</p> <p>Starting in 2016, certain commercial insurers are required to offer shared savings payments, but they can use their own methodology to calculate these payments.</p> <p>Episodes of Care (EOC): Providers that meet the criteria to qualify as a PAP continue to file claims as they have previously and are reimbursed according to each payer’s established fee schedule. At the end of a set time period, each PAP’s average cost per EOC is calculated and compared with “acceptable” and “commendable” levels of costs (e.g., for a colonoscopy EOC, the acceptable threshold is \$886, and the commendable threshold is \$796). If the PAP’s average cost is above the acceptable level (e.g., higher than \$886), the provider will pay 50% of the “excess” costs beyond this acceptable amount. If the PAP’s average cost is acceptable but not commendable (e.g., between \$796 and \$886), there will be no payment changes. If the PAP’s average cost is below the commendable level (e.g., below \$796), then he or she will be eligible to share in 50% of the difference between the PAP’s average cost and this commendable (e.g., \$796) amount (up to a maximum gain-sharing limit of \$717, in the case of colonoscopies), provided the PAP meets certain minimum performance targets for the EOC. Specific “acceptable” and “commendable” dollar amounts, gain-sharing limits, and quality targets vary by episode, and are specified in the Medicaid document titled ‘Section II – Episodes of Care’ cited below.</p>
<p>Are there any performance metrics? If so, what is being measured?</p>	<p>Care coordination payments: To maintain recognition as a PCMH, practices must complete 16 practice activities on schedule. (Some activities must be completed within 3 months, others within 6 months, and still others within 12 and 13 months of a performance period.) For example, a practice must identify the top 10% of their high-priority patients by the 3rd month of the 2016 Performance Period. See the ‘PCMH Program Policy Addendum’ cited below for more information.</p> <p>Shared savings payments: To qualify for shared savings bonuses, PCMH practices must meet the above requirements and also meet performance targets on 15 primary care clinical process and outcome measures (e.g., percent of children that received a well child visit in the past year, percent of diabetics with well-controlled HbA1c levels). The full list of these measures is available in Sec. 243.000 of the ‘2016 PCMH Program Policy Addendum,’ cited below.</p> <p>EOC payments: Providers subject to EOC payments report a limited set of quality metrics through an online Provider Portal. Measures vary by EOC and are described in the algorithm summaries for each episode – accessible at http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx.</p>
<p>Are there any performance incentives?</p>	<p>Care coordination payments: Providers are incentivized to meet PCMH practice transformation milestones in order to receive PCMH care coordination payments.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Arkansas Health Care Payment Improvement Initiative (ACPHII)	
If so, what is being incentivized?	Shared savings payments & EOC payments: Providers are also incentivized to reduce the total cost of their patients’ care while delivering enough care to perform highly on quality measures, in order to receive shared savings bonuses and EOC bonuses and avoid EOC financial penalties.
How do incentives operate?	See “How are providers paid?” above.
Is this a stand-alone payment model or is it used with other payment models?	These payment models are layered on top of fee-for-service payments. PCMH payments are paid in addition to usual fee-for-service payments, and fee-for-service payments are reconciled with spending targets to calculate shared savings and EOC bonuses or penalties.
Has the model been evaluated? Who funded this evaluation?	There are multiple internal analyses and analyses funded by AHCPPII and produced by the Arkansas Center for Health Improvement (ACHI). A recent <i>Statewide Tracking Report</i> is cited below.
Other pertinent information	<p>PCMH practices are required to meet various transformation milestones – e.g., offer extended office hours, 24/7 access to medical assistance, etc.</p> <p>PCMH practices are eligible to receive Medicaid-funded practice transformation support (i.e., technical assistance) from the Arkansas Foundation for Medical Care.</p> <p>PCMH practices receive access to quarterly, web-based, practice-specific quality measure data from Medicaid 45 days after the close of each quarter. Commercial insurers are also required to provide PCMH practices with performance reports in a pre-specified standardized format, and to share statistics in the form of analyzed claims data.</p> <p>EOC providers receive quarterly reports through an online portal detailing their quality, cost, and utilization for each type of EOC relative to that of their peers.</p> <p>Detailed information on each EOC (e.g., triggering billing codes, how the PAP is determined, duration of episode, services covered in the episode, measures used to assess quality) is available at http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx.</p>

The above information was excerpted or summarized from these sources:

Arkansas Center for Health Improvement, Arkansas Health Care Payment Improvement Initiative (AHCPPII), available at <http://www.achi.net/Pages/OurWork/Project.aspx?ID=47>; Arkansas Center for Health Improvement, An Overview of the Arkansas Payment Improvement Initiative, Jan. 2014, available at: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=204>; Arkansas Center for Health Improvement, Patient-Centered Medical Homes, Jan. 2015, available at: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=277>; Arkansas Center for Health Improvement, Patient-Centered Medical Homes: Medicaid Shared Savings Update, Oct. 2015, available at: <http://www.achi.net/Content/Documents/ResourceRenderer.ashx?ID=335>; Health Care Payment Improvement Initiative, How it works, available at: <http://www.paymentinitiative.org/howItWorks/Pages/default.aspx>; Health Care Payment Improvement Initiative, Episodes of care, available at: <http://www.paymentinitiative.org/episodesOfCare/Pages/default.aspx>; Health Care Payment Improvement Initiative, Practice Support, available at: <http://www.paymentinitiative.org/medicalHomes/Pages/Practice-Support.aspx>; Health Care Payment Improvement Initiative, Provider Reports, available at:

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

<http://www.paymentinitiative.org/medicalHomes/Pages/Provider-Reports.aspx>; Health Care Payment Improvement Initiative, Eligibility requirements, available at: <http://www.paymentinitiative.org/medicalHomes/Pages/Requirements-of-Becoming-PCMH.aspx>; Arkansas Health Care Payment Improvement Initiative, Principal Accountable Provider, available at: <http://www.paymentinitiative.org/referenceMaterials/Documents/pap.pdf>; Arkansas Center for Health Improvement, *Arkansas Health Care Payment Improvement Initiative: 2nd Annual Statewide Tracking Report*, Jan. 2016, available at: <http://www.achi.net/Docs/338/>; Health Care Payment Improvement Initiative, 2016 PCMH Program Policy Addendum, available at: http://www.paymentinitiative.org/referenceMaterials/Documents/2016%20PCMH%20Program%20Policy%20Addendum%2005052016_v16.pdf; Arkansas Department of Human Services, Division of Medical Services, Section II – Patient Centered Medical Home, available at: <http://www.paymentinitiative.org/referenceMaterials/Documents/2016%20PCMH%20manual.pdf>; Arkansas Department of Human Services, Division of Medical Services, Section II – Episodes of Care, available at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0ahUKewjcrmmWxeLOAhWKpB4KHRdOD6kQFggeMAA&url=https%3A%2F%2Fwww.medicaid.state.ar.us%2Fdownload%2Fprovider%2Fprovdocs%2Fmanuals%2Fepisode%2Fepisode_ii.doc&usg=AFQjCNHk-BWxd_LLH4w_EWV6mgIxKXSmXQ&sig2=v2X1nVzEODLvU3FuQRwu5g.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.15 BirthBundle

Model Name: BirthBundle	
Brief Description: The BirthBundle™ is a bundled payment for maternity and newborn care delivered by the Minnesota Birth Center to patients insured through UCare’s state public program. The episode covered by this bundled payment covers pre-natal, intra-partum, and post-partum care from 270 days prior and up to 56 days after the delivery. The bundle price is \$12,500 for a delivery at the birth center and \$9,000 for a delivery at the hospital across the street (Children’s Hospitals and Clinics of Minnesota). An additional estimated \$14,858 in hospital fees are incurred for hospital deliveries.	
Developer: Steve Calvin, MD	
What is the goal of this payment model?	The goal of the model is to show that a comprehensive bundle of maternity and newborn care can be provided for a single price using the foundation of midwife-led primary maternity care teams in independent-integrated birth centers.
How long has this payment model been in operation? Where has it been implemented?	In late 2014, the Minnesota Birth Center received a grant from UCare Foundation to launch a pilot bundled payment program for this health plan’s public program membership.
Type(s) of health care services, medical conditions, and health care settings addressed?	The services include pre-natal, intra-partum, and post-partum care from 270 days prior and up to 56 days after the delivery, including: maternity care, routine labs, ultrasound, physician consults, childbirth education, doula support, delivery, post-partum care, immediate newborn care, and facility fees for both the mother and the newborn. Overall, the bundle includes 50+ procedure codes.
Types of patients included?	The patients are pregnant women insured through UCare’s state public program.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	The providers include physicians, Certified Nurse Midwives and possibly others.
The entity accountable to the payer?	The Minnesota Birth Center.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	<i>Information is not currently publicly available.</i>
Are there any performance metrics? If so, what is being measured?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: BirthBundle	
Are there any performance incentives? If so, what is being incentivized?	<i>Information is not currently publicly available.</i>
How do incentives operate?	Minnesota Birth Center staff have an incentive to deliver the minimum amount of care needed within the episode, in order to generate a profit. If the cost of services actually delivered is less than the flat rate paid by UCare for the episode, the Minnesota Birth Center gets to keep any such unused funds.
Is this a stand-alone payment model or is it used with other payment models?	This is a stand-alone payment model for all services delivered during the episode by the Minnesota Birth Center.
Has the model been evaluated? Who funded this evaluation?	Katy B. Kozhimannil, PhD from the University of Minnesota School of Public Health is leading a cost and clinical outcomes study of this payment model.
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Calvin, Steve. A Bundled Clinical Care and Payment Model for Maternity and Newborn Care – presentation, available at: http://www.ehcca.com/presentations/BPSummit5/calvin_t4.pdf; “Minnesota Birth Center and the BirthBundle”, presentation available at: <http://mnhealthactiongroup.org/wp-content/uploads/2016/04/Calvin-Balazovic-Presentation-4.18.16.pptx>; Paying for Care, “BirthBundle” price breakdown, available at: <http://theminnesotabirthcenter.com/paying-for-care/> and Anderson, Jane, “Insurers, Large Employers Test Maternity Care Bundles; Some See Promising Results” May, 2016, available at: <https://www.aishealth.com/archive/nvbc0516-03>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.16 Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)

Model Name: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)	
<p>Brief Description: Provider organizations (e.g., independent practice associations, multi-specialty group practices, physician-hospital organizations) whose members are the primary care providers for at least 5,000 enrollees in Blue Cross Blue Shield of Massachusetts’s (BCBSM’s) HMO or POS plans can enter into voluntary 5-year contracts with this insurer as “AQC groups.” AQC groups agree to an annual spending target for their attributed patients. At the end of each year, if patients’ total health care spending is below an AQC group’s spending target, the AQC group is eligible to receive a shared savings payment from BCBSM. Conversely, if patient spending is above this target, the AQC group must pay BCBSM a share of these cost over-runs. AQC groups’ performance on 64 hospital and ambulatory quality measures determines the size of payments received or owed.</p> <p>Approximately 90% of the physicians in BCBSM’s HMO network are participating in this model. BCBSM encourages participating providers to enter into other ACO contracts with other payers, especially Medicare’s Pioneer ACO model, which it views as very similar to this model.</p>	
Developer: Blue Cross Blue Shield of Massachusetts	
What is the goal of this payment model?	This model seeks to reduce the growth in health care spending and improve care quality and patient health outcomes.
How long has this payment model been in operation? Where has it been implemented?	Contracts began in Jan. 2009 with 7 provider organizations. Today, approximately 90% of the physicians in BCBSM’s HMO network are participating in this model (with some groups now in their second 5-year contract).
Type(s) of health care services, medical conditions, and health care settings addressed	AQC groups’ spending targets include all health care received by enrollees, including primary care, specialty care, hospital care, ancillary services (e.g., diagnostic tests), behavioral health, and pharmacy expenses.
Types of patients included	Patients insured through BCBSM’s health maintenance organization (HMO) and point of service (POS) health insurance plans who identify their primary care physician as being a physician who is participating in an AQC group.
Method of attributing patient to participating providers	Patients insured through BCBSM’s HMO and POS health insurance plans must prospectively identify their primary care physician each year. If the patient selects a physician who belongs to an AQC group, the patient is considered attributed to that AQC group.
Types of providers participating in the payment model	AQC groups must include primary care physicians who collectively care for at least 5,000 enrollees in BCBSM HMO or POS plans. Provider organizations that have entered into these contracts with BCBSM include multi-specialty integrated groups, independent practice associations (which may represent many smaller practices), and physician-hospital organizations.
The entity accountable to the payer	An AQC group that has negotiated a contract with BCBSM under this model (see types of participating organizations in row immediately above).
The entity receiving payment from the payer (if different from above)	Same as above.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)	
How are providers paid under the payment model?	<p>AQC groups that enter into these voluntary, 5-year contracts with BCBSM agree to an annual spending target, which is negotiated separately for each group and based on their attributed patients’ prior total health care spending. After the first year, this spending target is adjusted for patients’ health status (using the Diagnostic Cost Groups risk adjustment model) and inflation (see “Inflation” note in “Other pertinent info” row at bottom) using growth rates negotiated separately for each AQC group. Providers in an AQC group receive FFS payments throughout the year; then, at the end of the year, BCBSM calculates whether the group’s patients generated more or less spending than the group’s spending target for that year (including care from providers not in the AQC group). If actual spending is below the spending target, the AQC group is eligible to receive a share of the savings generated. If spending is above the spending target, the group must pay a share of these cost over-runs to BCBSM.</p> <p>In the first two years of the payment model, AQC groups negotiated to take on between 50% and 100% up-side or down-side risk (depending on how much risk they were comfortable with), and could earn an additional stand-alone performance incentive worth up to 10% of their total spending target if they met quality measure targets. Starting in the third year, the model was changed, and the share of savings or losses was determined based on performance on quality measures, and the 10% bonus was retired. (See “How do incentives operate?” below for more.)</p>
Are there any performance metrics, if so, what is being measured?	<p>Spending is the primary measure used in this model, since total health care spending of attributed patients determines whether an AQC group is eligible to receive shared savings or owes shared risk payments.</p> <p>In addition, 64 quality measures are used to adjust the size of shared savings payments or shared risk penalties owed. These measures include clinical process measures, outcome measures, and patient experience measures assessing ambulatory and hospital care quality.</p>
Are there any performance incentives, if so, what is being incentivized?	<p>AQC groups are incentivized to perform highly on the 64 quality measures that are used to determine the size of payments in this model. Because targets for quality measures are absolute numbers, rather than a relative ranking compared to peers, providers face no disincentive to share best practices with each other.</p> <p>Groups also have a broader incentive to lower the total health care spending of their HMO patients, such as by referring these patients to low-cost, high-quality specialists and hospitals, and coordinating care more closely to keep patients healthy and avoid unnecessary health care utilization.</p>
How do incentives operate?	<p>See “How are providers paid?” above for how providers’ incentive to lower their patients’ total health care spending operates.</p> <p>In terms of quality, in the first two years of the payment model, a stand-alone performance incentive worth up to 10% of an AQC group’s spending target could be earned based on a group’s overall quality score. Starting in the third year, a change was made to the model, and a group’s overall quality score began to be used to adjust the share of savings or risk that groups were eligible to receive or pay (with better performance on quality measures earning groups larger shares of savings and smaller shares of risk); the 10% stand-alone bonus was retired at this time.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)	
	<p>An AQC group's overall quality score is determined based on the group's performance on 64 quality measures. Half of the score is determined based on ambulatory care quality measures, and half is determined based on hospital quality measures (even if the group does not have a participating hospital – thus giving AQC groups an incentive to refer patients to high-quality hospitals).</p> <p>Each measure has 5 absolute performance targets, allowing AQC groups to get partial credit for measures. Performance on each measure is translated from a percentage to a score out of 5. Scores on measures are then aggregated, with outcome measures getting triple the weight of clinical process measures. In the first two years of the model, an aggregate performance score that met the lowest of 5 performance targets qualified a group to receive a performance incentive bonus worth 2% of their annual spending target; meanwhile, an aggregate performance score that met the highest of the 5 performance targets qualified a group to receive a performance incentive worth 10% of their global budget. In the third year, the model was changed, and an aggregate performance score that met the lowest of the 5 performance targets now qualified a group to earn 20% of any savings, and owe 80% of any losses; an aggregate performance at the highest of the 5 performance targets qualified a group to earn 80% of any savings, and owe 20% of any losses.</p>
Is this a stand-alone payment model or is it used with other payment models?	This payment model is layered on top of fee-for-service payments, which are used to pay providers throughout the year, and to determine AQC groups' financial performance relative to their spending targets.
Has the model been evaluated? Who funded this evaluation?	<p>Researchers from Harvard Medical School have formally evaluated this model – see:</p> <p>"Changes in Health Care Spending and Quality 4 Years into Global Payment," <i>NEJM</i>, 2014, http://www.nejm.org/doi/full/10.1056/NEJMsa1404026</p> <p>Authors assessed the first 4 years of the BCBS AQC by comparing spending and process and outcome quality among enrollees whose physician organizations entered the AQC from 2009-2012 with those among persons in comparison states. They studied spending changes according to year, category of service, site of care, experience managing risk contracts, and price versus utilization.</p> <p>"The 'Alternative Quality Contract,' Based on A Global Budget, Lowered Medical Spending And Improved Quality," <i>Health Affairs</i>, 2012, http://content.healthaffairs.org/content/early/2012/07/09/hlthaff.2012.0327.abstract</p> <p>Authors evaluated changes in spending and quality associated with the AQC. The study population included BCBSM enrollees from January 2006–December 2010, continuously enrolled for at least one calendar year. The comparison group consisted of enrollees whose PCP did not enter the contract. A difference-in-differences approach was used to isolate the effect of the AQC on spending, and pre- and post-intervention periods were compared within cohorts that started in the program in 2009 and in 2010, respectively.</p> <p>"Health Care Spending and Quality in Year 1 of the Alternative Quality Contract – 2011," <i>NEJM</i>, http://www.nejm.org/doi/full/10.1056/NEJMsa1101416</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract (AQC)	
	<p>The authors analyzed 2006–2009 claims for 380,142 enrollees whose PCPs were in the AQC system (intervention group) and for 1,351,446 enrollees whose PCPs were not in the system (comparison group). A propensity-weighted difference-in-differences approach, adjusting for age, sex, health status, and secular trends was used to compare spending and quality in the intervention and comparison groups.</p>
Other pertinent information	<p>-Participating AQC groups are required to have reinsurance to protect them in the event of high-cost patients (e.g., generating \$100,000 a year).</p> <p>-Patients are not notified that their primary care physician is participating in this model, but they are free to receive care from any specialist in the BCBSM HMO network after a referral, and are free to change their primary care physician.</p> <p>-BCBSM provides technical assistance to AQC groups in the form of: 1) reports (identifying groups’ spending performance thus far, individual physicians’ quality performance, the performance of specialists that a group may consider referring patients to, a group’s rate of avoidable hospital utilization, and daily hospital census information), 2) one-on-one consultations with BCBSM staff about data reports and quality goals, 3) group learning activities, in which different AQC groups are encouraged to share best practices with each other.</p> <p>-BCBSM encourages AQC groups to apply to participate in other payers’ ACO initiatives, especially the Pioneer ACO model, which BCBSM views as most similar to its model.</p> <p>- A note about the inflation factor mentioned in “How are providers paid in this payment model?” above: In the first two years of the payment model, spending targets increased by predetermined percentages (usually starting at the average projected increase in spending in the region among BCBSM HMO network providers, and declining to about half of this rate or the general inflation rate by the end of the 5-year contract). Starting in the third year, the model was changed, and increases in spending targets were tied to regional spending benchmarks, with AQC groups often expected to beat the regional trend by a designated amount.</p>

The above information was excerpted or summarized from these sources:

Blue Cross Blue Shield of Massachusetts. “Massachusetts Payment Reform Model: Results and Lessons.” Available at: <https://www.bluecrossma.com/visitor/pdf/aqc-results-white-paper.pdf>; Michael E. Chernew, Robert E. Mechanic, Bruce E. Landon and Dana Gelb Safran, “Private-Payer Innovation In Massachusetts: The 'Alternative Quality Contract',” *Health Affairs* 30, no.1 (2011):51-61.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.17 Blue Cross Blue Shield of Michigan Physician Group Incentive Program

Model Name: Blue Cross Blue Shield of Michigan Physician Group Incentive Program	
Brief Description: The Physician Group Incentive Program (PGIP) is intended to help physician organizations evolve from loose federations of physicians in independent practice associations to high-performing health systems with responsibility and accountability for collectively managing a shared population of patients.	
Within PGIP, Blue Cross Blue Shield of Michigan (BCBSM) operates a number of initiatives, including the Patient-Centered Medical Home (PCMH), which supports primary care practices; the Organized System of Care (OSC), which expands PCMH care communities to also include hospitals, specialists, and other service providers; and the Michigan Primary Care Transformation Project (MiPCT), a demonstration project testing the value of the PCMH model.	
Developer: Blue Cross Blue Shield of Michigan	
What is the goal of this payment model?	The Physician Group Incentive Program (PGIP) is a collection of clinical and quality-based pay-for-performance initiatives developed that share the goals of improving the patient experience of care, improving the health of populations, and reducing health care costs in Michigan.
How long has this payment model been in operation? Where has it been implemented?	PGIP, established in 2005, includes more than 40 provider organizations from across the state of Michigan, representing over 19,000 primary care and specialty physicians who are members of the BCBSM network. Within PGIP, the PCMH initiative began in 2009, the OSC program began in 2011, and MiPCT began in 2012.
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>PGIP connects provider organizations to collect data, share information, and collaborate on initiatives that work to improve the health care system in Michigan. Through the program, primary care and some specialist physicians who meet quality and population-based care measures are eligible to receive a higher value-based reimbursement, for certain fees.</p> <p>Within PGIP, the PCMH initiative supports the implementation of 12 PCMH-related tools and processes by physician organizations: coordination of care; extended access; individual care management; linkage to community services; patient-provider partnership; patient registry; patient web portal; performance reporting; preventive services; self-management support; specialist referral process; and test results tracking.</p> <p>The OSC program uses the PCMH model as its foundation, expanding it to include hospitals, specialists and other providers in addition to primary care practices. These OSCs are similar to Accountable Care Organizations (ACOs), but have more flexibility in design than the national ACO standards. Like PCMHs, OSCs coordinate services across the health care continuum for a defined patient population and accepts accountability for delivering effective and efficient patient care over time and across settings of care.</p> <p>The Michigan Primary Care Transformation Project (MiPCT) is a demonstration project testing the value of the PCMH model. It is one of eight states in the Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP), sponsored by the Centers for Medicare and Medicaid (CMS) to create a uniform, sustainable primary care platform. MiPCT addresses the shortcomings in the current system by:</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Michigan Physician Group Incentive Program	
	<ul style="list-style-type: none"> • Providing capital to physicians to hire care coordinators and implement disease registries to track and follow up with patients, especially those with multiple chronic diseases. • Paying physicians to expand office hours and offer same day appointments. • Rewarding physicians for improving their patients’ health and decreasing their need to go to the emergency room. • Providing training for care managers, facilitating communication among practices and hosting learning collaboratives.
Types of patients included?	Providers participating in the AGIP program care for two million BCBSM members and a total of five million Michigan residents. Non-BCBSM members may benefit from the program through providers’ use of improved care processes for all patients.
Method of attributing patients to participating providers	The PGIP program does not involve attributing patients to providers.
Types of providers participating in the payment model?	Provider organizations; primary care practices; affiliated specialists; hospitals; and other health care providers.
The entity accountable to the payer?	Provider organizations
The entity receiving payment from the payer (if different from above)?	Provider organizations and physicians within provider organizations
How are providers paid under the payment model?	<p>The program uses fee-for-value reimbursement instead of the traditional fee-for-service model. With fee-for-value reimbursement, practitioners are rewarded for delivering efficient, high-quality care to patients. There are two components to the reimbursement model:</p> <ol style="list-style-type: none"> 1. Rewarding physician organizations for actively engaging in PGIP initiatives with financial incentives. <ol style="list-style-type: none"> a. Incentives are paid from a \$110 million PGIP reward pool b. The PGIP reward pool is funded by a portion of the provider’s reimbursement (0.5% of payments in 2005, increased to 4.7% in 2012) and, since 2009, channeling inflation-adjustment fee increases into the pool 2. Providing fee increases to PGIP physicians associated with high-quality, cost-efficient care based on claims data. <ol style="list-style-type: none"> a. Participating primary care physicians are eligible for up to 20% increased reimbursement in their office visit fees through PCMH <p>MiPCT participating practices and providers receive four payment components:</p> <ol style="list-style-type: none"> 1. Care coordination payment – \$3.00 per member per month (\$4.50 for Medicare) paid to the provider organization for distribution to practices as appropriate 2. Practice transformation payment – \$1.50 per member per month (\$2.00 for

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Michigan Physician Group Incentive Program	
	<p>Medicare) paid as per member per month</p> <p>3. Performance incentives – \$3.00 per member per month paid as a retrospective incentive</p> <p>4. A small administrative payment – \$0.26 per member per month for demonstration operations</p>
<p>Are there any performance metrics? If so, what is being measured?</p>	<p>To measure PGIP performance, BCBSM uses progress reports submitted by the physician organizations that describe the approaches they use to educate physicians, modernize practice systems, conduct performance measurement, identify and act on improvement opportunities, and collaborate across provider organizations. PCMH incentives are based on implementation of the 12 PCMH-related tools and processes; OSC incentives are based on participation in three OSC initiatives:</p> <ul style="list-style-type: none"> • OSC Integrated Patient Registry Initiative <ul style="list-style-type: none"> ○ Assists nascent OSCs in the development of a health information system that will be used to collect, track, use and store patient health data sets. ○ The aim is to enable the OSC and all of its associated providers in all settings of care to have the right information at the right time to effectively manage its patient population with the goal of high quality, cost-effective care. • OSC Integrated Performance Measurement Initiative <ul style="list-style-type: none"> ○ Enables OSCs to generate OSC-wide performance reporting for all patients. ○ Initially, performance reports are only for internal use, but in the longer-term, OSCs will collaborate to define a common set of measures that can be used to provide external entities with information for payment and public reporting. ○ OSCs should actively collaborate on working toward the development of a consistent set of performance metrics relevant to key stakeholders to which they are collectively accountable (e.g., local and regional health plans, CMS, Aligning Forces for Quality collaboratives). • OSC Processes of Care Initiative. <ul style="list-style-type: none"> ○ Builds on the foundational capabilities in the PCMH Initiatives, catalyzing the OSC to ensure that care partners communicate, coordinate, and collaborate to achieve clinical integration at the OSC level. • A fourth initiative measuring patient experience of care is under development
<p>Are there any performance incentives? If so, what is being incentivized?</p>	<p>BCBSM rewards PGIP physician organizations, PMCHs, and OSC for system transformation and population level management twice a year. An organization’s reward is based on the quality and efficiency of the care provided for the patient population and depends on: participation; performance and improvement; accomplishing goals with its PGIP physicians. Incentive payments take into account absolute performance and improvement within the physician organization’s patient population, as well as the degree of the organization’s participation in initiatives.</p>
<p>How do incentives operate?</p>	<p>Each organization can decide how to use its reward to further the PGIP goals of improving health care quality and transforming health care value.</p>
<p>Is this a stand-alone payment model or is it used with other payment models?</p>	<p>This fee-for-value payment model builds off of the traditional fee-for-service payment model.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Michigan Physician Group Incentive Program	
Has the model been evaluated? Who funded this evaluation?	<p>A 2015 study in <i>Health Affairs</i></p> <ul style="list-style-type: none"> • Analyzed the PGIP program’s impact on quality and spending from 2008 to 2011 for over three million beneficiaries in over 11,000 physician practices. • Participation in the incentive program was associated with approximately 1.1 percent lower total spending for adults (5.1 percent lower for children) and the same or improved performance on eleven of fourteen quality measures over time. <p>The Commonwealth Fund supported a comprehensive, independent evaluation of the Physician Group Incentive Program, conducted by a team of health services researchers from the University of Michigan:</p> <ul style="list-style-type: none"> • In semi-structured interviews with eighty-three people from sixty-one health care organizations, nearly every respondent expressed the view that the program is successfully improving primary care and health outcomes in the state of Michigan. <p>Based on an evaluation in progress by Blue Cross Blue Shield and the University of Michigan:</p> <ul style="list-style-type: none"> • Researchers estimate that the patient-centered medical home capabilities implemented as of 2011 were associated with \$155 million in lower medical costs in program year 2011 for the 1.5 million BCBSM members who received care at practices participating in the PGIP. This amount does not include any potential savings in pharmacy costs, which have yet to be evaluated. <p>In internal evaluation of the PCMH program found that the program saved an estimated \$427 million from July 2008 through June 2014, as improved quality of care and preventive care helped patients avoid emergency room visits and hospital stays. The BCBSM PCMH program has been highlighted in national peer-reviewed literature, including:</p> <ul style="list-style-type: none"> • <i>Medical Care Research and Review</i> April 2015 <ul style="list-style-type: none"> ○ Presented evidence suggesting that both the level and amount of change in PCMH practices are positively associated with quality of care and use of preventive services. Also, lower overall medical and surgical costs are associated with higher levels of PCMH implementation. • <i>JAMA Internal Medicine</i> February 2015 <ul style="list-style-type: none"> ○ Examined breast, cervical and colorectal cancer screening rates for practices’ with Blue Cross patients. Evidence suggested that implementation of the PCMH model was associated with higher breast, cervical and colorectal cancer screening rates across most socioeconomic levels. • <i>Health Services Research</i> July 2013 <ul style="list-style-type: none"> ○ Showed a link between the level of PCMH transformation in a practice and cost savings. A practice that fully implemented the PCMH program would have, on average, \$26.37 lower per-member, per-month costs than a practice that implemented no PCMH capabilities. <p>The MiPCT program has been evaluated by the Research Triangle Institute, CMS’ national evaluator for the MAPCP demonstration.</p> <ul style="list-style-type: none"> • MiPCT program savings for Medicare in Michigan were estimated at about \$148 per full-year eligible Medicare beneficiary in the first year. An all-payer evaluation will also be conducted by the Michigan Public Health Institute with results to be released later in in 2016.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Michigan Physician Group Incentive Program	
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Blue Cross Blue Shield Blue Care Network of Michigan Organized Systems of Care Website. Available at: <http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog/models-of-care/organized-systems-of-care.html>; Blue Cross Blue Shield Blue Care Network of Michigan Patient-Centered Medical Homes Website. Available at: <http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog/models-of-care/patient-centered-medical-home-initiatives.html>; Blue Cross Blue Shield Blue Care Network of Michigan Physician Group Incentive Program Website. Available at: <http://www.bcbsm.com/providers/value-partnerships/physician-group-incentive-prog.html>; Blue Cross Blue Shield Value Partnerships. "Patient-Centered Medical Home." Available at: <http://www.bcbsm.com/content/dam/public/Providers/Documents/value/patient-centered-medical-home-fact-sheet.pdf>; Blue Cross Blue Shield Value Partnerships. "Organized Systems of Care." Available at: <http://www.valuepartnerships.com/vp-program/organized-systems-of-care/>; The Physician Alliance. BCBSM Organized Systems of Care Goals and Details. Available at: <http://thephysicianalliance.org/wp-content/uploads/2014/09/2015-BCBSM-Organized-Systems-of-Care-OSC-FINAL-3-19-15.pdf>; Blue Cross Blue Shield of Michigan Organized Systems of Care. Frequently Asked Questions. May 2013 Version. Available at: <http://www.bcbsm.com/content/dam/public/Providers/Documents/value/osc-faq.pdf>; BCBSM Physician Group Incentive Program Organized Systems of Care Initiatives Interpretive Guidelines. July 2013 V.7.0. Available at: <http://www.bcbsm.com/content/dam/public/Providers/Documents/value/pgip-osc-interpretive-guidelines.pdf>; BCBSM Physician Group Incentive Program. Patient-Centered Medical Home and Patient-Centered Medical Home-Neighbor Domains of Function Interpretive Guidelines. 2015-2016 V1.0. Available at: <http://www.bcbsm.com/content/dam/public/Providers/Documents/value/pcmh-and-pcmh-n-interpretive-guidelines.pdf>; Value Partnerships Physician Group Incentive Program Website. Available at: <http://www.bcbsm.com/content/dam/public/Providers/Documents/physician-group-incentive-program-basics.pdf>; Value Partnerships Patient-Centered Medical Home Website. Available At: <http://www.valuepartnerships.com/vp-program/patient-centered-medical-home/>; MiPCT Demonstration Project Website. Available at: <https://mipct.org/about-us/>; 2016 Michigan Primary Care Transformation Project (MiPCT) Overview. Available at: <https://mipctdemo.files.wordpress.com/2011/05/mipct-fact-sheet-2016.docx>; MiPCT Project Frequently Asked Questions. Available at: <http://www.mipcc.org/sites/mipcc.org/files/u4/MiPCT%20FAQ%209%206%2011.pdf>; Share, David A., and Margaret H. Mason. "Michigan's Physician Group Incentive Program offers a regional model for incremental 'fee for value' payment reform." *Health Affairs* 31.9 (2012): 1993-2001. Available at: <http://content.healthaffairs.org/content/31/9/1993.full.pdf>; Lemak, Christy Harris, et al. "Michigan's fee-for-value physician incentive program reduces spending and improves quality in primary care." *Health Affairs* 34.4 (2015): 645-652. Available at: <http://content.healthaffairs.org/content/34/4/645.full.pdf+html>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.18 Blue Cross Blue Shield of Minnesota Aligned Incentive Contracts

Model Name: Blue Cross Blue Shield of Minnesota Aligned Incentive Contracts	
Brief Description: The Aligned Incentive Contracts (AIC) program transitions participating integrated care systems from traditional fee-for-service contracts to three-year contracts with reimbursement based on a combination of fee for service, quality, and total cost of care payments.	
Developer: Blue Cross and Blue Shield of Minnesota	
What is the goal of this payment model?	The goal of the Aligned Incentive Contracts (AIC) model is to create a pay-for-value payment partnership with integrated care delivery systems, ultimately aligning incentives around value.
How long has this payment model been in operation? Where has it been implemented?	AIC was implemented January 1, 2011, with contracts starting at least one year later. Currently, 10 integrated care delivery systems are participating in AIC: CentraCare, North Memorial, Allina, Essentia Health, Fairview, Park Nicollet, HealthEast Care System, Family Health Services Minnesota, University of Minnesota Physicians, and Sanford Health. These care systems represent 33% of Blue Cross Blue Shield Minnesota’s total statewide volume and 65% of metro volume.
Type(s) of health care services, medical conditions, and health care settings addressed?	The AIC model transitions participating integrated care systems from the standard volume-based fee-for-service model to an accountable care model that rewards providers based on improving patients’ health outcomes and effectively managing the cost of care for all patients. The four key aspects of the AIC program are: <ol style="list-style-type: none"> 1. Generate provider buy-in on details of total cost of care measurement and quality outcomes 2. Establish payment incentives tied to lowering the total cost of care and improving quality with appropriate shared risk and reward 3. Enable provider competition based upon performance via products which feature providers with low total cost of care and transparency tools for members 4. Provide actionable data, analytics, and tools to assist providers in lowering the total cost of care
Types of patients included?	Approximately 370,000 attributed BCBS members in the 10 care systems that contract through AIC.
Method of attributing patients to participating providers	Patients are attributed to care systems in a retrospective and passive method, based on their majority of E&M visits by a PCP
Types of providers participating in the payment model?	Primary care physicians, RNs/NP and other non-physician providers, hospital inpatient, integrated hospital systems, and other providers
The entity accountable to the payer?	Integrated care delivery systems

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Minnesota Aligned Incentive Contracts	
The entity receiving payment from the payer (if different from above)?	Same
How are providers paid under the payment model?	<p>Providers enter into three-year contracts with reimbursement based on a combination of fee-for-service, quality, and total cost of care payments. Over time, more of the payment becomes based on quality and total cost of care payments and less based on fee for service payments.</p> <p>BCBSMN provides a risk-adjusted PMPM (calculated as the aggregate attributed member payments) along with an allowed trend for attributed members' TCOC (calculated as the aggregate price, type, and volume of services, regardless of setting). If the provider's actual per member per month payment for those attributed members is below the PMPM target, the provider is eligible to receive a share of those savings.</p>
Are there any performance metrics? If so, what is being measured?	<p>In addition to the total cost of care targets set for shared savings, initial quality improvement metrics included:</p> <ul style="list-style-type: none"> • Chronic Illness <ul style="list-style-type: none"> ○ Optimal diabetic care (composite measure) ○ Optimal vascular care (composite measure) ○ Hypertension control • Prevention & Wellness <ul style="list-style-type: none"> ○ Breast cancer screening ○ Colorectal cancer screening ○ Body mass index (measurement and referral) ○ Tobacco cessation (measurement and referral) • Patient Care Integration <ul style="list-style-type: none"> ○ Depression remission rate • Safety <ul style="list-style-type: none"> ○ Reduction of elective deliveries < 39 weeks ○ Reduction in elective C-sections ○ Hospital-associated deep vein thrombosis/pulmonary embolus ○ Pulmonary embolism for knee and hip replacement • Utilization <ul style="list-style-type: none"> ○ Potentially preventable events: admissions, readmissions, complications ○ Low back pain (MRI, CT, X-ray utilization) ○ Advanced care directives <p>Starting in 2014, BCBS moved to align more with community standards such as the Minnesota Community Measurement quality metrics. In addition, the quality program has been streamlined to include fewer measures so providers can have more targeted efforts. These updated performance measures include:</p> <ul style="list-style-type: none"> • Potentially preventable admissions • Potentially preventable readmissions • Potentially preventable complications

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Blue Cross Blue Shield of Minnesota Aligned Incentive Contracts	
	<ul style="list-style-type: none"> • Potentially preventable ER visits • Optimal management of diabetes • Optimal management of vascular care • Optimal management of depression • Optimal management of asthma • Colon cancer screening
Are there any performance incentives? If so, what is being incentivized?	Provider performance is further incentivized, as BCBS is establishing financial disincentives for members to use low performing providers, such as higher co-pays and transparency tools for members.
How do incentives operate?	Provider performance on quality metrics and provider outcomes improvement determine quality payments to providers.
Is this a stand-alone payment model or is it used with other payment models?	This payment model builds on the fee-for-service model.
Has the model been evaluated? Who funded this evaluation?	Internal analyses have found that from 2011-2015, AIC reduced overall medical costs by approximately \$73.2 million after paying provider incentives, while increasing key measures of better health outcomes for patients.
Other pertinent information	<p>BCBS has developed a roadmap to data integration and information exchange between the providers and the payer. This includes technologies to increase accessibility and use of more and different data to better manage costs, improve efficiency and make the most of financial and clinical outcomes. The plan is also advancing its health management and data analytics capabilities and increasing the number of data integration points with third parties.</p> <p>Data analytics is evolving from static reports and retrospective and transactional claims data to providing reports that share claims and payment discrepancies, reviews case management and practice utilization patterns and maximizes preventive care opportunities. These new data sets also allow employers to understand and anticipate how to better manage future healthcare system use by their employees.</p>

The above information was excerpted or summarized from these sources:

Eppel, J. "The Role of Payment Reform in the Transformation of the HealthCare System. Blue Cross and Blue Shield of Minnesota. Presented at the 2012 American & German Healthcare Experts Forum. Available at: http://cges.umn.edu/docs/Eppel_RoleofPaymentReformintheTransformationoftheHealthCareSystemNov2012.pdf;
 Healthcare Finance Staff. "Minnesota Blue's new contracting model geared toward ACO development." *Healthcare Finance News*. November 10, 2011. Available at: <http://www.healthcarefinancenews.com/news/minnesota-blues-new-contracting-model-geared-toward-aco-development>;
 National Campaign on Payment Reform. Program Details. Available at: <http://compendium.catalyzepaymentreform.org/compendium-search/4612/22634>;
 Freedman, WM. "How the Affordable Care Act is Driving Change Across the Health Care Landscape." Presented at Atrium Medical Center Foundation 16th Annual Estate & Tax Planning Seminar November 14, 2014. Available at:

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

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EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.19 Boeing’s Preferred Partnership

Model Name: Boeing’s Preferred Partnership	
Brief Description: Boeing has implemented an employer-led ACO under which they directly contract with high performing health care systems (without involvement of an insurance company other than for administrative purposes). Once the employees and their dependents select their health plan, they can choose to participate in the ACO by opting for the “Preferred Partnership” option. Members selecting the option have better access to care, pay reduced or no copays when they receive care at the partner organizations and also do not need referrals to see specialists. Selecting this option is voluntary but has financial incentives compared to the traditional broader network plan that Boeing still offers its employees. Boeing launched the program in the Washington State’s Puget Sound area where it tied up with two hospital networks — Providence-Swedish Health Alliance and UW Medicine Accountable Care Network. The media and Boeing officials often describe this payment model as an ACO, but the shared savings approach and the quality metrics providers are required to achieve to trigger those saving (that often define the incentives ACOs face) are not available in online sources.	
Developer: Boeing	
What is the goal of this payment model?	The goal is to provide better care for Boeing employees at more affordable prices. According to Boeing, their priorities align around the Triple Aim: improving the member experience, achieving better- quality outcomes, and lowering costs. From a benefits perspective, the goal of the Preferred Partnership program, according to Boeing, was to maintain employee choice, at the point of service and in health plan selection, and to make the choice as simple as possible.
How long has this payment model been in operation? Where has it been implemented?	The Preferred Partnership model has been or will be implemented in: <ol style="list-style-type: none"> 1) Puget Sound, Washington (2015) 2) St. Louis, Missouri (2016) 3) Charleston, South Carolina (2016) 4) Southern California (2017)
Type(s) of health care services, medical conditions, and health care settings addressed?	For Boeing’s employees and their dependents, the Preferred Partnership option includes free primary care office visits (on most plans and includes internists, family medicine doctors, pediatricians, and obstetricians and gynecologists.), free generic drugs (on most plans), better access to preferred primary care providers and specialists, more after-hours care availability and dedicated care teams for complex medical situations and patients with chronic illnesses. Partner health care systems provide additional resources, such as dedicated call centers (24/7 nurse-lines) and websites that can be used for appointment scheduling, triage, prescriptions, bill payments, etc. Emergency services received anywhere are considered in-network.
Types of patients included?	Washington: The Boeing Preferred Partnership Plan is available in the Puget Sound region for non-union Boeing employees and their covered dependents, employees represented by the SPEEA Pilot/Instructors Unit (SPIU) and their covered dependents, and employees represented by the International Union of Operating Engineers Power Plant (IUOE 286 PP) and their covered dependents. Retirees of the groups listed above and their dependents are also eligible if not covered by Medicare. Missouri and South Carolina: The Preferred Partnership options are available to all Boeing nonunion employees in the Charleston area and the greater St. Louis area (including Maryville, Illinois)

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Boeing’s Preferred Partnership	
	<p>In Puget Sound, Boeing saw a 30% enrollment in year 1 and 35% in year 2. In St. Louis, MO, and Charleston, SC, enrollment in year 1 was 15%–30%.</p> <p>Southern California: All Boeing employees and their dependents in the Long Beach, South Bay and Orange County communities.</p>
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Primary care providers, specialists, urgent care facilities and hospitals that are part of the alliances with the program in Puget Sound, Washington (Providence-Swedish Health Alliance, UW Medicine Accountable Care Network), St. Louis, Missouri (Mercy Health Alliance), Charleston, South Carolina, (The Roper St. Francis Health Alliance), and Southern California (MemorialCare Health Alliance).
The entity accountable to the payer?	The partner entities as listed above are accountable to Boeing which directly contracts with the providers and uses Blue Cross Blue Shield as the plan administrator.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	On the HCP-LAN website, Boeing considers this model as an APM built on fee-for-service architecture, with upside gainsharing and downside risk.
Are there any performance metrics? If so, what is being measured?	Information on this is not available from online sources.
Are there any performance incentives? If so, what is being incentivized?	The partnering health care systems are incentivized to meet cost and quality performance targets for Boeing’s employees seeking care their centers, but these are not available from online sources.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	<i>Information is not currently publicly available.</i>
Has the model been evaluated? Who funded this evaluation?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Other pertinent information	<i>Information is not currently publicly available.</i>
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The above information was excerpted or summarized from these sources:

Boeing Preferred Partnerships, website: <http://www.healthpartnershioptions.com/SiteAssets/pub/index.html> ; Advisory Board Daily Briefing, “Boeing signs shared savings deal with Washington hospitals”, June 16, 2014, available at: <https://www.advisory.com/daily-briefing/2014/06/16/boeing-signs-shared-savings-deal-with-washington-hospitals>; HCP-LAN, “Contracting Directly with Health Systems to Achieve the Triple Aim: The Boeing Experience” Interview, March 7, 2016, available at: <https://hcp-lan.org/2016/03/contracting-directly-with-health-systems-to-achieve-the-triple-aim-the-boeing-experience/#1457376747062-bd445b21-e7d6> ; Boeing, “Preferred Partnership- Key Facts”, available at: http://www.pbgh.org/storage/documents/PreferredPartnership_KeyFacts.pdf; MemorialCare Health Systems, “Boeing and MemorialCare Health System Partner on Boeing’s First California Customized Health Plan Option Offering Better Benefits and Lower Costs for Boeing Employees and Their Families”, Press Release, June 21, 2016, available at: <http://www.memorialcare.org/about/pressroom/news/boeing-and-memorialcare-health-system-partner-boeing-first-california>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.20 Bridges to Care Program in Aurora, CO

Model Name: Bridges to Care Program in Aurora, CO	
Brief Description: The Bridges to Care program in Aurora, Colorado was funded by a CMMI Health Care Innovation Award. Through this care delivery intervention, patients who frequently visited the emergency department (ED) received eight home visits over a 60-day period after their last ED visit. Home visits were conducted by a primary care provider, behavioral health provider, clinical care coordinator, health coach, and/or a community health worker. Over a three year period, the program enrolled nearly 600 patients. One of the program leaders is quoted as saying that this care delivery model is being looked at by the American College of Emergency Physicians as the basis for a potential MACRA advanced payment model (APM).	
Developer: The program was developed by a coalition of five partner organizations in Aurora, CO: Metro Community Provider Network (the local FQHC), Doctors of the University of Colorado Hospital (UCH), Aurora Mental Health, Aurora Health Access (a community organization), and Together Colorado (another community organization). This model was based on the “Hotspotters” model developed by Jeffrey Brenner, MD of the Camden Coalition of Healthcare Providers in New Jersey.	
What is the goal of this payment model?	The goal of the program is to reduce emergency room and inpatient hospitalizations by identifying high utilizing patients and providing intensive services for 60 days after they leave the hospital. Goals include demonstrating cost savings associated with decreased use of the ER, increasing Medicaid enrollment, decreasing illness burden, transitioning patients from home visits to clinic visits, and establishing medical homes for patients.
How long has this payment model been in operation? Where has it been implemented?	<p>CMS funded the three-year implementation of this model from 2013-2015 (or perhaps 2011-2014, or 2012-2015 – sources vary).</p> <p>Five partners were involved:</p> <ul style="list-style-type: none"> -Together Colorado (community organization comprised of 120 congregations, schools and faith leaders) -Aurora Health Access (community organization of residents, professionals and public officials focused on creating a healthier Aurora) -Metro Community Provider Network (the only FQHC in Aurora) -Aurora Mental Health -Doctors of the University of Colorado Hospital <p>A central role was played by the Metro Community Provider Network (MCPN). The FQHC acted as the “care team” and coordinated care between the hospital and primary care and specialty providers. It hired the community health workers, social workers, and nurse practitioners involved in the project.</p>
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>Patients received a minimum of eight home visits from nurse practitioners and other staff, and received the following in-home services:</p> <ul style="list-style-type: none"> ○ Health coaching to promote healthy behavior lifestyle changes ○ Preventive care from a primary care provider ○ Care coordination and referrals to community resources ○ Health advocacy training to promote better delivery of health care services ○ Behavioral health assessment & interventions/referrals <p>A community organization called Together Colorado made 2 house visits “for relational conversations” (i.e., to explain to staff their story and understand their barriers to care) and to explain the larger vision and goals of the Bridges to Care</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Bridges to Care Program in Aurora, CO	
	program. After the 2 house visits, a representative from this organization invited patients to a meeting with other patients to share stories and talk about the barriers to health care access in Aurora. Upon “graduating” from the program, patients were invited to join the community organization’s Health Care Committee.
Types of patients included?	The program recruited high utilizers of the emergency department at University of Colorado Hospital. Specifically, adults with 3 or more visits to the ED in 6 months (excluding patients with chief complaints related to acute mental health and substance abuse conditions, end stage chronic disease, and pregnancy). One source indicated that patients with 2 or more hospital admissions in the past 6 months were also included. The program hoped to enroll 150 patients in its first year, and 900 by the end of the 3 years. The program ultimately enrolled almost 600 patients.
Method of attributing patients to participating providers	To identify patients, a Bridges to Care community health worker worked in the University of Colorado Hospital ED and had access to the EHR. When a patient with a flagged medical record arrived, the community health worker asked an ED physician or nurse for permission to approach the individual with information about the program, and made a note in the medical chart. If the patient agreed, the community health worker enrolled the patient in Bridges to Care and scheduled an appointment with an MCPN nurse practitioner.
Types of providers participating in the payment model?	During the 60-day period, services were provided by a multi-disciplinary team involving a: <ul style="list-style-type: none"> ○ Health coach ○ Primary care provider ○ Care coordinator ○ Community organizer ○ Behavioral health professional
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	This care delivery model was funded by a portion of a CMS Health Care Innovation Award; the portion used to fund this model was either \$3.3 million or \$4.2 million, depending on the source.
Are there any performance metrics? If so, what is being measured?	<i>Information is not currently publicly available.</i>
Are there any performance incentives? If so, what is being incentivized?	<i>Information is not currently publicly available.</i>
How do incentives operate?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Bridges to Care Program in Aurora, CO	
Is this a stand-alone payment model or is it used with other payment models?	Not applicable – this is not a payment model.
Has the model been evaluated? Who funded this evaluation?	MCPN contracted with Smith & Lehmann Consulting to evaluate the program. Their pre-post findings are cited below.
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Together Colorado, Bridges to Care Fact Sheet, available at: <http://www.togethercolorado.org/documents/Bridges-to-Care-Fact-Sheet.docx>; Smith & Lehmann Consulting, *Bridges to Care Program Evaluation Final Report*, Dec. 19, 2014, available at: <http://www.slideshare.net/JennaBagnallReilly/bridges-to-care-final-report-121914>; Wiler J, Bridges to Care:- A Multidisciplinary Care Coordination Developed To Improve The Health Of High Utilizers In Aurora, Colorado, available at: http://www.p4summitportal.com/assets/480/resources/wiler_ms11.pdf; Parks T, Testing new payment models: One pilot program’s success, *AMA Wire*, April 19, 2016, available at: <http://www.ama-assn.org/ama/ama-wire/post/testing-new-payment-models-one-pilot-programs-success>; CMS, Health Care Innovation Awards: Colorado, Aug. 23, 2016, available at: <https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Colorado.html>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.21 CalPERS Reference Pricing

Model Name: CalPERS Reference Pricing	
Brief Description: Starting in 2011, the California Public Employees Retirement System (CalPERS) incorporated reference pricing for routine hip and knee replacements into the health insurance benefit design of members enrolled in CalPERS’s Anthem PPO plan. CalPERS and Anthem determined that \$30,000 would be an appropriate upper limit to pay for hip and knee replacements: CalPERS members using a hospital that charged this price or less for these procedures paid coinsurance for the cost of the procedure, up to an out-of-pocket maximum of \$3,000; meanwhile, CalPERS members who selected a more expensive facility paid this cost-sharing plus the full cost of the procedure above the \$30,000 cap. (The reference price applies to the hospital facility fee only—not payments for the surgeon or other providers, such as physical therapists.) (CalPERS uses the same reference price for all regions in California.) To help CalPERS members identify lower-cost hospitals, CalPERS identified and informed members about hospitals that charged \$30,000 or less for these procedures. In 2012, CalPERS expanded reference pricing to facility payments for outpatient colonoscopies, cataract surgeries and arthroscopy. The rates were set at \$1,500 for colonoscopy, \$2,000 for cataract surgery and \$6,000 for arthroscopy. In the first two years after implementation, reference pricing saved CalPERS \$2.8 million for joint replacement surgery, \$1.3 million for cataract surgery, \$7.0 million for colonoscopy, and \$2.3 million for arthroscopy.	
Developer: CalPERS and Anthem	
What is the goal of this payment model?	The goal of reference pricing is to save money by giving enrollees an incentive to select a lower-priced provider, while also motivating higher-priced providers to lower their prices to retain market share. Reference pricing is typically used when there is high variation in prices charged by different providers coupled with low variation in quality across these providers.
How long has this payment model been in operation? Where has it been implemented?	This model was launched by CalPERS in 2011 for routine hip and knee replacements and in 2012 for outpatient colonoscopies, cataract surgeries and arthroscopy. In 2011, for routine hip and knee replacements, the program was launched in 45 “designated hospitals,” which was increased to 54 designated hospitals by 2012, after hospitals renegotiated contracts with Anthem to offer lower prices.
Type(s) of health care services, medical conditions, and health care settings addressed?	Non-emergency and non-complicated routine hip and knee replacements and outpatient colonoscopies, cataract surgeries and arthroscopy.
Types of patients included?	Active and retired public employees and their dependents enrolled in CalPERS’s PPO plan administered by Anthem Blue Cross of California.
Method of attributing patients to participating providers	Patient are attributed to the facility that performed their procedure using claims data.
Types of providers participating in the payment model?	For the hip and knee replacements, a list of “designated hospitals” was created by Anthem. For other procedures, ambulatory surgery centers were also included.
The entity accountable to the payer?	Provider organization (hospital or ambulatory surgical center)

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CalPERS Reference Pricing	
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Hospitals and ambulatory surgery centers are paid lower fees for the four services mentioned. They continue to bill Anthem on a fee-for-service basis, but Anthem only agrees to pay its cost-share up to the new reference price (e.g., \$30,000 for a hip replacement). Patients pay the remainder.
Are there any performance metrics? If so, what is being measured?	<p>Performance measures are used by CalPERS and Anthem to select “designated hospitals.” These hospitals met the following criteria:</p> <ul style="list-style-type: none"> - Procedure prices were less than \$30,000, - Quality was acceptable*, and - Collectively, the hospitals provided sufficient geographic dispersion. <p>*A hospital’s quality was ascertained with the help of Anthem. Quality measurements included:</p> <ul style="list-style-type: none"> - whether the facility had been accredited by a recognized quality accrediting entity, - whether it performed a sufficient number of joint replacement surgeries annually (because surgical volume is associated with positive outcomes), - its scores on the surgical prevention indicators reported by hospitals to the Joint Commission, and - its participation in the California hospital quality reporting system and its results reported by that system.
Are there any performance incentives? If so, what is being incentivized?	Hospitals have an incentive to reduce the price of their procedures to retain market share.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This is a fee-for-service payment model. Providers bill Anthem and patients on a fee-for-service basis for procedures, just as they would for any other procedure.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CalPERS Reference Pricing	
Has the model been evaluated? Who funded this evaluation?	Several evaluations of this payment approach have been published in peer-reviewed journals. A 2015 <i>Health Affairs</i> article studied cataract removal surgery, and found that CalPERS’s adoption of reference-based pricing increased ambulatory surgery center use by 8.6% and decreased payments per procedure by 19.7% compared to trends among Anthem Blue Cross plans (which did not use reference-based pricing), after adjusting for differences between these two patient populations – saving CalPERS \$1.3 million in the two years after implementation. That same year, a <i>JAMA Internal Medicine</i> article reported savings of \$7 million on colonoscopies, and a 2013 <i>Health Affairs</i> article reported that CalPERS members shifted from using high-cost to low-cost facilities and saved CalPERS \$2.8 million in the first year that reference-based pricing was used for knee and hip replacement surgery.
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Lechner AE, Gourevitch R, and Ginsburg P, The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer, HSC Research Brief No. 30, December 2013, available at: <http://www.hschange.org/CONTENT/1397/>; Robinson JC and Brown TT, “Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery”, *Health Affairs*, 2013; 32(8):1392-1397, available at: <http://content.healthaffairs.org/content/32/8/1392.full.pdf+html>; Robinson JC, Brown TT, and Whaley C, “Reference-Based Benefit Design Changes Consumers’ Choices And Employers’ Payments For Ambulatory Surgery” *Health Affairs*, 2015; 34(3):415-422, available at: <http://content.healthaffairs.org/content/34/3/415.full.pdf+html>; Robinson JC, Brown TT, Whaley C, Finlayson E, “Association of Reference Payment for Colonoscopy With Consumer Choices, Insurer Spending, and Procedural Complications,” *JAMA Internal Medicine*, 2015;175(11):1783-1789, available at: <http://archinte.jamanetwork.com/article.aspx?articleid=2434733>; Boynton A and Robinson JC, Appropriate Use Of Reference Pricing Can Increase Value, *Health Affairs Blog*, July 7, 2015, available at: <http://healthaffairs.org/blog/2015/07/07/appropriate-use-of-reference-pricing-can-increase-value/>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.22 CalPERS Sacramento ACO

Model Name: CalPERS Sacramento ACO	
Brief Description: This ACO, formed in 2010, is considered one of the longest-running commercial ACOs in the country. Each year, it sets a global spending target (covering the total cost of all health care provided) for 41,000 patients insured through the California Public Employees Retirement System (CalPERS) who are enrolled in Blue Shield’s HMO plan in the Sacramento area and receiving their care from Hill Physician Medical Group IPA’s primary care practices. Hill Physicians IPA and the hospital system that they refer most of their patients to, Dignity Health, continue to be paid by Blue Shield under pre-existing payment approaches (i.e., capitation and fee-for-service, respectively), but actual total spending for Hill’s patients is reconciled against the global spending target at the end of each year. Savings or cost over-runs are then shared between the IPA, the hospital system, and Blue Shield. Each of these organizations’ shares of savings or cost over-runs are commensurate with their premium share and their ability to influence spending in each of several cost categories: partner hospital, out-of-area non-partner hospital, other non-partner hospital, professional, mental health, pharmacy, and ancillary care services. (See “Exhibit 2” at end of this profile.) To reduce spending, the three organizations have worked together to analyze data and develop and implement numerous care delivery interventions (see “Other” row at end of this profile). This is a “virtual” ACO model since the IPA, hospital system, and Blue Shield did not set up a separate joint legal entity for this venture. The parties claim that from 2010-2013, they generated over \$105 million in gross savings and earned \$10.36 million in shared savings payments, leaving net savings for CalPERS of nearly \$95 million over the ACO’s first 4 years.	
Developer: Blue Shield of California; Hill Physician Medical Group (Northern California’s largest independent practice association (IPA), with 600 physicians practicing in the Sacramento area); Dignity Health, with 4 hospitals in the Sacramento area).	
What is the goal of this payment model?	The ACO partners aimed to collectively reduce spending and bring Blue Shield’s premiums for CalPERS members below those of their main competitor, Kaiser Permanente. More specifically, the ACO’s goals were also to: <ul style="list-style-type: none"> - Deliver cost savings and an immediate premium credit to CalPERS by reducing the growth in the cost of health care from 10 percent to 0 percent in the first year. - Grow the organization’s membership by attracting new public agencies to contract with CalPERS for health benefits and increasing enrollment for the partners in the pilot. - Maintain or, if possible, improve the quality of health care provided by the three partners. According to the agreement signed by the partners, no cost containment initiative could be launched if it was expected to have a negative impact on quality. - Create a sustainable model for expansion to other geographic areas.
How long has this payment model been in operation? Where has it been implemented?	This ACO first began operating in 2010 in the Sacramento area of northern California.
Type(s) of health care services, medical conditions, and health care settings addressed?	The ACO’s participating organizations are responsible for the cost of all health care provided to its 41,000 CalPERS members, including services provided by partner (Dignity) hospitals, out-of-area non-partner (non-Dignity) hospitals, other non-partner (non-Dignity) hospitals, professional services, mental health services, pharmacy, and ancillary care services.
Types of patients included?	The population served by this virtual ACO consists of approximately 41,000 CalPERS members covered by Blue Shield’s HMO plan in the Sacramento area who receive their primary care from Hill Physicians Medical Group IPA’s primary care practices.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CalPERS Sacramento ACO	
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Primary care practice staff in the Hill Physicians IPA and Dignity Health hospital staff in the Sacramento area.
The entity accountable to the payer?	Hill Physicians IPA and Dignity Health hospital system are accountable, along with Blue Shield of California, for meeting spending targets while avoiding reductions in quality.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>Each year, the ACO partners sets a global spending target (covering the total cost of all health care provided). Dignity Health hospitals and Hill Physicians IPA practices continue to be paid by Blue Shield under pre-existing payment approaches (i.e., fee-for-service and capitation, respectively). At the end of the year, actual total spending for Hill’s attributed patients is reconciled against the global spending target, and savings or cost over-runs are then calculated and shared between the IPA, the Dignity Health hospital system, and Blue Shield (i.e., Blue Shield pays shared savings payments to, or collects payments from, Hill Physicians IPA and Dignity Health). Each of these organizations’ shares of savings or cost over-runs are commensurate with their relative share of historical costs and their ability to influence spending in each of the several cost categories identified above. (See “Exhibit 2” below for specific spending targets and savings/liabilities shares for each organization in 2010 – reproduced from the <i>Health Affairs</i> article cited below.)</p> <p>Hill Physicians IPA uses its capitated payments from Blue Shield to pay providers on a fee-for-service basis, with base reimbursements to primary care physicians set at 85% of fee-for-service Medicare rates. Performance-based bonuses enable top-performing physicians to earn as much as 150% of Medicare rates, while average performers earn around 120%.</p>
Are there any performance metrics? If so, what is being measured?	<p>The ACO produces a monthly, high level dashboard of key financial and utilization metrics and other information needed to manage. Some examples of measures that are monitored include:</p> <ul style="list-style-type: none"> - The per member per month cost - 30-day readmission rates - Average length of stay - Total inpatient days - Costs in following categories: facility costs, professional costs, mental health costs, pharmacy costs, and ancillary costs.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CalPERS Sacramento ACO	
Are there any performance incentives? If so, what is being incentivized?	Hill Physicians IPA has an incentive to encourage primary care practices to attempt to lower the total cost of their patients' care (e.g., by coordinating their patients' care with other providers to avoid unnecessary care and preventable hospital admissions and ED visits). Dignity Health hospitals have an incentive to encourage their staff to lower the total cost of their patients' care (e.g., by adhering to evidence-based clinical guidelines to avoid unnecessary care, and coordinating with primary care practices to ensure smooth transitions out of the hospital). Blue Shield has an incentive to share useful claims data with Hill Physicians IPA and Dignity Health hospitals (e.g., data showing when ACO patients are admitted to non-Dignity hospitals – which Dignity then uses to identify these patients and repatriate them to a Dignity hospital, once patients are stabilized).
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This payment model is layered on top of existing payment approaches. Blue Shield continues to pay Hill Physicians IPA practices on a capitated basis and Dignity Health hospitals on a fee-for-service basis.
Has the model been evaluated? Who funded this evaluation?	Blue Shield of California engaged Milliman (an actuarial and consulting firm), to evaluate the results of the ACO's first year, which are reported in the <i>Health Affairs</i> article cited below. Milliman found that the ACO's spending was 10% lower than Northern California CalPERS members not in the ACO. CalPERS members' expenditures in the ACO decreased by 1.6%, while expenditures for Northern California CalPERS members <i>not</i> in the ACO increased by 9.9%. Milliman also found an unexplained increase in ED visits in the ACO.
Other pertinent information	The numerous care delivery interventions that this ACO has pursued are clustered in five areas: improving information exchange; coordinating processes such as hospital discharge planning; eliminating unnecessary care; reducing variation in practice and resources; and reducing pharmacy costs. Examples of interventions implemented include: a standardized hospital discharge procedure to improve care transitions; assigning Hill IPA hospitalists to Dignity hospitals and Hill physicians to skilled nursing facilities to prevent hospital admissions; adhering to evidence-based guidelines (e.g., for surgeries, managing inpatient stays, treating sepsis and pneumonia); developing a chronic pain case management program aimed at reducing pharmacy costs and ED visits; creating "virtual care teams" (composed of a pharmacist, social worker, health coach, and nurse case manager) to help primary care physicians manage the complex clinical and psychosocial needs of patients with chronic conditions, who amount to 12% of attributed patients but 75% of the ACO's overall costs.

The above information was excerpted or summarized from these sources:

Melnick G and Green L, "Four Years Into A Commercial ACO For CalPERS: Substantial Savings And Lessons Learned," *Health Affairs Blog*, April, 17, 2014, available at: <http://healthaffairs.org/blog/2014/04/17/four-years-into-a-commercial-aco-for-calpers-substantial-savings-and-lessons-learned/>; Melnick G and Green L, "Early Lessons From A Shared Risk, Integrated Care Organization Serving A Commercial Population," *Health Affairs Blog*, May, 15, 2012, available at: <http://healthaffairs.org/blog/2012/05/15/early-lessons-from-a-shared-risk-integrated-care-organization-serving-a-commercial-population/>; Markovich P, "A Global Budget Pilot Project Among Provider Partners And Blue Shield Of California Led To Savings In First Two Years," *Health Affairs*, 2012;31(9):1969-1976, available at: <http://content.healthaffairs.org/content/31/9/1969.abstract>; Cohen A, Klein S, and McCarthy D, "Hill Physicians Medical Group: A Market-Driven Approach to Accountable Care for Commercially Insured Patients," Oct. 2014, available at: http://www.commonwealthfund.org/~media/files/publications/case-study/2014/oct/1770_cohen_hill_physicians_aco_case_study.pdf.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

EXHIBIT 2

Allocation Of Risk For Three Partners In A Pilot Accountable Care Organization In California

Cost category	Per member per month target cost	Allocation of risk if actual costs fall above or below target cost		
		Dignity Health	Hill Physicians Medical Group	Blue Shield
Total facility				
Partner hospital	\$180	50.0%	25.0%	25.0%
Out-of-area nonpartner hospital	25	25.0	25.0	50.0
Other nonpartner hospital	45	30.0	30.0	40.0
Professional	125	30.0	35.0	35.0
Mental health	10	0.0	0.0	100.0
Pharmacy	55	33.3	33.3	33.3
Ancillary	10	25.0	25.0	50.0

SOURCE Blue Shield of California. **NOTES** Total facility target cost is \$250. Total target cost is \$450.

Exhibit 2 is excerpted from:

Markovich P, "A Global Budget Pilot Project Among Provider Partners And Blue Shield Of California Led To Savings In First Two Years," *Health Affairs*, 2012;31(9):1969-1976, available at:

<http://content.healthaffairs.org/content/31/9/1969.abstract>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.23 California Value-Based Pay-for-Performance (VBP4P) Program

Model Name: California Value-Based Pay-for-Performance (VBP4P) Program	
Brief Description: The Integrated Healthcare Association (IHA) has developed a recommended one-sided shared savings model (including an annually-updated recommended performance measure set) for commercial health insurers to use with contracted physician organizations (POs). This VBP4P program has four key components: a common set of measures and benchmarks; health plan incentive payments to POs; public reporting of PO results; and public recognition awards. IHA runs this program on behalf of ten commercial HMO/POS health insurers that insure 9 million Californians; IHA is responsible for collecting data, deploying a common measure set, and reporting results for 200 POs that includes approximately 35,000 physicians – although each insurer determines its own budget and methodology for calculating incentive payments to POs. IHA believes that the VBP4P program is one of the largest non-governmental alternative payment models in the country.	
Developer: IHA (a multi-stakeholder convening organization that seeks to advance high-quality, affordable, patient-centered care for consumers).	
What is the goal of this payment model?	According to IHA, adoption of common performance measures and benchmarks across health plans and physician organizations helps harness market forces to drive improvements in patient care. Additionally, aggregation of data across participating health plans significantly improves measurement reliability and validity and decreases reporting burden for physician organizations by eliminating competing and conflicting health plan rating systems.
How long has this payment model been in operation? Where has it been implemented?	The ACO-like VBP4P model was first implemented by a participating plan in 2014, and superseded a precursor IHA P4P program started in 2001. Today, participants include 10 health insurers and over 200 POs caring for over 9 million Californians enrolled in commercial health maintenance organization (HMO) and point of service (POS) plans.
Type(s) of health care services, medical conditions, and health care settings addressed?	Recommended measures for 2016 are in the following categories: “Clinical domain” (including cardiovascular, diabetes, maternity, musculoskeletal, prevention, respiratory, other services); and “Meaningful use of health IT domain;” “Patient experience domain” (including CAHPS questions); and “Appropriate resource use domain.” Services addressed include preventive screenings, chronic disease monitoring, behavioral health medication management, inpatient admissions, ED visits, labor and delivery, and various surgeries.
Types of patients included?	Californians enrolled in the 10 participating commercial health insurers’ HMO and POS plans.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	VBP4P is intended to be available to all POs that contract to participate in commercial HMO and POS plans with one or more health insurers participating in the program.
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: California Value-Based Pay-for-Performance (VBP4P) Program	
How are providers paid under the payment model?	IHA developed a recommended VBP4P payment model, which participating insurers are free to modify and implement or not implement as they see fit. The recommended payment model is a one-sided shared savings model with requirements that POs meet minimum quality standards, as well as demonstrate a total cost of care trend of no more than the CPI plus three percentage points, in order to earn shared savings payments. Additional advice and considerations for payers as they design their own VBP4P shared savings payment model are available in the “Value Based Pay for Performance Design” document and the “IHA Value Based P4P: Quality Composite Score Calculation” document cited below.
Are there any performance metrics? If so, what is being measured?	IHA’s VBP4P measures set is updated annually. Measure categories are discussed above in the “Types of services addressed” row, and lists of current and recent measure sets are available at the IHA “Measure Set” website cited below. One measure is discussed in its own fact sheet: the “Total cost of care (TCC)” measure. TCC measures actual payments associated with care provided to participating HMO/POS enrollees in a PO. Participating health plans report a single lump sum payment for each member of all contracted POs to a data aggregator; the lump sum includes both capitation and fee-for-service payments, as well as member co-payments, paid to the PO or any providers caring for its members (e.g., hospitals, pharmacies, ancillary providers). Per member costs above \$100,000 per year are truncated, and payments for mental health and chemical dependency services, acupuncture or chiropractic services, dental and vision services, and P4P quality incentive payments are excluded from the calculation. The TCC measure is risk-adjusted to account for the differences in the health status of the patient population using Verisk DxCG Relative Risk methodology, and geography-adjusted to account for differences in the price of inputs (using CMS’s Hospital Wage Index Geographic Adjustment Factor).
Are there any performance incentives? If so, what is being incentivized?	Incentive payments are currently tied to resource use <i>reductions</i> (although quality measure targets must also be met to qualify for shared savings payments). According to IHA, some high-performing POs have complained that there are no incentives to <i>maintain</i> already-low resource use, so IHA is considering an attainment incentive that would reward POs that reach targeted levels of resource use, even if no savings are generated in a given year. The program’s other incentives are related to public reporting and public recognition awards. IHA partners with the state of California’s Office of the Patient Advocate to publicly report performance results each year using standard specifications for measuring TCC, and IHA publicly recognizes the top performing and the most improved POs each year. POs have an incentive to perform highly on quality and cost measures since these results are made public. The VBP4P program’s public recognition awards recognize POs that demonstrate the highest levels of performance or the greatest year-over-year improvement in their region.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: California Value-Based Pay-for-Performance (VBP4P) Program	
Has the model been evaluated? Who funded this evaluation?	<i>Information is not currently publicly available.</i>
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Integrated Healthcare Association. California’s Value Based Pay For Performance Program. 2016 (webpage). Accessed August 2016 at: <http://www.iha.org/our-work/accountability/value-based-p4p>; Integrated Healthcare Association. Total Cost of Care: Measuring and Using Total Cost of Care Data in California. April 2015 (PDF document). Accessed August 2016 at: <http://www.iha.org/sites/default/files/resources/fact-sheet-total-cost-of-care-2015.pdf>; Integrated Healthcare Association. Measure Set. 2016 (webpage). Accessed August 2016 at: <http://www.iha.org/our-work/accountability/value-based-p4p/measure-set>; Integrated Healthcare Association. Value Based Pay for Performance Design. December 2014 (PDF document). Accessed August 2016 at: www.iha.org/sites/default/files/resources/value-based-p4p-design-update.pdf; Integrated Healthcare Association. Medicare Advantage Stars. 2016 (webpage). Accessed August 2016 at: <http://www.iha.org/our-work/accountability/medicare-advantage-stars>; Integrated Healthcare Association. Medi-Cal. 2016 (webpage). Accessed August 2016 at: <http://www.iha.org/our-work/accountability/medi-cal/standardizing-p4p>; Integrated Healthcare Association. Value Based Pay for Performance in California: Using Alternative Payment Models to Promote Health Care Quality and Affordability. September 2015 (PDF document). Accessed August 2016 at: <http://www.iha.org/sites/default/files/resources/fact-sheet-value-based-p4p-2015.pdf>; Integrated Healthcare Association. Value Based Pay for Performance in California. September 2013 (PDF document). Accessed August 2016 at: <http://www.iha.org/sites/default/files/resources/issue-brief-value-based-p4p-2013.pdf>; Integrated Healthcare Association. IHA Value Based P4P: Quality Composite Score Calculation. May 2016 (PDF document). Accessed August 2016 at: www.iha.org/sites/default/files/resources/my_2015_standard_payment_methodology_qcs_calculation.pdf; Integrated Healthcare Association. Awards. 2016 (webpage). Accessed August 2016 at: <http://www.iha.org/our-work/accountability/value-based-p4p/awards>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.24 Capital District Physicians’ Health Plan (CDPHP)’s Enhanced Primary Care (EPC) Program

Model Name: Capital District Physicians’ Health Plan (CDPHP)’s Enhanced Primary Care (EPC) Program	
Brief Description: CDPHP is a physician-led health plan in New York state that began offering this patient-centered medical home (PCMH)-focused payment model in 2008. In the first year of the model, practices that choose to participate receive a \$20,000 stipend to support time spent adopting the PCMH model. At the end of a year-long PCMH transformation program, practices become eligible to receive a monthly risk-adjusted capitated fee for primary care services per eligible member, and become eligible for an up to 20% pay-for-performance bonus opportunity.	
Developer: Capital District Physicians' Health Plan (CDPHP)	
What is the goal of this payment model?	The guiding principal of the EPC model is that each patient has an ongoing relationship with a primary care practice (PCP) that delivers continuous, comprehensive, and coordinated care. The mission of CDPHP’s PCMH approach is to create an innovative and sustainable model for the reimbursement of primary care physicians that leads to a resurgence in the interest in primary care medicine as a career for medical students. CDPHP hops to accomplish this while demonstrating better health outcomes and market-leading satisfaction scores for patients, employers, and physicians.
How long has this payment model been in operation? Where has it been implemented?	CDPHP has been using this payment model since 2008. As of June 2015, 836 clinicians in 193 practices in New York state were participating in this payment model.
Type(s) of health care services, medical conditions, and health care settings addressed?	CDPHP’s risk-adjusted global payment for primary care services “accounts for the vast majority of codes for which CDPHP reimburses.” The plan continues to use fee-for-service payment for a small set of services that are outside of the capitation code list, such as immunizations and skin biopsies.
Types of patients included?	CDPHP members enrolled in a commercial (HMO or non-HMO), Medicaid, or Medicare plan – but not CDPHP members covered by a Capital District Physicians’ Healthcare Network, Inc. (CDPHN) self-insured plan, and not members in a Medicare Supplemental plan.
Method of attributing patients to participating providers	CDPHP members are attributed to a particular practitioner based on evaluation & management claims in the past 24 months. The member is assigned to the provider entity who: (1) rendered the most E&M services; or (2) rendered the most preventive services; or (3) was the attributed entity for the previous month; or (4) had the highest total allowed dollars; or (5) performed the most recent service. (The first of these rules that can be met by an entity determines the relationship.) Members’ attribution is prospectively determined using this historical data at the beginning of each month.
Types of providers participating in the payment model?	Primary care providers in CDPHP’s provider network who voluntarily choose to participate.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Capital District Physicians' Health Plan (CDPHP)'s Enhanced Primary Care (EPC) Program	
The entity accountable to the payer?	Same as above.
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>In the first year of this payment model, CDPHP pays primary care practices a \$20,000 stipend to support their time away from the practice engaging in: leadership and cultural assessments by CDPHP; and four learning collaboratives that facilitate the sharing of best practices among provider groups and provide additional education.</p> <p>At the end of the year-long transformation program, practices receive a monthly risk-adjusted capitated fee for primary care services per eligible member. CDPHP calculates these payments based on patients' prior diagnoses. (Sample payment rates provided by CDPHP for members aged 18 and over ranged from \$11.30 to \$28.70 PMPM, but may not represent the minimum and maximum payment rates available. Sample payment rates for members under the age of 18 include a base rate that ranged from \$7.96 to \$9.12 – but again, may not represent the minimum and maximum rates available – plus a risk-adjusted case management fee that ranged from \$1.00-\$10.00.) Participating providers receiving these primary care capitation payments are still required to submit claims, to allow CDPHP to accurately assign claims-based risk adjustment scores to patients and to ensure that patients are attributed to the correct provider.</p> <p>Participating providers also become eligible for an up to 20% pay-for-performance bonus opportunity based on their performance on various measures (described in “Are there any performance metrics?” below.)</p> <p>In addition to these payments, CDPHP has provided “substantial” financial support for practices to acquire electronic health record systems, establish connections to the local health information exchange and achieve meaningful use designation.</p>
Are there any performance metrics? If so, what is being measured?	<p>Cost or efficiency is assessed using a risk-adjusted relative utilization of health care resources in six categories: inpatient hospital, emergency room, medical imaging, pharmacy, laboratory and specialists. CDPHP uses a risk-adjusted total cost of care assessment that creates an index of practice performance compared to the other practices in the network. The practice is then assigned a rank of its efficiency performance, which creates an <i>efficiency score</i>.</p> <p>Quality is assessed using HEDIS metrics or composites in four categories: population health and prevention, management of chronic conditions, use of antibiotics and behavioral health, as well as an experience of care composite of ten patient experience questions. CDPHP creates an aggregate quality score by creating a ratio of the sum of the numerators to the sum of the denominators in these measures. This aggregate quality score is then assigned a percentile rank, which creates an <i>effectiveness score</i>.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Capital District Physicians' Health Plan (CDPHP)'s Enhanced Primary Care (EPC) Program	
Are there any performance incentives? If so, what is being incentivized?	Participating primary care practices have an incentive to adopt the PCMH model of care in order to become eligible to receive monthly primary care capitation payments. They also have an incentive to reduce spending on categories of services included in the “efficiency score” mentioned above, and to increase delivery of the services included in the “effectiveness score” above, in order to receive up to a 20% pay-for-performance bonus.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This payment model relies on primary care practices continuing to submit fee-for-service claims to allow CDPHP to accurately assign claims-based risk adjustment scores to patients, to ensure that patients are attributed to the correct provider, and to allow CDPHP to calculate quality and utilization measures that are used to determine pay-for-performance bonuses. In addition, practices must continue to bill on a fee-for-service basis for certain services that are excluded from the primary care capitation payments (e.g., immunizations and skin biopsies).
Has the model been evaluated? Who funded this evaluation?	<p>In 2014, an internal analysis using a matched comparison group reported that CDPHP realized cost savings of \$20.7 million directly related to the EPC program (\$17.11 per EPC member per month). Approximately 60 percent of this savings was experienced by members within the commercial market, while approximately 20 percent was experienced by the sickest 10 percent of members in the Medicaid and Medicare markets.</p> <p>The actual rate of visits for healthy members decreased as physicians found alternate ways of providing necessary care, such as telehealth or group visits. At the same time, the rate of visits went up for those with the greatest need — those covered by Medicaid and Medicare and the sickest 10 percent of the population.</p> <p>EPC providers received an estimated \$12.8 million more in reimbursements and enhanced bonuses than if they had not participated in the program. Primary care services cost an additional \$10.7 million (\$8.91 PMPM) in 2014. This increase was offset by reductions of \$11.4 million (\$9.46 PMPM) for outpatient services and \$4.1 million (\$3.35 PMPM) for prescription drugs, among other categories.</p> <p>From 2010 to 2014, EPC sites also achieved larger gains on a series of quality measures (e.g., breast and colorectal cancer screenings, childhood immunizations, childhood well visits) than matched comparison practices.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Capital District Physicians' Health Plan (CDPHP)'s Enhanced Primary Care (EPC) Program	
Other pertinent information	<p>Investments by CDPHP: CDPHP made infrastructure investments for transformation in order to build the capability to coach physician practices. CDPHP invested in resources such as a performance management department and additional analytics experts to support practices in the program. This support includes:</p> <ul style="list-style-type: none"> - Engagement and training to achieve a cultural shift across organizational boundaries, to create a more collaborative, patient-centered approach. - Coaching and support of primary care practices to achieve NCQA Level 3 Patient-Centered Medical Home recognition, a critical milestone in New York for practices to receive value-based payments. - Engagement with practices to help them identify and promote opportunities and provide assistance with the clinical integration of care management. <p>Experience has shown that practices, overwhelmed with day-to-day operations, often do not take the initiative to access the performance data. To address this, CDPHP proactively provides them with the reports and highlights recommendations for specific areas of focus, such as lowering number of visits to the emergency room or improving medication adherence. Together, CDPHP and the practice use the data to develop detailed goals for improvement.</p> <p>In addition, CDPHP staff members from the clinical areas of case and disease management, behavioral health, and pharmacy are sometimes embedded within practices to assist in coordination of care.</p>

The above information was excerpted or summarized from these sources:

CDPHP, Enhanced Primary Care, available at: <https://www.cdphp.com/providers/programs/enhanced-primary-care> ; CDPHP, [Enhanced Primary Care: Primary Care for a New Era](#), available at: https://www.cdphp.com/~media/files/employers/epc_employer_brochure.pdf; CDPHP, CDPHP Enhanced Primary Care (EPC) Initiative, available at: <https://www.cdphp.com/~media/files/providers/epc/enhanced-primary-care-summary.pdf>; CDPHP, Enhanced Primary Care: Practice Transformation, available at: <https://www.cdphp.com/~media/files/providers/epc/enhanced-primary-care-practice-transformation.pdf>; CDPHP, Section 21 Enhanced Primary Care, Oct. 2015, available at: <https://www.cdphp.com/~media/files/providers/poam/section-21-enhanced-primary-care-epc.pdf>; Alliance of Community Health Plans, Strengthening Primary Care for Patients: Capital District Physicians' Health Plan, Inc., Albany, NY, 2013, available at: <http://www.achp.org/wp-content/uploads/CDPHP-ACHP-Strengthening-Primary-Care-Profile.pdf>; CDPHP, CDPHP Enhanced Primary Care (EPC) Initiative, available at: <https://www.cdphp.com/~media/files/providers/epc/enhanced-primary-care-summary.pdf?la=en>; Wood EF, Enhanced Primary Care: The CDPHP Medical Home, available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_workshops/september_17-18_2015/evolving_role_of_mcos/docs/cdphp.pdf; Alliance of Community Health Plans, Rewarding High Quality: Practical Models for Value-Based Physician Payment, April 20, 2016, available at: http://www.achp.org/wp-content/uploads/ACHP-Report-Rewarding-High-Quality_4.20.16.pdf.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.25 CareFirst (of Maryland, DC, & Northern Virginia) Patient-Centered Medical Home Program

Model Name: CareFirst BlueCross BlueShield’s Patient-Centered Medical Home (PCMH) Program	
<p>Brief Description: Primary care physicians (PCPs) and nurse practitioners (NPs) who agree to form “panels” of 5-15 providers can participate in CareFirst’s PCMH Program. Through the program, panels can earn shared savings add-on payments to their fee-for-service rates if their attributed patients’ total health care spending is below their spending target. Panels must also meet a range of structural, process, and outcome measure targets to qualify for these payments, and agree to various participation requirements (e.g., to only refer to other providers in the CareFirst network). Providers do not have to pay CareFirst if costs exceed their spending target – they take on no financial risk in this model.</p> <p>Providers also are eligible to receive new \$200 fees for developing a Care Plan for patients identified by CareFirst as having a high Illness Burden Score, and \$100 fees for Care Plan maintenance at periodic review visits (on top of regular fees for these visits).</p> <p>As of the end of 2015, nearly 1.2 million CareFirst enrollees in Maryland, D.C., and northern Virginia were in this PCMH Program, being served by more than 4,000 primary care physicians (PCPs) and nurse practitioners (NPs). The program started in 2011, and in 2013 was expanded to 35,000 Medicare FFS beneficiaries in 14 of its panels, using funding from a CMMI Health Care Innovation Award (HCIA). If successful, CareFirst’s goal is to expand participation to all Medicare FFS beneficiaries served by participating providers.</p>	
Developer: CareFirst BlueCross BlueShield and CareFirst BlueChoice (“CareFirst”)	
What is the goal of this payment model?	The goal of the CareFirst PCMH Program is to address the continuing increases in health care costs occurring in its service area. Its intent is to focus on root causes of suboptimal quality and continuing cost growth. Its purpose is to reward PCPs for providing, arranging, coordinating, and managing high-quality, efficient, and cost-effective health care services.
How long has this payment model been in operation? Where has it been implemented?	The program was launched in January 2011 in Maryland, northern Virginia, and the District of Columbia. As of the end of 2015, more than 4,000 primary care physicians (PCPs) and nurse practitioners (NPs) were participating in the program, serving nearly 1.2 million CareFirst Members in this area. In 2013, CareFirst began a Medicare pilot involving 14 panels serving 35,000 Medicare FFS beneficiaries, paid for using CMMI HCIA funds.
Type(s) of health care services, medical conditions, and health care settings addressed	“Panels” of PCPs and NPs are held financially responsible for health care costs from all health care settings incurred by patients in their panel.
Types of patients included	Patients included in panels are CareFirst members insured through individual policies, small and mid-sized employer policies, the Federal Employees Health Benefit Plan, and some large administrative-services only (ASO) self-insured employers.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CareFirst BlueCross BlueShield’s Patient-Centered Medical Home (PCMH) Program	
Method of attributing patient to participating providers	CareFirst members are attributed to participating PCPs and NPs each month, based on the following criteria: 1) the primary care provider that the member selected within the last six months; or 2) if none selected, the primary care provider that the member visited most frequently for primary care services in the past year; or 3) if none visited in the past year, the primary care provider most visited in the year before that. If a member has an active Care Plan established with a primary care provider, all prior steps are overridden and the member is attributed to that provider. A patient can also be attributed to a provider if the provider finds that the member is missing from their attribution list and brings it to the attention of the plan.
Types of providers participating in the payment model	PCPs and NPs in good standing and contracted to render services in both the CareFirst BlueChoice Participating Provider Network (HMO) and CareFirst Regional Participating Preferred Network (RPN) are eligible to participate in this program. Such providers must agree to form “panels” of 5-15 providers that agree to be collectively held responsible for the cost and quality of their attributed patients’ care. PCPs and NPs in small practices can form “virtual” panels by reaching out to other PCPs and NPs in other practices to meet the minimum panel requirement of 5 providers (while still remaining separate legal entities). Conversely, PCPs and NPs in large practices or employed by health systems must organize themselves into panels of 5-15 providers. PCPs and NPs who work in a multi-specialty group practice but mainly deliver primary care may form a panel to participate in this program.
The entity accountable to the payer	“Panels” of 5-15 PCPs and/or NPs, described above.
The entity receiving payment from the payer (if different from above)	Same as above.
How are providers paid under the payment model?	<p>Participating providers who form a panel are converted to being paid using a different, budget-neutral base payment approach, involving: a lower base fee schedule, plus a 12%-point “participation fee” added on to each fee-for-service payment. (This lower base fee plus the 12%-point participation fee is equivalent to what their fee schedule rates were before they joined the PCMH program – so if providers earn no shared savings add-on payments, they will be no worse off financially for having participated in this program.) Providers bill CareFirst on a fee-for-service basis throughout the year. At the end of the year, if the total cost of all care received by a panel’s attributed CareFirst patients is lower than the panel’s spending target (described below), the panel is eligible to receive a shared savings add-on payment to the following year’s fee-for-service rates.</p> <p>Spending targets are set by calculating health care spending in all settings for attributed patients in the year prior to entry into the program, which is then trended forward to subsequent years using CareFirst’s “overall medical trend” (the expected or actual change in all CareFirst health care costs in the region), and adjusted each year to reflect the changing CareFirst Illness Burden Scores of attributed patients. Spending targets are not re-based using actual panel spending in subsequent years, so panels have an incentive to achieve savings as quickly as possible to maximize total savings earned over the course of multiple years.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CareFirst BlueCross BlueShield’s Patient-Centered Medical Home (PCMH) Program	
	<p>Panels are eligible to receive shared savings payments if attributed patients’ spending is below a panel’s spending target for that year, and additional criteria are met:</p> <ul style="list-style-type: none"> • The panel was responsible for at least 12,000 (in 2015) or 18,000 (in 2016) CareFirst member months per year; • The panel earned at least 22 out of 35 “Engagement” quality points in 2015, or at least 35 or 50 “Engagement” points in 2016 (see below); • The panel developed an average of at least 3 Care Plans per provider per year (with at least 80% of providers contributing to this average) in 2015, or at least 5 Care Plans per provider (with 90% contributing to this average) in 2016; • The panel’s providers attest to: <ul style="list-style-type: none"> ○ Obtaining patient consent to participate in the program; ○ Engaging with members that CareFirst thinks need Care Plans; ○ Communicating and cooperating with CareFirst care coordinators; and ○ Referring only to other CareFirst HMO and RPN providers; <p>If a panel’s actual spending is lower than their spending target, the amount of shared savings add-on payment to be applied to the following year’s fee-for-service rates is then calculated. This add-on percentage depends on the panel’s quality score (described below) and the size of savings it generated, and can range from an additional 9%-points to 67%-points added on to a panel’s base fee-for-service rates (which, as noted above, are lower than they would be if the panel were not participating in this program). In addition, panels that generate savings multiple years in a row qualify for an additional “persistence award” of an additional 15%-points added to their base fee schedule rates in its second “winning” year, then an additional 35%-points thereafter. This persistence award was reduced to 10%-points and 20%-points, respectively, starting in 2015.</p> <p>The program includes an individual stop loss protection limit per patient per year to guard against extremely high-cost cases that could distort a panel’s financial results: if a patient generates \$75,000 in costs, only 20% of any costs beyond this threshold are counted toward the panel’s financial performance.</p> <p>In addition, participating providers are eligible to receive a \$200 fee for developing a Care Plan for a patient identified by CareFirst as having a high Illness Burden Score and needing care management, and a \$100 fee for Care Plan maintenance at each periodic review visit (on top of regular fees for these visits) – but these payments are included when calculating a panel’s financial performance. Providers are expected to work collaboratively with and meet frequently with CareFirst’s local care coordinators to create and maintain these Care Plans (or to have their own staff complete CareFirst care coordinator certification), and to enter Care Plan updates in a CareFirst website, in addition to recording this information in the provider’s own EHR.</p>
<p>Are there any performance metrics, if so, what is being measured?</p>	<p>The PCMH program uses measures of spending, utilization, clinical quality, patient experience, and practice structure and operational details to determine a panel’s quality score, which is in turn used to determine the size of shared savings payments.</p> <p>A 100-point “scorecard” measures five broad components (<i>with the amount of available points associated with each component in 2015 noted below - the relative weights of each of these categories has changed over time</i>):</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CareFirst BlueCross BlueShield’s Patient-Centered Medical Home (PCMH) Program	
	<ol style="list-style-type: none"> 1) Primary care provider engagement (measured through assessments by CareFirst’s local care coordinator, assessment by a practice consultant about the use of quality measure data, patient experience survey results, and participation in learning activities) – <i>35 points</i> 2) Appropriate use of services (measured through utilization measures assessing rates of preventable utilization of hospitals, ERs, ambulatory services, diagnostic imaging, and antibiotics) – <i>20 points</i> 3) Effectiveness of care (measured using HEDIS clinical care process measures that assess routine delivery of chronic care maintenance and preventive services) – <i>20 points</i> 4) Patient access (measured through presence of practice structures such as expanded office hours, weekend hours, online appointment scheduling) – <i>15 points</i> 5) Structural capabilities (measured through use of e-prescribing, an EHR, “meaningful use” attestation, medical home certification from one of several accrediting bodies, etc.) – <i>10 points</i> <p>Starting in 2016, panels’ quality score is now determined based on:</p> <ol style="list-style-type: none"> 1) Engagement score (assessed by the CareFirst local care coordinator and quality improvement program consultant using new criteria) – <i>50 points</i> 2) Clinical score (now using CMS’s core clinical measures) – <i>50 points</i>
Are there any performance incentives, if so, what is being incentivized?	Participating panels have a financial incentive to lower the total cost of all health care received by attributed CareFirst patients, to perform highly on various quality measures, to develop at least a few Care Plans per provider per year, to maintain a positive relationship with their CareFirst local care coordinator and quality improvement program consultant (who assess panels’ performance on numerous measures), and to refer patients to low-cost, in-network providers. They also have an incentive to earn savings as soon as possible, and to continue to earn savings for multiple years in a row. Since panel quality is assessed in isolation from other panels, as opposed to using a relative ranking of panels compared to their peers, panels also have no disincentive to share best practice with other panels.
How do incentives operate?	See the three rows above.
Is this a stand-alone payment model or is it used with other payment models?	This program builds on the fee-for-service payment system to calculate panels’ cost and quality performance. CareFirst’s detailed description of this program includes language advocating for the preservation of the FFS system, so that models like this one can be layered on top of it.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: CareFirst BlueCross BlueShield’s Patient-Centered Medical Home (PCMH) Program	
Has the model been evaluated? Who funded this evaluation?	In March, 2013, CareFirst announced the selection of three teams of organizations to conduct independent, comprehensive evaluations of the PCMH program: 1) a joint team from Harvard University, Brandeis University and the Massachusetts Institute of Technology, 2) George Mason University, and 3) Westat. These groups will conduct qualitative and quantitative analyses of the PCMH program. All three selected groups have begun work on their evaluations, which will continue through 2017. Evaluation reports are scheduled annually. The purpose of the evaluation is to understand how the program is working and determine whether the program achieved improved patient outcomes while reducing costs. Some early results have been published in PCPCC’s annual reviews of the evidence of PCMH programs in recent years.
Other pertinent information	<p>-CareFirst identifies the 3-7% of a panel’s patients with recent hospitalizations or ER visits and high CareFirst Illness Burden Scores who typically generate 30% of a panel’s costs, and recommends that they develop Care Plans for these patients. Interestingly, CareFirst does not recommend the sickest 2-3% of patients for Care Plans, since it assumes those patients are already in the hands of specialists and it is not likely that primary care providers can play a central role with these members.</p> <p>-Obtaining formal recognition as a PCMH from NCQA or another accrediting body was worth only 2% of a panel’s quality score from 2011-2015 (and was not mandatory), and starting in 2016, it is no longer even considered when calculating a panel’s quality score.</p> <p>-Participating panels are given online access to:</p> <ul style="list-style-type: none"> • A roster of CareFirst patients attributed to their panel (including their CareFirst Illness Burden Score); • A Member Health Record, containing patients’ Care Plans, medical claims, etc. (but not EHR data); • An online referrals management system; • Costs incurred and quality measure performance achieved so far (updated monthly). <p>-Starting in 2016, CareFirst is offering additional incentive payments to high-performing panels it invites to participate in its “PCMH Plus” program. CareFirst members will be incentivized to choose these panels as their primary care provider, through a deductible credit or a credit on a medical expense debit card.</p>

The above information was excerpted or summarized from these sources:

CareFirst Patient-Centered Medical Home Program (PCMH). “Overview” and “Part III: Building Blocks of the PCMH Program: The Ten Essential Design Elements” in *Program Description And Guidelines, 2014* available at: <https://provider.carefirst.com/carefirst-resources/provider/pdf/pcmh-program-description-guidelines.pdf>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.26 Cigna Collaborative Care

Model Name: Cigna Collaborative Care	
Brief Description: Cigna has entered into 156 ACO-style shared savings contracts with selected large physician groups in 29 states. In addition to standard fee-for-service payments, participating medical groups receive a semi-annual care coordination fee, which varies based on the expected impact of activities planned in the first contract year (but was equivalent to \$1.00-2.00 per patient per month in 2010 in two sample practices profiled in <i>Health Affairs</i>). If the medical group meets minimum quality targets and its total medical cost trend has improved by at least 2% relative to comparison practices in their area (which was the minimum savings threshold in 2010, at least), Cigna increases the size of the medical group’s care coordination fee in the following year, with the size of the fee increase varying depending on the medical group’s performance on cost and quality measures. If performance is worse than a specific cost and/or quality benchmark (which appears to be unspecified publicly), care coordination fees are reduced in subsequent years. When calculating cost performance, Cigna risk adjusts the spending generated by a medical group, and does not count any costs over \$100,000 for an individual patient. The shared savings percent does not appear to be publicly available.	
Developer: Cigna Corporation	
What is the goal of this payment model?	The company wants to achieve the same population health goals as accountable care organizations: better health, affordability, and experience.
How long has this payment model been in operation? Where has it been implemented?	The program has been operational since 2008, when it was launched as the “Cigna Accountable Care” initiative. There are now 156 Cigna Collaborative Care arrangements with large physician groups in 29 states covering 1.7 million commercial customers, 34,000 primary care physicians, and 36,000 specialists.
Type(s) of health care services, medical conditions, and health care settings addressed?	Participating medical groups are held accountable for total medical costs, which include allowable charges typically covered under medical plan benefits (e.g., inpatient facility, outpatient facility, professional, and ancillary expenses), except retail and mail pharmaceuticals and behavioral health benefits appear to be excluded, based on a 2012 <i>Health Affairs</i> article.
Types of patients included?	The model covers patients insured by Cigna and receiving care from a participating medical group.
Method of attributing patients to participating providers	Patients are aligned to the practice that they receive the majority of their primary care from.
Types of providers participating in the payment model?	Cigna currently has contracts with large primary care practices, multi-specialty groups, fully-integrated delivery systems, physician-hospital organizations, independent practice associations/independent physician associations. Cigna looks to partner with medical groups that have or are on track to receive NCQA PCMH or ACO accreditation, are participating in the Medicare Shared Savings Program, provide care to at least 5,000 Cigna customers, have full organizational commitment to the triple aim, and meet other criteria.
The entity accountable to the payer?	The medical group is accountable to the payer.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Cigna Collaborative Care	
How are providers paid under the payment model?	<p>Although Cigna’s payment model is currently called Cigna Collaborative Care, details are only available for a predecessor model called Cigna Accountable Care.</p> <p>In addition to standard fee-for-service payments, participating medical groups receive a semi-annual care coordination fee, which varies based on the expected impact of activities planned in the first contract year (but was equivalent to \$1.00-2.00 per patient per month in 2010 in two sample practices profiled in <i>Health Affairs</i>). If the medical group meets minimum quality targets and its total medical cost trend has improved by at least 2% relative to comparison practices in their area (which was the minimum savings threshold in 2010, at least), Cigna increases the size of the medical group’s care coordination fee in the following year, with the size of the fee increase varying depending on the medical group’s performance on quality measures. If performance is worse than a specific cost and/or quality benchmark (which appears to be unspecified publicly), care coordination fees are reduced in subsequent years. When calculating cost performance, Cigna risk adjusts the spending generated by a medical group, and does not count any costs over \$100,000 for an individual patient. The shared savings percent does not appear to be publicly available. Care coordination fees are counted as total medical costs for purposes of calculating shared savings payments.</p>
Are there any performance metrics? If so, what is being measured?	<p>It appears that 69 evidence-based measures of care were used to assess participating medical groups’ quality in this program in 2010.</p> <p>Cigna also provides medical groups with quality measure reports that show how their performance compares to comparison practices in their area. These reports assess performance in five areas:</p> <ol style="list-style-type: none"> 1. Access: ER visit rate totals for minor illnesses, chronic illnesses and frequent utilizers. 2. Optimal Care Coordination: Inpatient admission, with a focus on avoidable admissions and readmission rates. 3. Adherence to evidence-based medicine: Preventive care (e.g., mammography rate), chronic care (e.g., appropriate diabetes testing) and acute care (e.g., high-tech imaging rates). 4. Appropriate Prescribing: Generic fill rate and formulary adherence. 5. Value-Based Referrals: Use of preferred laboratories or preferred specialists to achieve the greatest quality and cost-efficiency results. <p>It is unknown whether there is overlap between the measures used to calculate the size of care coordination fee increases and the measures distributed to practices in quality measure reports.</p>
Are there any performance incentives? If so, what is being incentivized?	<p>Participating medical groups are incentivized to meet minimum absolute targets or improvement gains on specified quality measures in order to qualify for increases to their care coordination fee. They also appear to be incentivized to perform highly on these measures, since higher performance appears to yield higher fee increases.</p>
How do incentives operate?	<p>See previous row.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Cigna Collaborative Care	
Is this a stand-alone payment model or is it used with other payment models?	Under this payment model, the care coordination fee is paid in addition to standard fee-for-service payments.
Has the model been evaluated? Who funded this evaluation?	In a 2012 <i>Health Affairs</i> article, a Cigna executive and coauthors reported on 2010 cost and quality performance in three practices in Arizona, New Hampshire, and Texas. Although not statistically significant, the results from 2010 showed favorable trends in total medical costs and quality of care.
Other pertinent information	Participating medical groups must agree to allocate a nurse to serve as an embedded care coordinator. Cigna provides training and support to these care coordinators, who are responsible for 10,000 patients each. The embedded care coordinator: coordinates the care of patients being discharged from the hospital who are at risk for readmission; proactively reaches out to at-risk patients identified through Cigna’s predictive modeling methodology; reaches out to patients identified with gaps in care to resolve clinical gaps related to medication adherence, medication safety instructions and preventive care; refers patients to other programs available to Cigna customers such as case management, disease management, and healthy lifestyle coaching.

The above information was excerpted or summarized from these sources:

Cigna Corporation. “Cigna Collaborative Care” available at: <http://www.cigna.com/newsroom/knowledge-center/aco/> and “Collaborative Accountable Care” – Cigna’s Approach to Accountable Care Organizations – a white paper, available at: <http://www.cigna.com/assets/docs/employers-and-organizations/Collaborative-Care-White-Paper.pdf>; Salmon RB, Sanderson MI, Walters BA, Kennedy K, Flores RC, Munez AM. “A Collaborative Accountable Care Model In Three Practices Showed Promising Early Results On Costs And Quality Of Care.” *Health Affairs*, 2012;31(11): 2379-2387. <http://content.healthaffairs.org/content/31/11/2379.full>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.27 City and County of San Francisco ACO Collaboration

Model Name: City and County of San Francisco ACO Collaboration	
Brief Description: Launched in 2011, the San Francisco ACO (SFO ACO) collaboration evolved from an accountable care pilot program developed between Blue Shield of California, Catholic Healthcare West, and Hill Physicians a year earlier in Sacramento to care for employees and dependents of CalPers. SFO ACO was designed as a patient centered medical home that provides coordinated comprehensive health services to HMO enrollees of the San Francisco Health Service System (HSS). Partners in this collaboration include Blue Shield of California, five physician groups – Brown & Toland Physicians, California Pacific Medical Center, Catholic Healthcare West (Dignity Health), Hill Physicians Medical Group, and University of California, San Francisco – and eight area hospitals. The initiative is designed to drive health care transformation through integrated processes of care, use of clinical best practices, data integration, alignment of provider financial incentives, and collective monitoring of process and outcome measures.	
Developer: The Health Service System of the City & County of San Francisco and Blue Shield of California	
What is the goal of this payment model?	The goal of this model is ensure the continued affordability of health care by improving the quality and long term efficiency of services offered.
How long has this payment model been in operation? Where has it been implemented?	The model has been in operation since July 2011 and is centered in Northern California.
Type(s) of health care services, medical conditions, and health care settings addressed?	Health care settings represent the care continuum from primary care physician, acute care hospitals, and post-acute providers.
Types of patients included?	Enrollees include approximately 26,000 (in 2011) city employees, dependents and retirees of the San Francisco Health Service System enrolled in the Blue Shield HMO.
Method of attributing patients to participating providers	[Not stated]
Types of providers participating in the payment model?	Full range of physicians and hospitals
The entity accountable to the payer?	Affiliated physician groups and hospital partners are accountable to the payer.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Partners contribute to cost savings and are at financial risk for any variance from targeted cost reduction goals.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: City and County of San Francisco ACO Collaboration	
Are there any performance metrics? If so, what is being measured?	Financial and utilization metrics are monitored. Specific initiatives are designed to reduce hospital readmissions, enhance patient wellness, and increase generic drug prescribing.
Are there any performance incentives? If so, what is being incentivized?	Incentive payments are based on meeting cost goals.
How do incentives operate?	Claims-based targets are set as a cost per insured life. Providers are incentivized to attain these cost levels and are awarded bonuses if achieved. The payout allocation between the medical groups and associated facilities is negotiated by Blue Shield and HSS.
Is this a stand-alone payment model or is it used with other payment models?	<i>Information is not currently publicly available.</i>
Has the model been evaluated? Who funded this evaluation?	No formal evaluation is mentioned. Analyses conducted by Blue Shield and the San Francisco Health Service System found the following results for period between July 1, 2011-June 30, 2012: Brown & Toland: admissions/1,000 declined by 13%; days/1,000 declined by 12%; ER visits increased by 2%. Dignity Health & Hill Physicians: admissions/1,000 declined by 13%; days/1,000 declined by 19%; average length of stay declined by 7%; and ER visits declined by 5%.
Other pertinent information	The Blue Shield accountable care model has expanded beyond the Northern California region. There are currently 35 similar ACO collaborations covering more than 325,000 lives.

The above information was excerpted or summarized from these sources:

Aon Hewitt Health and Benefits Consulting, "Health Service Board Rates and Benefits Committee Meeting: Blue Shield Medical Group ACO Review," April 10, 2014. Available at: http://www.myhss.org/downloads/board/regular_meetings/2014/RM_041014_BlueShieldACO.pdf. Accessed August 30, 2016.

Blue Shield of California, "Blue Shield of California and Leading Healthcare Providers to Collaborate on Coordinated Care Model that Ensures No 2011-2012 Rate Increase for City and County of San Francisco," March 2, 2011. Available at: <https://www.blueshieldca.com/bzca/about-blue-shield/media-center/coordinated-care-SF.sp>. Accessed August 30, 2016.

City and County of San Francisco Health Service System, "City and County of San Francisco ACO Collaboration Accomplishments," November 8, 2012. Available at: http://www.myhss.org/downloads/board/regular_meetings/2012/RM_110812_ACOPresentation.pdf. Accessed August 30, 2016.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.28 Community Health Choice’s Maternity and Newborn Care Bundled Payment Pilot

Model Name: Community Health Choice’s Maternity and Newborn Care Bundled Payment Pilot	
Brief Description: Community Health Choice, a Medicaid managed care organization, has been paying two hospitals in Texas a bundled episode payment for maternity and newborn care since 2015. The bundle includes maternity care, including prenatal visits up to 270 days prior to a delivery, and extends 60 days post-delivery; it also includes all care delivered to newborns during the hospital stay and up to 30 days after hospital discharge. Providers can earn shared savings bonuses in Year 1, and are subject to two-side shared savings risk in Year 2. This pilot is projected to pay for about 2,000 of the 24,000 deliveries paid for annually by Community at these two hospitals.	
Developer: Community Health Choice, Inc. (a non-profit HMO in Houston, TX) with involvement from the Health Care Incentives Improvement Institute (the developers of the PROMETHEUS model)	
What is the goal of this payment model?	Community’s goal was to develop an innovative payment program that would incentivize the right care, the right amount of care and improved outcomes, but save money at the same time.
How long has this payment model been in operation? Where has it been implemented?	This pilot began on March 1, 2015 at the University of Texas (UT) Medical School in Houston (which includes Memorial Hermann-Texas Medical Center hospital and Harris Health System’s Lyndon B. Johnson Hospital) and the UT Medical Branch in Galveston. It was initially expected to be a two-year pilot, but a publicly available slide presentation mentions plans for “Year 3 and beyond.”
Type(s) of health care services, medical conditions, and health care settings addressed?	The bundle includes maternity and newborn care, physician services, inpatient services at hospitals (including NICU stays), and ancillary services.
Types of patients included?	Medicaid managed care (HMO) enrollees insured by Community Health Choice, Inc. seeking maternity care at University of Texas (UT) Medical School in Houston and the UT Medical Branch in Galveston.
Method of attributing patients to participating providers	Providers identify eligible patients.
Types of providers participating in the payment model?	Participating providers include physicians (specializing in obstetrics/gynecology, maternal-fetal medicine, pediatrics, and neonatology), hospitals, and providers of ancillary services.
The entity accountable to the payer?	University of Texas Medical School in Houston and the UT Medical Branch in Galveston.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Providers are given a spending target for a bundle of services to be provided during a specified episode. The spending target or bundled payment price covers all maternity services provided from the first prenatal visit through to 60 days after delivery, and the delivery stay plus all care provided to newborns up to 30 days after hospital discharge. There appear to be different bundled payment prices for pregnancies of different complexity: (1) a payment rate for vaginal or caesarean section births (\$8,952 – which includes \$5,803 for pregnancy and delivery, and \$3,149 for neonate); (2) a

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Community Health Choice’s Maternity and Newborn Care Bundled Payment Pilot	
	<p>payment rate for births requiring Level 1, 2, or 3 hospital nursery services (with higher levels needed for babies born more prematurely); and (3) a payment rate for births requiring Level 4 nursery services (the most acute care available for newborns). The bundled payment price is set using historical average costs and adjusted based on the mother’s risk factors to arrive at a patient-specific bundled payment amount.</p> <p>At the end of a pilot year, the actual cost of an episode is calculated and reconciled against the bundled episode payment. In the first year of the pilot, providers faced one-sided risk: they could earn bonus payments if the cost of the episode was less than the bundled payment amount. In the second year, providers face two-sided shared savings risk: they can earn bonuses if they meet quality measure targets and the cost of care is less than the bundled payment amount, but if the cost of care exceeds the bundled payment amount they must absorb those losses. In Year 3, Community plans to “move away from current contractual payments to flat dollar or other budget payments with reconciliation.”</p>
Are there any performance metrics? If so, what is being measured?	<p>In Year 1, a quality measurement scorecard was used for monitoring purposes and to set Year 2 performance targets that must be met in order to earn shared savings payments. Measures in this scorecard include:</p> <p>Patient-Reported Outcome Measures (PROMs): the Childbirth Connection PROM Survey (inclusive of birth information, prenatal care, birth experience, and postpartum care).</p> <p>Normal birth weight: Prenatal care and screenings; Delivery care (cesarean section rate, elective deliveries); Postpartum care with depression screening; Baby care (breastfeeding, hepatitis B vaccine).</p> <p>Low birth weight: Similar to normal birth weight measures, plus NICU infection rates.</p> <p>Additional measures are used for monitoring purposes only.</p>
Are there any performance incentives? If so, what is being incentivized?	<p>Providers have an incentive to minimize the cost of maternity and newborn care, while providing enough care to perform highly enough on quality measures in Year 2 to qualify to receive shared savings payments.</p>
How do incentives operate?	<p><i>Information is not currently publicly available.</i></p>
Is this a stand-alone payment model or is it used with other payment models?	<p>This payment model is layered on top of fee-for-service payments. Providers bill the payer on a fee-for-service basis during the episode. At the end of the year, reconciliations are done and payments are paid or penalties are imposed.</p>
Has the model been evaluated? Who funded this evaluation?	<p>No formal evaluations are available.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Other pertinent information	<i>Information is not currently publicly available.</i>
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The above information was excerpted or summarized from these sources:

Love K, Maternity and Newborn Care Bundled Payment Pilot, available at: http://www.ehcca.com/presentations/BPSummit5/love_t4.pdf; Hawryluk M, "Pilot pregnancy program aims to reduce costs, improve outcomes," *Houston Chronicle*, June 2, 2015, available at: <http://www.houstonchronicle.com/news/health/article/Pilot-pregnancy-program-aims-to-reduce-costs-6302928.php>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.29 Community Oncology Medical Home (COME HOME)

Model Name: Community Oncology Medical Home (COME HOME)	
Brief Description: The COME HOME is a care delivery model that has been piloted in seven practices through a \$20 million CMS Health Care Innovation Award (HCIA) and, more recently, has been supported in one practice through payments per member per month (PMPM) from Blue Cross Blue Shield of New Mexico. The model targets newly diagnosed or relapsed Medicare, Medicaid, and commercially-insured cancer patients, and offers them comprehensive outpatient oncology care, including extended clinic hours, patient education, team care, medication management, 24/7 practice access, and inpatient care coordination. The CMS grant was used to fund nurses, data analysts, patient care coordinators, telephone triage operators (a key aspect of the program), and other office staff and clinical managers. (Funds could not be used to pay for any services that are already payable through existing Medicare FFS E/M codes.) The model’s developer projected that the three-year, seven-practice pilot would reduce the expenditures of 8,022 Medicare beneficiaries by \$33.5 million (\$4,178 per beneficiary per year), through reduced hospital admissions, ED visits, and pharmacy costs. In February 2016, Blue Cross began offering payments PMPM to the Albuquerque office of the New Mexico Cancer Center; the size of payments is unavailable publicly, but varies depending on whether the patient is in the “initial assessment” stage, “active treatment” stage, or “post-treatment” stage.	
Developer: Dr. Barbara McAneny, of the New Mexico Cancer Center and Innovative Oncology Business Solutions	
What is the goal of this payment model?	<p>The goal of this care delivery model is to improve health outcomes, enhance patient care experiences, and significantly reduce costs of care.</p> <p>As the payer, Blue Cross’s goals are to provide more coordinated care for members by improving their access to physicians, improving their care, and cutting out unnecessary services.</p>
How long has this payment model been in operation? Where has it been implemented?	<p>This care delivery model was funded by a three-year grant from CMMI that began in 2012. Seven community oncology practices are participating in the COME HOME pilot:</p> <ul style="list-style-type: none"> - Austin Cancer Center - Ft Worth Centers for Cancer & Blood Disorders - Dayton Physicians Network - New England Cancer Specialists - New Mexico Cancer Center - NW Georgia Oncology Centers - Space Coast Cancer Center <p>Blue Cross began making payments to the Albuquerque office of the New Mexico Cancer Center in February 2016.</p>
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>COME HOME clinics deliver all outpatient cancer care, including: “triage pathways that ensure patients receive the right care for all aspects of cancer care, diagnostic pathways that address appropriate imaging, pathologic testing and molecular diagnostics, and therapeutic pathways delineating chemotherapy, radiation oncology, supportive care, and surgery (when applicable).” In addition, the enhanced services offered include: “patient education and medication management counseling, team care, 24/7 practice access (telephone triage, night/weekend clinic hours, and on-call oncologists), on-site or near-site imaging and laboratory testing, and admitting physicians who shepherd patients through inpatient encounters, avoiding handoffs and readmissions, to ensure seamless, safe and efficient care.”</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Community Oncology Medical Home (COME HOME)	
Types of patients included?	<p>The targeted patients include newly diagnosed or relapsed Medicare, Medicaid and commercially insured patients seeking oncology care at one of 7 participating clinics with one of the following seven cancer types: breast, lung, colon, pancreas, thyroid, melanoma and lymphoma. This totaled 26,548 unique patients as of March 31, 2015.</p> <p>As of March 2016, approximately 50 patients were enrolled in this program at the Albuquerque office of the New Mexico Cancer Center and eligible for payments PMPM from Blue Cross. This number is expected to eventually increase to 150 patients.</p>
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	<i>Information is not currently publicly available.</i>
The entity accountable to the payer?	The entity responsible is the community oncology practice.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	The Albuquerque office of the New Mexico Cancer Center receives payments PMPM which vary in size depending on whether the patient is in the “initial assessment” stage, “active treatment” stage, or “post-treatment” stage. (Specific amounts are not available.)
Are there any performance metrics? If so, what is being measured?	<p>For the CMS HCIA grant, several types of measures were used:</p> <p>Structural measures:</p> <ul style="list-style-type: none"> - Extended hours - Number of same-day appointment slots available - EHR down-time - Pulls of data from EHR into other systems - Missing records and incomplete data <p>Process Measures</p> <ul style="list-style-type: none"> - Compliance reports of triage for symptom management pathways - Treatment dashboards for adherence to clinical pathways - Number of extended hours visits per month - Number of calls triaged per month - Number of triage pathways used - Percentage of patients staged (QOPI) within one month of diagnosis <p>Outcome Measures</p> <ul style="list-style-type: none"> - Patient satisfaction survey (e.g., getting an appointment and starting treatment for a condition that needed care right away) - ED utilization (data from CMS) - “Real time comparative effectiveness research of clinical pathways” (e.g., percentage of patients completing regimen on time; percentage of patients who accessed required auxiliary pathways – nausea, diarrhea, etc.)

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Community Oncology Medical Home (COME HOME)	
Are there any performance incentives? If so, what is being incentivized?	<i>Information is not currently publicly available.</i>
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	<i>Information is not currently publicly available.</i>
Has the model been evaluated? Who funded this evaluation?	<p>Researchers from the University of Tennessee Health Science Center’s Department of Preventive Medicine, led by Dr. Teresa Waters, “are providing expertise and manpower to support COME HOME’s real-time outcome evaluation and cost analysis.”</p> <p>Additionally, the Brookings Institution released a case study of the COME HOME model which includes a description, lessons learned, and recommendations for the program (Sanghavi, et al).</p>
Other pertinent information	<p>The COME HOME model builds on the concept of a patient-centered medical home by including seven important components: (1) an ongoing relationship with a personal physician to provide first contact, continuous and comprehensive care; (2) physician-directed team care; (3) whole person orientation; (4) integrated/coordinated care; (5) evidence-based medicine and performance measurement to assure quality and safety; (6) enhanced access; and (7) payment to recognize the value-added of a medical home.</p>

The above information was excerpted or summarized from these sources:

The COME HOME Program. <http://www.comehomeprogram.com/index.php/come-home-practices/>; “Oncology Medical Home: Effect on cost of care,” presentation by Barbara McAneny, http://www.p4psummitportal.com/assets/468/resources/mcaneny_1.pdf; Sanghavi, et al, “Transforming Cancer Care and the Role of Payment Reform- Lessons from the New Mexico Cancer Center,” August 2014, <https://www.brookings.edu/wp-content/uploads/2016/06/Oncology-Case-Study-August-2014-FINAL-WEB.pdf>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.30 Geisinger Health System’s Physician Compensation Model

Model Name: Geisinger Health System’s Physician Compensation Model (as of 2012)	
<p>Brief Description: Geisinger’s compensation model for salaried physicians has two components: their base salary (80% of their pay) is based on past productivity, experience, and the market rate for that specialty; the remainder takes the form of incentive payments. For specialists, these are based on: quality (40%); delivering selected innovative new care processes (10%); legacy (i.e., educational and research activities) (10%); efforts to attract new business for Geisinger (15%); and productivity (25%).</p> <p>Primary care physicians’ base salary constitutes 78.5% of their pay. They receive another 8% for active participation in Geisinger’s medical home program. The remaining 13.5% is based on: quality (60%); citizenship (6%); and productivity (34%).</p> <p>As of 2012, 220 primary care and 654 specialty physicians were employed by Geisinger and paid under this model.</p>	
Developer: Geisinger Health System	
What is the goal of this payment model?	Geisinger’s physician compensation approach incorporates its strategic vision of improving the quality and efficiency of care through innovation and integration of care.
How long has this payment model been in operation? Where has it been implemented?	This compensation model was implemented in 2002 across the Geisinger Health System, which is a nonprofit, integrated delivery system that consists of tertiary and community hospitals, outpatient facilities, and nearly 60 community practices, distributed predominantly in central and northeast Pennsylvania. As of 2012, 220 primary care and 654 specialty physicians were employed by Geisinger and therefore received compensation under this model.
Type(s) of health care services, medical conditions, and health care settings addressed	All services delivered by salaried physicians at Geisinger.
Types of patients included	All patients treated by a physician employed by Geisinger.
Method of attributing patient to participating providers	Not applicable – patients are not attributed to providers for purposes of this model. Physicians’ productivity is measured by fee-for-service work units for all care provided to all patients.
Types of providers participating in the payment model	Primary care physicians and specialists employed by Geisinger.
The entity accountable to the payer	Not applicable – this is a model for how an entity that receives payments from payers distributes these funds to employed physicians.
The entity receiving payment from the payer (if different from above)	See above.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Geisinger Health System’s Physician Compensation Model (as of 2012)	
How are providers paid under the payment model?	<p>Specialists’ base compensation (the 80% delivered in monthly paychecks) is set for each physician based on productivity (as measured by panel size, number of patients seen, and number of work relative value units (RVUs) generated, which measure the time, skill, judgment, and stress involved in delivering various services, and other factors; teaching, research, and administrative activities are also considered. The remaining 20% of specialists’ compensation takes the form of incentive payments, which are based on: quality (40%); innovation – e.g., making sure all CABG patients meet 120 best practice treatment requirements (10%); legacy – i.e., completing educational and research efforts, such as completing resident evaluations within 30 days (10%); growth – i.e., efforts to increase the population that Geisinger serves – e.g., by developing Spanish podcasts for a women’s health website (15%); and financial – i.e., productivity over the last 6 months, relative to a 60th percentile benchmark (25%).</p> <p>Primary care physicians’ base salary constitutes 78.5% of their total pay and is adjusted every 6 months, based on their productivity in the previous year. Another 8% of pay comes in the form of payments for active participation in Geisinger’s medical home model of care delivery. The remaining 13.5% of pay is based on: quality (60%); citizenship – i.e., collaboration and teamwork with colleagues (6%); and financial performance – i.e., productivity (34%).</p>
Are there any performance metrics, if so, what is being measured?	Measures used to calculate the “quality” proportion of physicians’ incentive payments differ by specialty, but include clinical outcome measures (e.g., the % of diabetics with certain hemoglobin A1c levels), clinical process measures (e.g., delivering the care processes included in the ProvenCare bypass surgery bundle), and patient satisfaction measures.
Are there any performance incentives, if so, what is being incentivized?	Physicians are incentivized to maximize their productivity (i.e., the number of work RVUs they deliver to patients), and deliver high-quality care. Specialists are further incentivized to deliver care using recommended protocols, complete educational and research responsibilities, and generate new business for Geisinger. Primary care physicians are incentivized to participate in Geisinger’s medical home effort and be a good Geisinger citizen by collaborating with other staff.
How do incentives operate?	See “How are providers paid under the payment model?” above. On average, physicians have 4-5 clinical quality measures that determine the size of their “quality” incentive payment.
Is this a stand-alone payment model or is it used with other payment models?	This payment model relies on fee-for-service work units to measure physicians’ productivity.
Has the model been evaluated? Who funded this evaluation?	No evaluation has been conducted that we are aware of. Furthermore, a 2012 <i>Health Affairs</i> article by Geisinger staff indicated that the compensation model is modified each year and not structured as a tightly controlled experiment for which scientifically valid results could be reported.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Other pertinent information	-Quality metrics are defined for each specialty through iterative discussions between specialty leaders and Geisinger senior management. -Most of Geisinger’s clinical care is paid for under fee-for-service contracts. -Geisinger believes the % of physician compensation determined by performance incentives is probably lower at most other delivery systems.
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The above information was excerpted or summarized from these sources:

Thomas H. Lee, Albert Bothe and Glenn D. Steele, “How Geisinger Structures Its Physicians’ Compensation To Support Improvements In Quality, Efficiency, And Volume,” *Health Affairs*, 2012: 31(9): 2068-2073. Available at: <http://content.healthaffairs.org/content/31/9/2068.abstract>; Glenn D. Steele, Jr., “A Proven New Model for Reimbursing Physicians,” *Harvard Business Review*, September 15, 2015. Available at: <https://hbr.org/2015/09/a-proven-new-model-for-reimbursing-physicians>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.31 Geisinger Health System’s ProvenCare® Acute Episodes of Care

Model Name: Geisinger Health System’s ProvenCare® Acute Episodes of Care	
<p>Brief Description: ProvenCare® Acute is Geisinger’s bundled episode payment program that is designed to promote clinical best practices for certain “acute-care” procedures and conditions. It involves redesigning the clinical workflow and EHRs to improve provision of evidence-based care. This is done along with setting an episode price. It is a prospective payment retrospectively reconciled against claims, with upside gainsharing and/or downside risk. This model is also referred to as the “warranty” model where the episode price usually includes risk for the services provided in post-procedure period up to a certain time period. In other words, Geisinger offers a warranty against complications related to their service based on the confidence they have in best practices they implement. For example, in the first ProvenCare Acute model for coronary artery bypass graft (CABG), with implementation of 40 best practices, the episode price for the surgery includes CABG-associated follow-up treatment for up to 90 days. The fixed price for CABG was set at the historical payment for a typical CABG hospitalization plus 50 percent of the average cost of post-acute care over 90 days (including readmissions).</p> <p>Launched in 2006, ProvenCare Acute is now available for more services, including procedures such as angioplasties, cardiac bypass surgeries, cataract surgery, bariatric surgeries, hip and knee total replacements, perinatal care. This profile will focus only on ProvenCare Acute models for episodes of coronary artery bypass graft (CABG) and perinatal care as well-developed examples of this approach.</p>	
Developer: Geisinger Health System	
What is the goal of this payment model?	The goal of ProvenCare is to promote delivery of evidence-based medicine. According to Geisinger, ProvenCare is a collaborative approach to medicine that focuses on getting medical teams, patients, and families on the same page while eliminating unnecessary and possibly harmful care.
How long has this payment model been in operation? Where has it been implemented?	<p>The program was implemented in 2006 with a model for coronary artery bypass graft. It was implemented in all 3 hospitals in the Geisinger Health System in Pennsylvania.</p> <p>In 2008, the perinatal care model was implemented in 22 practice sites spanning 31 counties. Infants were delivered at two Geisinger tertiary care centers and two non-Geisinger community hospitals.</p>
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>The CABG model included preoperative, inpatient, and postoperative care within 90 days of an elective CABG.</p> <p>The perinatal model incorporates all prenatal, labor and delivery, and postpartum care. Patients have an average of 13 clinic visits during the pregnancy plus an inpatient stay. The model expects that at least 12 continuous weeks of prenatal care and delivery must be performed by a Geisinger provider. The episode begins with the identification of the pregnancy in the first or second trimester and concludes with postpartum visits 21-56 days post-delivery. Usually low-risk patients were included and excluded patients were: late referrals, high-risk patients, members without continuous enrollment during the entire episode or other primary coverage.</p> <p>Neonatal care is not included in the perinatal model. The global payment for perinatal care includes technical and professional, physician, consultations, and supporting clinician fees. In the prenatal phase, only professional and outpatient services (including routine testing) are covered and in the postpartum phase, inpatient readmissions, outpatient, and professional services are covered. Goals included seeking reductions in C-section rates and premature births, enhancing management of comorbid conditions and improving fetal/child health and wellness.</p>
Types of patients included?	Patients seeking care (in this case CABG surgery and perinatal care) at Geisinger’s facilities.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Geisinger Health System’s ProvenCare® Acute Episodes of Care	
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Multi-disciplinary teams of surgeons and other providers at Geisinger’s hospitals and health care facilities. For perinatal model, it includes non-Geiringer community hospitals.
The entity accountable to the payer?	Geisinger providers.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	<p>Payment to providers is made prospectively and then retrospectively reconciled against claims based on the pre-set episode price. In the CABG model, there is only upside gainsharing for providers where as in the Perinatal care model, there is both upside gainsharing and downside risk for providers.</p> <p>The flat fee or episode price is negotiated and based on historical cost and reimbursement data.</p> <p>In CABG, a single payment is made to the hospital system and a single payment to the provider system (payment to the provider is allocated to multiple service lines or provider encounters i.e., CABG surgery, anesthesiology, cardiology; presumably the allocation is done by Geisinger, but the allocation approach is not clearly explained in available sources).</p>
Are there any performance metrics? If so, what is being measured?	<p>CABG: Geisinger followed guidelines developed by the American Heart Association (AHA) and the American College of Cardiology (ACC) in the “AHA/ACC 2004 Guideline Update for CABG Surgery”. These guidelines initially led to 40 best practices measures which have now become more than 120.</p> <p>Perinatal care: A combination of evidence-based medicine promoted through Institute for Clinical Systems Improvement (ICSI) health care guidelines and consensus-driven guidelines promoted through the American College of Obstetricians and Gynecology (ACOG) led to 103 unique best practice measures which would be tracked for every patient. Even though neonatal care is not included in the bundle, the best practices track measures such as the reason for a NICU admission, NICU length of stay, and NICU outcomes. This is done as a way of assessing the quality the prenatal care that was provided to the mother.</p>
Are there any performance incentives? If so, what is being incentivized?	The goal of the ProvenCare Acute episode payment is to promote adoption of evidence-based medicine and best practices of care.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Geisinger Health System’s ProvenCare® Acute Episodes of Care	
How do incentives operate?	In the CABG model, after incorporating 40 best practices for CABG management, Geisinger developed an episode price for the preoperative, inpatient, and postoperative care within 90 days, which is what the payers paid Geisinger. At Geisinger, those responsible for the clinical services agreed to reduce their readmission rate as one measure of complication. Following that, Geisinger reduced the cost of its historical readmission rate to the payer by 50% upfront. If Geisinger reduced their CABG-related readmission rate by more than 50%, it would be an opportunity for them to earn profits. Whether or not Geisinger actually reduced the readmission rate, the payer still saves 50% of what they would have paid, on average, historically.
Is this a stand-alone payment model or is it used with other payment models?	This approach seems to use underlying FFS payment rates to set the episode price as well as to price claims for the purpose of the retrospective reconciliation.
Has the model been evaluated? Who funded this evaluation?	<p>Evaluations have been published in peer-reviewed journals.</p> <p>In the CABG model, according to an analysis published in 2007 in the Annals of Surgery, ProvenCare:</p> <ul style="list-style-type: none"> - reduced average length of stay by 16% from 6.3 to 5.3 days and that was reflected in a 5% reduction in hospital charges; and - reduced 30-day readmission rates by 15.5 percent from 7.1% to 6%. <p>The Health Care Payment Learning & Action Network included some preliminary results related to the Perinatal model, but the explanation of methods and findings were not sufficient to be reported here.</p>
Other pertinent information	Geisinger also has developed bundled payment approaches for conditions such as diabetes, congestive heart failure, hypertension, COPD under “ProvenCare Chronic and Prevention.” These are complex bundles because of comorbid conditions that involve overlapping bundles and not addressed here.

The above information was excerpted or summarized from these sources:

ProvenCare, website: <http://www.geisinger.org/sites/provencare/>; The Health Care Payment Learning & Action Network (LAN), “Accelerating and Aligning Clinical Episode Payment Models”, August 1, 2016, available at: <http://hcp-lan.org/workproducts/cep-whitepaper-final.pdf>; Casale et al, “ProvenCareSM”: a provider-driven pay-for-performance program for acute episodic cardiac surgical care”, Annals of Surgery, October 2007, available at: <http://www.ncbi.nlm.nih.gov/pubmed/17893498>; Berry et al, “ProvenCare Perinatal: A Model for Delivering Evidence/Guideline-Based Care for Perinatal Populations” The Joint Commission Journal on Quality and Patient Safety, May 2011, available at: <http://www.ncbi.nlm.nih.gov/pubmed/21618899>; Paulus et al, “Continuous Innovation In Health Care: Implications Of The Geisinger Experience”, Health Affairs, September 2008, available at: <http://content.healthaffairs.org/content/27/5/1235.full>; Henry, Robert, “ProvenCare: Geisinger’s Model for Care Transformation through Innovative Clinical Initiatives and Value Creation- Interview with Ronald A. Paulus”, American Drug Health Benefits, April-May, 2009, available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4106555/>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.32 Horizon Blue Cross Blue Shield of New Jersey Episodes of Care Program

Model Name: Horizon Blue Cross Blue Shield of New Jersey Episodes of Care program	
Brief Description: Horizon Blue Cross Blue Shield of New Jersey has implemented an episode of care (EOC) payment model structured around an episode that involves a single physician or practice providing a full spectrum of care related to a specific service within a defined time period. The program began with episode payments for hip and knee total joint replacement and then expanded to knee arthroscopy, maternity care, colonoscopy, breast cancer, colon cancer, lung cancer, heart failure, coronary artery bypass graft and hysterectomy. The physician or practice at the center of the episode is called the “conductor”. Payments are based on retrospective reconciliation (usually quarterly) against a target price and savings, if any, are shared with the “conductor” after adjustment based on performance on a set of quality measures and patient satisfaction scores. There is no downside risk. The episodes are built using PROMETHEUS algorithms.	
Developer: Horizon Blue Cross Blue Shield of New Jersey	
What is the goal of this payment model?	Horizon BCBSNJ’s EOC program goals are to achieve better quality outcomes, improve the patient experience and reduce the total cost of care using national quality standards and best practices for these procedures.
How long has this payment model been in operation? Where has it been implemented?	The model has been implemented across New Jersey and it began with the hip and knee joint replacement program in 2010.
Type(s) of health care services, medical conditions, and health care settings addressed?	The program has episode payments for the following procedures: <ul style="list-style-type: none"> - hip and knee total joint replacement - knee arthroscopy (includes diagnosis and treatment of several knee problems and injuries) - maternity care (includes all care related to a patient’s pregnancy, delivery and post-delivery recovery) - colonoscopy (includes the surgical procedure and all pre- and post-procedure services related to the colonoscopy) - mastectomy/breast cancer - colon cancer - lung cancer - heart failure - coronary artery bypass graft (EOC additionally includes valve replacement and other complex heart surgeries) - hysterectomy
Types of patients included?	Patients insured by Horizon BCBSNJ that select a physician or organization contracting with the EOC program participate in this model.
Method of attributing patients to participating providers	Patients are attributed to participating providers based on claims data.
Types of providers participating in the payment model?	Single physicians or practices, hospitals and other provider organizations that contract with Horizon BCBSNJ to provide the full spectrum of services for the identified episodes participate in the program. The participating physicians and providers work in the hospital (inpatient and outpatient procedures) as well as ambulatory surgery center settings.
The entity accountable to the payer?	The “conductor” or the physician or provider organization contracting with Horizon BCBSNJ is the accountable entity in this program.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Horizon Blue Cross Blue Shield of New Jersey Episodes of Care program	
The entity receiving payment from the payer (if different from above)?	Same as above
How are providers paid under the payment model?	Under the program, all providers throughout the continuum get paid through traditional FFS mechanisms as their care is delivered and claims processed. Quarterly, the costs are reconciled against the bundled episode price. All defined episodes are also reviewed against quality benchmarks and patient experience thresholds. If the costs are below the target price, savings are shared with the “conductor” (the provider who is contracted for the episode management) after being adjusted based on performance on quality and patient satisfaction scores.
Are there any performance metrics? If so, what is being measured?	Quality outcomes, patient experience and the total cost of care are all monitored. For each of the defined episodes, the providers follow evidence-based guidelines proposed by their respective professional organizations. For example, in colonoscopy, a participating provider looks at measures such as adenoma detection rate and cecal intubation rate along with patient satisfaction rates.
Are there any performance incentives? If so, what is being incentivized?	<i>Information is not currently publicly available.</i>
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	The EOC program works along with the underlying traditional FFS mechanism.
Has the model been evaluated? Who funded this evaluation?	No mention of a formal evaluation found. A press release from February 2016 indicates that Horizon BCBSNJ paid approximately \$3 million to 51 specialty medical practices in New Jersey as part of shared savings generated through EOC Program.
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Horizon BCBSNJ Episodes of Care Program, website: <http://www.horizonblue.com/members/plans-services/patient-centered-programs/episodes-of-care> ; Fitzgerald, Beth, “Pregnancy care is the subject of Horizon's latest best-practices program for doctors”, January, 28, 2015, NJBIZ, available at: <http://www.njbiz.com/article/20150128/NJBIZ01/150129747/Pregnancy-care-is-the-subject-of-Horizon%27s-latest-best-practices-program-for-doctors>; Gooch, Jamie J., “Coordinating bundled payments: The first step toward coordinated care” <http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/coordinating-bundled-payments-first-step-toward-coordinated-care?page=0,0>; Zabinski, Stephen J., “Transforming payment and care models for total joint replacement”, presentation available at: http://www.p4psummitportal.com/assets/468/resources/zabinski_1.pdf and Accurso, Charles, “Implementing a Value Based Colonoscopy Contract in Gastroenterology”, presentation available at: http://www.p4psummitportal.com/assets/494/resources/accurso_ms17.pdf; Horizon BCBSNJ, “Results show that doctors, patients and Horizon BCBSNJ members all win from company’s innovative “Episodes of Care” program”, press release, Feb, 2016, available at: <http://www.horizonblue.com/about-us/news-overview/company-news/results-show-doctors-patients-and-horizon-bcbsnj-members-all-win>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.33 Horizon Blue Cross Blue Shield of New Jersey Patient-Centered Medical Home Program

Model Name: Horizon Blue Cross Blue Shield of New Jersey Patient-Centered Medical Home (PCMH) Program	
Brief Description: Participating practices receive up-front payments from Horizon to support their PCMH transformation efforts and additional staff (e.g., the nurse care coordinator they are required to employ). Practices have an opportunity to receive outcome-based or shared savings payments for improving patient health outcomes, patient experience, and controlling unnecessary utilization and cost of care. Further payment model details appear to be unavailable.	
Developer: Horizon Blue Cross Blue Shield of New Jersey, in collaboration with the New Jersey Academy of Family Physicians and the leadership of eight primary care practices.	
What is the goal of this payment model?	Horizon aims to eliminate wasteful and duplicative testing, and inefficient to hospitals for primary care – which they hope will lead to better patient outcomes and an improved experience of care with lower out-of-pocket costs to individuals and lower costs for the system overall.
How long has this payment model been in operation? Where has it been implemented?	Horizon’s PCMH efforts began in 2010 or 2011. As of Sept. 2014, more than 3,700 physicians at 900 practice locations were participating in this program.
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>Participating practices must employ a nurse care coordinator, who is expected to: develop and implement care plans for high-risk or at-risk patients (in collaboration with primary care physicians); follows up with patients who have been hospitalized; engage in population health management by reminding patients about clinical screenings, preventive services, and/or chronic-care management; and other duties. Care coordinators undergo a 2-day training from Horizon on motivational interviewing, data analytics, managing chronic conditions, and other topics.</p> <p>Horizon's patient centered practices provide patients with coordinated and personalized care, including:</p> <ul style="list-style-type: none"> - A care coordinator who provides additional patient support, information and outreach. - Wellness and preventive care based on national clinical guidelines. - Extra wellness support and education. - Active patient monitoring and communication from the doctor and care coordinator. - Active coordination of a patient's care with specialists and other providers
Types of patients included?	<i>Information is not currently publicly available.</i>
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Horizon Blue Cross Blue Shield of New Jersey Patient-Centered Medical Home (PCMH) Program	
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Participating practices receive up-front payments to support their PCMH transformation efforts and additional staff (e.g., nurse care coordinator). Practices have an opportunity to receive outcome-based or shared savings payments for improving patient health outcomes, patient experience, and controlling unnecessary utilization and cost of care. Further details appear to be unavailable.
Are there any performance metrics? If so, what is being measured?	Quality measures that help determine the receipt and/or size of outcome-based or shared savings payments include measures that assess patient health outcomes, patient experience, and unnecessary utilization and cost of care.
Are there any performance incentives? If so, what is being incentivized?	Practices have an incentive to improve patient health outcomes, patient experience, and reduce unnecessary utilization and cost of care in order to receive outcome-based or shared savings payments.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	The up-front PCMH transformation payments and the outcome-based or shared savings payments appear to be offered in addition to existing fee-for-service payments.
Has the model been evaluated? Who funded this evaluation?	Evaluations for the particular model are unavailable.
Other pertinent information	A 2014 article stated that Horizon had recently introduced two new patient-centered health plans for small businesses (≤ 50 employees), which cost 15% less than Horizon’s lowest-priced non-patient-centered plan for small businesses, and extend savings to employees (i.e., when care is delivered by a patient-centered practice, the employee pays no deductible or coinsurance). Participating practices receive quality measure reports at the individual patient level and at the practice level that identify gaps in care.

The above information was excerpted or summarized from these sources:

Patient-Centered Primary Care Collaborative, Horizon Blue Cross Blue Shield of New Jersey’s Patient-Centered Medical Home Program, –profile page on PCPCC’s website available at: <https://www.pcpcc.org/initiative/horizon-blue-cross-blue-shield-new-jersey%E2%80%99s-patient-centered-medical-home-program>; Horizon Blue Cross Blue Shield of New Jersey, Patient-centered care continues to deliver on promise of better quality care at a lower cost, August 4, 2015, available at: <http://www.horizonblue.com/about-us/news-overview/company-news/horizon-bcbnsj-patient-centered-care-on-promise-of-better-quality>; Peskin SR, “Transformation Through Collaboration: Horizon’s Patient-Centered Program Is Delivering Results,” *American Journal of Managed Care*, Sept. 23, 2014; 2(3); available at <http://www.ajmc.com/journals/ajac/2014/2014-1-vol2-n3/transformation-through-collaboration-horizons-patient-centered-program-is-delivering-results/P-1>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.34 Intel’s Connected Care

Model Name: Intel’s Connected Care	
Brief Description: Connected Care is Intel’s “ACO approach based on a PCMH model” for its employees in New Mexico, Oregon and Arizona. The payment model is based on a global per-member per-month (PMPM) target with shared savings and shared risk based on performance. It is centered on a network of PCMHs and medical “neighborhoods” of selected local specialists. In New Mexico for example, Intel partnered with Presbyterian Healthcare Services (PHS) which has a network of 8 hospitals, a medical group of 600+ providers and a health plan – all of which provide services to Intel’s employees under this Connected Care Program.	
Developer: Intel	
What is the goal of this payment model?	<p>The model aims to give Intel employees more personalized, evidence-based, coordinated, and efficient care. Specifically, Intel summarized its objectives as five “requirements”:</p> <ul style="list-style-type: none"> • Right care: use of evidence-based medicine • Right time: same-day access to care • Right price: material decrease in the cost of care • Best life: rapid return to productivity for the member • Best outcome: patient satisfaction 100 percent of the time
How long has this payment model been in operation? Where has it been implemented?	The model was launched on January 1, 2013 in partnership with Presbyterian Healthcare Services (PHS) for employees and dependents at Intel’s facility at Rio Rancho, New Mexico. As of January 2015 Connected Care was also launched in the Portland, Oregon area with Kaiser Permanente and Providence Health and Services as collaborating institutions. In January, 2016, Intel launched Connected Care in Arizona in partnership with the Arizona Care Network.
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>All services that Intel employees seek at partner health systems including primary care and specialty care are included in the model.</p> <p>For example, in New Mexico, the focus of the program’s plan design is:</p> <ul style="list-style-type: none"> - Patient centered medical homes with team-oriented care - Medical “neighborhood” of selected local specialists - High-value external network for special cases - National in-network coverage when out of area - 100 percent coverage of preventive services - Comprehensive prescription drug coverage, including 100 percent coverage of specific medications for diabetes, hypertension, and other targeted conditions - Elimination of nearly all prior authorizations - Available as a high-deductible health plan (HDHP) or co-pay plan - Same-day, 24/7 access, including secure messaging - Nurse navigators for high-needs members
Types of patients included?	Employees and dependents at Intel’s New Mexico, Oregon and Arizona facilities.
Method of attributing patients to participating providers	Eligible patients include Intel employees (and their dependents) who select the particular ACO health benefit plan.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Intel’s Connected Care	
Types of providers participating in the payment model?	Primary care providers working for participating PCMHs and selected local specialists that form a “medical neighborhood”. There are nurse “navigators” for “high-needs” members. On-site Intel walk-in clinic was transformed into a PCMH (Level 3).
The entity accountable to the payer?	The participating provider network – for e.g. Presbyterian Healthcare Services for the New Mexico employees of Intel.
The entity receiving payment from the payer (if different from above)?	Same as above
How are providers paid under the payment model?	A per-member per-month cost baseline is set based on data validated through an underwriting analysis. Shared costs/risks are realized when PMPM costs, based on submitted claims, fall outside the established corridor +/- 2% of target PMPM level
Are there any performance metrics? If so, what is being measured?	Performance metrics and categories measured by Intel to evaluate its performance in Year 1 of the New Mexico Connected Care Program: <ul style="list-style-type: none"> A. Member Experience <ul style="list-style-type: none"> - Provider Quality of Care - Satisfaction with experience, likelihood of recommending B. Evidence-Based Medicine <ul style="list-style-type: none"> - Diabetes (D3) bundle (Minnesota Criteria) - Depression screening C. Right Time, Right Service <ul style="list-style-type: none"> - Nurse call response time - Time to 3rd next available PCP appointment - Initial engagement with PCMH D. Cost <ul style="list-style-type: none"> - Medical and prescription costs E. Function-Learning Measure <ul style="list-style-type: none"> - Short-term disability (rapid return to productivity following a short-term disability).
Are there any performance incentives? If so, what is being incentivized?	The incentives are upside and downside shared savings based on performance on cost and quality above and below a designated threshold (the global PMPM).
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	<i>Information is not currently publicly available.</i>
Has the model been evaluated? Who funded this evaluation?	Detailed evaluations are not available but Intel released descriptive findings from Year 1 of Connected Care Program in New Mexico that report the model exceeded goals for member experience, evidence-based medicine, and “right time, right service” but did not meet cost goal.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Intel's Connected Care	
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

DeVore, Brian L, Wilson, Ben and Parsons, JJ. White Paper: "Employer-Led Innovation for Healthcare Delivery and Payment Reform: Intel Corporation and Presbyterian Healthcare Services", available at:

<http://www.intel.com/content/dam/www/public/us/en/documents/white-papers/healthcare-presbyterian-healthcare-services-whitepaper.pdf>

DeVore, Brian L and Cates, Lauren. White Paper: "Disruptive Innovation for Healthcare Delivery-Year 1 Report from Intel Corporation and Presbyterian Healthcare Services" available at:

<http://www.intel.com/content/dam/www/public/us/en/documents/white-papers/disruptive-innovation-healthcare-delivery-paper.pdf>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.35 Intel’s Healthcare Marketplace Collaborative (HMC)

Model Name: Intel’s Healthcare Marketplace Collaborative (HMC)	
Brief Description: Intel organized a learning collaborative involving health care systems in the Portland, OR area, and trained these health systems’ staff on how to use Intel’s version of the Toyota Production System to remove unnecessary steps from workflows and adopt clinical processes used by Seattle-based Virginia Mason Medical Center. Participating health systems used the model to attempt to improve quality, remove waste, and thereby reduce costs in both the clinical and administrative sides of their operations. No payment model was involved in this five-year learning collaborative.	
Developer: Intel, in collaboration with Virginia Mason Medical Center, Cigna, Providence Health & Services, Tuality Healthcare, Oregon’s Public Employees’ Benefit Board and the Oregon Educators Benefit Board.	
What is the goal of this payment model?	To tame what Intel perceived as soaring health care costs, Intel sought to use its deep expertise in supply chain management to improve quality, remove waste, and thereby reduce costs in both the clinical and administrative sides of local health care. The HMC strived to eliminate waste, achieve zero defects, and, where possible, focus on keeping people well, reducing the need for reactive care.
How long has this payment model been in operation? Where has it been implemented?	Intel’s Healthcare Marketplace Collaborative (HMC) began in 2009. Intel initially invited Cigna; Providence Health & Services, a multistate health care system; and Tuality Healthcare, a small health local system with two community hospitals, to join HMC. On Providence’s recommendation, two state agencies, Oregon’s Public Employees’ Benefit Board and the Oregon Educators Benefit Board, were asked to participate in 2010. The Collaborative ended in June 2014 after the improvement process had been established at both health systems and Intel felt it was no longer needed to drive the effort. As of 2015, Intel was applying elements of the HMC approach to health care providers its employees receive care from in Oregon and New Mexico, and planned to do so elsewhere as well.
Type(s) of health care services, medical conditions, and health care settings addressed?	HMC implemented best-practice clinical processes, called “value streams,” developed by Virginia Mason Medical Center. These methods are based on the Toyota Production System (TPS) to make its processes “lean”—in other words, strip them of activities that did not add value and caused delays or waits in patient care. The specific clinical episodes targeted in the HMC were: lower back pain; shoulder, knee, and hip pain; headache; breast problems; upper respiratory illness; diabetes; and “screening.” Intel paid for the clinical processes and Virginia Mason’s expertise in installing them and trained people at the local health systems to use Intel’s version of TPS to adapt them. Intel also enlisted its health plan administrator, Cigna, to contribute the claims data required to establish priorities and track progress. Based on this claims analysis, Intel chose medical conditions to focus on whose improvement would most benefit its employees, their dependents, and the company, based on expenditures and impact on patients; level of complication and risk; ease of standardization; and benefit to the health care system. HMC successfully implemented new clinical processes for treating six medical conditions and for screening patients for immunizations status and illnesses such as diabetes and high blood pressure. Providence and Tuality each decided whether or how to adopt each of the new clinical processes. In the end, Tuality chose to adopt some form of all these value streams. Providence adopted four, but decided that its programs for upper respiratory illness, diabetes, and screening were robust and would be kept; it was still committed, however, to achieving HMC goals for all three.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Intel’s Healthcare Marketplace Collaborative (HMC)	
Types of patients included?	Clinical processes were modified for all patients served by the participating health care systems – not just Intel’s 18,000 employees and their nearly 21,000 dependents in the Portland, OR area, nor the 270,000 active and retired employees insured by the state agencies.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Providence Health & Services, a multistate health care system, and Tuality Healthcare, a small health local system with two community hospitals.
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	No change in payment to providers; Intel invested funds to implement clinical best practices and streamline workflow processes at the participating health care systems. This assistance included loaning the HMC several of Intel’s “lean” experts and training 48 people at Providence and Tuality in Intel’s version of the TPS technique.
Are there any performance metrics? If so, what is being measured?	<p>HMC chose five standard metrics to assess their progress over time:</p> <p>To assess the goal of better care, HMC used two metrics:</p> <ul style="list-style-type: none"> • Whether or not patients received evidence-based care. The goal for this measure was 100%. • The proportion of patients who responded “probably” or “definitely” to the survey question “Based on today’s visit, would you refer a friend to our medical clinic?” The goal for this measure was 100%. <p>To assess the goal of faster care, HMC choose two metrics:</p> <ul style="list-style-type: none"> • The percentage of patients who could get a next-business-day appointment with an appropriate provider. The goal was for 85% of patients to experience this level of access to care. • The number of days before patients can resume their normal daily routines. Targets were set for each value stream, and the goal was for 90% of patients to meet or beat the target. <p>To assess how affordable care was, HMC measured:</p> <ul style="list-style-type: none"> • The total cost to employer and patient of treating a condition (i.e., the total fees paid to providers). The goal was to <i>reduce</i> costs (no numerical target was set), not just slow the rate of increase.
Are there any performance incentives?	Participating health care systems had an incentive to adopt the changes to clinical workflows recommended in the HMC in order to stay in Intel’s provider network. (Intel self-insures 18,000 employees and 21,000 dependents in the Portland area.)

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Intel’s Healthcare Marketplace Collaborative (HMC)	
If so, what is being incentivized?	
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This care delivery intervention makes no changes to the fee-for-service payment system.
Has the model been evaluated? Who funded this evaluation?	HMC has reported some high-level results from internal evaluations, available in the <i>Harvard Business Review</i> article cited below.
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

McDonald PA, Mecklenburg RS, Martin LA. The employer-led health care revolution. *Harvard Business Review*. 2015 Jul-Aug;33-50. available at <https://hbr.org/2015/07/the-employer-led-health-care-revolution>; Blackmore, CC, Mecklenburg RS, and Kaplan GS. "At Virginia Mason, collaboration among providers, employers, and health plans to transform care cut costs and improved quality." *Health Affairs*; 2011;30(9): 1680-1687, available at: <http://content.healthaffairs.org/content/30/9/1680.full>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.36 MDVIP

Model Name: MDVIP	
Brief Description: MDVIP is a for-profit network of 650 primary care physicians practicing concierge medicine in 42 states and DC. To retain one of these physicians and access the various non-covered services they offer, adult patients pay out-of-pocket membership fees that range from \$125 to \$183 per month (averaging \$1,800 annually). MDVIP patients have access to same-day or next-day appointments with their MDVIP primary care physician, an annual 60- to 90-minute wellness visit, and 24/7 access to their physician via email and phone. Patients typically also have a traditional insurance policy, to cover services received from hospitals, specialists, or other providers. The company reports that each doctor in their network manages 300 to 600 patients annually, totaling around 240,000 patients nationwide. According to MDVIP’s CEO, their patients are typically: (1) busy, active executives, or (2) people managing multiple chronic illnesses (e.g., their 100,000 Medicare beneficiaries). The company believes that Medicare would realize a 200% return on investment if they paid MDVIP concierge fees on behalf of Medicare beneficiaries, due to reduced ED utilization and better management of chronic diseases. In the commercial market, the company sees potential in associating with high-deductible health plans with HSAs, since MDVIP is HSA/FSA-qualified payment. MDVIP screens participating physicians, helps them build and market their concierge practice, provides research and technological and operational support, provides insurance and regulatory services, and conducts regular quality assurance surveys. MDVIP does not employ its affiliated physicians; MDVIP maintains an independent contractor relationship with its affiliated physicians.	
Developer: MDVIP	
What is the goal of this payment model?	MDVIP’s goal is to be a personalized healthcare program that empowers people to reach their health and wellness goals through in-depth knowledge, expertise and one-on-one coaching with primary care doctors in MDVIP’s network.
How long has this payment model been in operation? Where has it been implemented?	The company was founded in 2000. As of 2015, the company had 800 physicians in its network, with 650 practicing and the remainder in transition to adopt the model, in 42 states and DC.
Type(s) of health care services, medical conditions, and health care settings addressed?	At the core of the model is an annual “wellness” visit, which includes a comprehensive assessment of the patient’s health and a personalized wellness plan. MDVIP primary care physicians also deliver urgent and non-urgent care through same-day or next-day visits, and answer patients’ emails and phone calls 24/7. MDVIP physicians refer patients to and consult with specialists, and coordinate patient care received from other providers.
Types of patients included?	Adult patients who choose to pay the out-of-pocket subscription fee to retain a MDVIP primary care physician, including Medicare beneficiaries.
Method of attributing patients to participating providers	Not applicable.
Types of providers participating in the payment model?	<i>Information is not currently publicly available.</i>
The entity accountable to the payer?	Not applicable – the MDVIP primary care physician does not bill any payers for their services. Instead, patients pay subscription fees to these physicians to cover services provided by these physicians.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: MDVIP	
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	MDVIP does not employ its affiliated physicians; MDVIP maintains an independent contractor relationship with its affiliated physicians. Further details on the kinds of contracts MDVIP establishes with its physicians do not appear to be available online.
Are there any performance metrics? If so, what is being measured?	Not applicable.
Are there any performance incentives? If so, what is being incentivized?	<i>Information is not currently publicly available.</i>
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	<i>Information is not currently publicly available.</i>
Has the model been evaluated? Who funded this evaluation?	An evaluation of the program’s impact on its members who are enrolled in Medicare Advantage (MA) plans was published in the <i>American Journal of Managed Care</i> (cited below). MDVIP members experienced reduced utilization rates for emergency department visits and inpatient admissions, and the reduced medical utilization resulted in program savings of \$86.68 per member per month (PMPM) in year 1 and \$47.03 PMPM in year 2 compared with other MA plan members who were not MDVIP members.
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

MDVIP, available at: <http://www.mdvip.com/>; Mullin J, “Concierge care for all? Why MDVIP thinks the model makes sense for execs, teachers, and truck drivers,” *The Daily Briefing*, June 10, 2015, available at: <https://www.advisory.com/daily-briefing/2015/06/10/interview-with-mdvip-ceo>; Musich S, et al, “Personalized preventive care reduces healthcare expenditures among Medicare Advantage beneficiaries,” *American Journal of Managed Care*, 2014;20(8):613-620, available at: <http://www.ajmc.com/journals/issue/2014/2014-vol20-n8/Personalized-Preventive-Care-Reduces-Healthcare-Expenditures-Among-Medicare-Advantage-Beneficiaries/>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.37 Presbyterian Health Plan’s Medicaid Multi-Specialty Sub-Capitation Payment Model

Model Name: Presbyterian Health Plan’s Medicaid Multi-Specialty Sub-Capitation Payment Model	
Brief Description: Starting in 2015, Presbyterian Health Plan in Albuquerque, New Mexico has been paying primary care practices and multi-specialty group practices in Presbyterian Medical Services (the provider group affiliated with this plan) monthly sub-capitation payments for Medicaid members (covering the services that only they would be expected to provide, and not services provided in outpatient or other settings). The sub-capitation rate is based on 2013 and 2014 fee-for-service medical costs, reduced by an unknown percentage in 2015 and subsequent years. Outpatient pharmacy costs are included in the capitated rate and are reduced by 30% compared to 2013-2014 spending, giving providers a strong incentive to reduce drug spending, in particular. Any savings realized from diverting Medicaid members from the emergency department are calculated and split equally between the plan and the provider group. In the first year of the program, risk corridors ensured that the provider group’s losses or gains were capped at 2% above or below what would have been earned if they were still paid on a fee-for-service basis. The level of financial risk and reward grows over a five-year process and culminates in 100 percent shared risk.	
Developer: Presbyterian Health Plan, Albuquerque, NM	
What is the goal of this payment model?	The goal of the model is to improve care management and coordination within the parameters of a pre-determined budget and also to reward providers who can demonstrate improved performance.
How long has this payment model been in operation? Where has it been implemented?	The payment model was first implemented in 2015 and covers services provided at primary care practices and multi-specialty group practices in Presbyterian Medical Services, the provider group affiliated with the Presbyterian Health Plan.
Type(s) of health care services, medical conditions, and health care settings addressed?	<i>Information is not currently publicly available.</i>
Types of patients included?	Medicaid members insured by Presbyterian Health Plan and seeking services from primary care practices and multi-specialty group practices within Presbyterian Medical Services.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Primary care practices and multi-specialty group practices in Presbyterian Medical Services, the provider group affiliated with the Presbyterian Health Plan. Participating practices are expected to have invested in care management infrastructure and demonstrate the ability to improve performance.
The entity accountable to the payer?	Presbyterian Medical Services
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Presbyterian Health Plan’s Medicaid Multi-Specialty Sub-Capitation Payment Model	
How are providers paid under the payment model?	<p>The provider organization receives a monthly sub-capitated payment for its Medicaid members (covering the services that only they would be expected to provide, and not services provided in outpatient or other settings).</p> <p>For 2015, the monthly capitated payment rate is arrived at by using 2013 and 2014 Medicaid membership and claims data using models developed by Presbyterian Health Plan to measure medical costs for fee-for-service claims.</p> <p>The annual capitated payments are calculated from prior-year fee-for-service claims data and then reduced by an unknown percentage so that the plan can lower its spending, on a per capita basis, in the subsequent year.</p> <p>Outpatient pharmacy costs are included in the capitated rate and are reduced by 30% compared to 2013-2014 spending, giving providers a strong incentive to reduce drug spending, in particular.</p> <p>Any savings realized from diverting Medicaid members from the emergency department are calculated and split equally between the plan and the provider group. During a provider’s first year in the program, the plan institutes risk corridors so that losses or gains are within 2% of what would have been earned under fee-for-service. The level of financial risk and reward grows over a five-year process and culminates in 100 percent shared risk.</p>
Are there any performance metrics? If so, what is being measured?	<p>The primary performance measures examine outpatient pharmacy costs, emergency department visits and emergency department costs.</p> <p>Additional performance measures are used to attempt to ensure that the payment model does not cause access and quality to deteriorate, including measures of: the value of services for members, timely submission of encounters, hospitalization rates, complaint and grievance data, and emergency department visits by people with significant behavioral health needs.</p>
Are there any performance incentives? If so, what is being incentivized?	<p>Participating practices have an incentive to reduce the total cost of the health care provided to Medicaid beneficiaries, while simultaneously providing enough primary care services to keep hospitalization rates, emergency department visit rates, and complaint and grievance rates low. Also, outpatient pharmacy costs are included in the capitated rate and are reduced by 30% compared to 2013-2014 spending, giving providers a strong incentive to reduce drug spending, in particular.</p>
How do incentives operate?	<p><i>Information is not currently publicly available.</i></p>
Is this a stand-alone payment model or is it used with other payment models?	<p>This payment model is used in lieu of fee-for-service payments for participating practices, but was developed using historical fee-for service claims data.</p>
Has the model been evaluated? Who funded this evaluation?	<p>Formal evaluations are unavailable.</p>

**EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING
USED IN THE PUBLIC AND PRIVATE SECTORS**

Model Name: Presbyterian Health Plan’s Medicaid Multi-Specialty Sub-Capitation Payment Model	
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Alliance of Community Health Plans, “Rewarding High Quality: Practical Models for Value-Based Physician Payment,” April 20, 2016, available at: http://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.38 Priority Health’s Spine Centers of Excellence Program

Model Name: Priority Health’s Spine Centers of Excellence Program	
Brief Description: Since 2007, Priority Health (a Michigan insurer) has required members with persistent neck and back pain to consult with a physiatrist (a physician trained to diagnose and manage musculoskeletal problems) at a practice recognized by the insurer as a “Priority Health Spine Center of Excellence (COE)” before the patient may seek a non-urgent surgical consultation from an orthopedist or neurosurgeon. COEs are required to evaluate acute patients within 2 business days, and non-acute patients within 10 business days. COE physiatrists confirm diagnoses, and give patients and the referring physician information on different treatment options. COEs use shared decision-making tools to help patients understand the various treatment options, including their risks and benefits. COE physiatrists receive an additional \$100 beyond their usual consultation fee for this initial patient visit.	
Developer: Priority Health	
What is the goal of this payment model?	The health plan created a Spine Centers of Excellence program to reduce unwarranted variation, surgical costs, and the total number of spine surgical procedures in its patient population.
How long has this payment model been in operation? Where has it been implemented?	The program was launched by Priority Health (a health insurer) in 2007 and is currently implemented in 67 physiatrist practices across Michigan.
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>This program is intended to provide a physiatrist-led (i.e., Physical Medicine and Rehabilitation specialist) comprehensive medical evaluation, including a patient-centered review of all the treatment options available for a patient’s neck and low back pain.</p> <p>Evaluation by a COE is required prior to referral to an orthopedist or neurosurgeon for back or neck care unless there is an acute indication for surgical evaluation – meaning one of the following “red flags” are present: (1) evidence of tumor, infection, or fracture; (2) acute weakness in both arms or both legs; (3) Cauda equina syndrome (new onset of bowel or bladder dysfunction with areflexia, asymmetric paraparesis).</p> <p>Patients cannot obtain follow-up care following inpatient or emergency department care for spine-related conditions from a non-COE provider, unless the patient was previously seen by a spine surgeon in the ED or inpatient setting or has one of the three conditions mentioned above.</p> <p>Patients do not require prior authorization for care provided in the ED or inpatient setting.</p> <p>Patients may be required to view a shared decision-making tool/information prior to surgical consultation/referral. Patients may also be required to view a pre-surgery decision-making tool before surgery.</p> <p>Surgeons are not reimbursed unless services were previously authorized by Priority Health. After evaluation by a physiatrist, patients can elect to continue care with the physiatrist or be evaluated by a spine surgeon without further limitations. No limitations are placed on access to other specialists, including neurologists, other physiatrists, therapists, or pain specialists.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Priority Health’s Spine Centers of Excellence Program	
Types of patients included?	Patients aged 18 or older, insured by a Priority Health plan, who are experiencing back or neck pain and are interested in seeking a non-urgent surgical consultation must first obtain a physiatrist consultation from a COE practice. Priority Health members employed by RCO Engineering (a self-funded employer group) are exempt from this requirement.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	To be recognized by Priority Health as a COE, practices’ medical director must be board certified in Physical Medicine & Rehabilitation, a member of the North American Spine Society or another organization specifically dedicated to the treatment of spinal disorders, earn 10 hours of CME in back pain management per year. The practice must also employ a physical therapist, chiropractic consultant, or D.O. with advanced certification in the treatment of musculoskeletal conditions (including knowledge of the McKenzie Method). The practice must also employ a care coordinator responsible for scheduling, triage, outcomes tracking, and communications.
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Physiatrists participating in this program receive an additional \$100 beyond their usual payment rate for an initial consultation. No further details on this payment amount appear to be available.
Are there any performance metrics? If so, what is being measured?	<i>Information is not currently publicly available.</i>
Are there any performance incentives? If so, what is being incentivized?	Physiatrists have an incentive to recommend non-surgical treatment courses since Priority Health’s enhanced payment rate for physiatrist consultations is premised upon the assumption that mandating consultations with physiatrists will reduce the rate of surgeries among Priority Health members and thus save the plan money.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This is a fee-for-service payment model, used with the payer’s existing fee-for-service fee schedule; the payer has modified the payment rate for one fee-for-service code (initial consultations by physiatrists in COE practices).
Has the model been evaluated? Who funded this evaluation?	A pre-post analysis was published in the journal <i>SPINE</i> .

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Priority Health’s Spine Centers of Excellence Program	
Other pertinent information	<p>Background on the development of the program: Priority Health formed an advisory committee of primary care physicians, physiatrists, neurologists, and pain management specialists. This committee defined the criteria required for physician practices to obtain the health plan’s Spine Center of Excellence designation, as well as appropriate referral criteria. These criteria were reviewed and approved by the plan’s Medical Affairs Committee (composed of 14 practicing physicians, including both primary care and surgical specialists). The criteria included:</p> <ul style="list-style-type: none"> o staffing by a board-certified physical medicine and rehabilitation physician; o membership in the North American Spine Society or another organization specifically dedicated to the treatment of spinal disorders; o use of evidence-based treatment guidelines; o completion of annual continuing medical education in back pain management (minimum of at least 10 hr); o access to a physical therapist, chiropractic consultant, or D.O. with advanced certification in the treatment of musculoskeletal conditions; o commitment to provide access to acute patients within 48 hours and all patients within 10 business days; o use of a shared decision-making tool for patient education; o monitoring of clinical outcomes using standardized data collection tools; and o the health plan committed to <ul style="list-style-type: none"> - provide intensive member, provider, and employer education; - publish a list of approved centers; - provide comparative reports for each spine center; - provide, at no cost, 4 spine-related shared decision-making videos from the Foundation for Informed Medical Decision Making in Boston, MA; and - increase reimbursement for each new patient seen by \$100. <p>More information on the rationale for this program: Priority Health considers treatment of back and neck pain a preference-sensitive condition (meaning multiple treatment options exist, and patient values, experiences and preferences influence the chosen treatment option). Priority Health believes that physician networks where physiatry referral rates are higher have consistently demonstrated lower surgical rates. They also believe that there is evidence that patients, when fully informed of all their treatment options, tend to be more conservative than their physicians, are more satisfied with their decisions, and less likely to pursue legal action for poor outcomes.</p>

The above information was excerpted or summarized from these sources:

Priority Health, Spine Centers of Excellence, available at: <http://www.priorityhealth.com/provider/manual/auths/spine-coes>; Haig AJ, Spine care: Controlling the midfield, available at: http://www.p4psummitportal.com/assets/475/resources/haig_ms6.pdf; Fox J, et al, “The Effect of Required Physiatrist Consultation on Surgery Rates for Back Pain,” *SPINE*: 38(3): E178–E184, available at: http://www.medscape.com/viewarticle/778650_2; Priority Health, Medical Policy No. 91531-R2, Oct. 1, 2015, available at: http://www.priorityhealth.com/provider/manual/auths/~/_/media/documents/medical-policies/91531.ashx.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.39 Project Sonar

Model Name: Project Sonar	
Brief Description: Project Sonar is a medical home care delivery model for patients with Crohn’s disease, implemented at the Illinois Gastroenterology Group in Chicago and supported through Blue Cross Blue Shield Illinois’s specialty intensive medical home program payment model. Key components of Project Sonar are team-based care involving a nurse care manager, supported by proprietary care management software that includes a patient communication tool, clinical decision support for clinicians, and data analytics. Two types of additional payment are made by Blue Cross for patients enrolled in Project Sonar: a payment for an initial “supervisit,” and then supplemental payments per member per month (PMPM) for clinical infrastructure. (Specific amounts do not appear to be publicly available.)	
Developer: Dr. Lawrence Kosinski, of Illinois Gastroenterology Group and SonarMD, LLC (a software company he founded)	
What is the goal of this payment model?	The goal of Project Sonar is to improve patient access, care coordination, and illness management among high-risk, multi-chronic patients with Crohn’s disease (an inflammatory bowel disease that causes a high incidence of complications).
How long has this payment model been in operation? Where has it been implemented?	Blue Cross began making payments to Illinois Gastroenterology Group as of Sept. 1, 2014. This medical group has physicians practicing in 13 hospitals, 6 ambulatory surgery centers, and 12 offices in the Chicagoland area.
Type(s) of health care services, medical conditions, and health care settings addressed?	<i>Information is not currently publicly available.</i>
Types of patients included?	Targeted patients have Crohn’s disease (an inflammatory bowel disease) plus multiple other chronic conditions, are at the highest risk, and have been covered by Blue Cross for at least 12 months.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	<i>Information is not currently publicly available.</i>
The entity accountable to the payer?	The Illinois Gastroenterology Group is accountable to the payer.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Project Sonar	
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Details are unavailable online, but two kinds of payments are made in addition to traditional fee-for-service payments. These are: <ol style="list-style-type: none"> 1) A payment for an initial “supervisit” conducted after a patient is enrolled in Project Sonar; 2) A PMPM fee for clinical infrastructure.
Are there any performance metrics? If so, what is being measured?	The performance measures that are monitored include: quarterly claims data and quarterly pharmaceutical data.
Are there any performance incentives? If so, what is being incentivized?	The medical group is incentivized to perform highly on the performance measures, since this performs determines the size of PMPM payments.
How do incentives operate?	See above.
Is this a stand-alone payment model or is it used with other payment models?	Payments available through this model are available in addition to usual fee-for-service payments.
Has the model been evaluated? Who funded this evaluation?	No formal evaluations are available online, but a 2016 <i>Gastroenterology</i> journal article reported that in the first 10 months of implementation, costs decreased by 11%, inpatient costs decreased by over 57%, ED costs decreased by 53%, total biologic costs declined by 4%, use of physician-administered biologics rose by 9% and use of injectable biologics decreased by 25%. The study did not include a comparison group, and was funded by Takeda Pharmaceuticals, the maker of a Crohn’s disease drug. In June 2015, SonarMD, LLC signed an agreement with Takeda “to validate [the Sonar] platform.”

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Project Sonar	
Other pertinent information	<p>A nurse care manager (NCM) does initial outreach to 200 patients identified as the most critically-ill. The patients will receive a call, letter or email inviting them to enroll in the program at no cost. At an initial intake visit with the patient, the NCM does an assessment of medical and psychosocial needs and develops an action plan. The NCM will then monitor the patient's progress against the action plan, assist with care coordination and offer resources.</p> <p>A smart phone-based application facilitates monitoring patients' health status. Patients receive monthly secure communications including a set of questions; the answers to these questions produce a "Sonar Score," which is a numerical value that correlates with symptom intensity. The slope of this score is then plotted over time to reveal trends. The medical group monitors these trends and may intervene if a patients symptoms have worsened and they believe a patient is at risk of needing ED or hospital care.</p>

The above information was excerpted or summarized from these sources:

Kosinski LR, "Project Sonar – A Care Management Platform for Chronic Disease," Presentation at Global Health Care, LLC's Value-Based Summit & Pay for Performance Summit, February 18th, 2016, http://www.p4psummitportal.com/assets/480/resources/kosinski_ms11.pdf; "BLUE CROSS AND BLUE SHIELD OF ILLINOIS PIONEERS FIRST SPECIALTY INTENSIVE MEDICAL HOME PROGRAM," BCBS Press release, <http://www.bcbsil.com/company-info/news/news?lid=i18dwg7e>; Kosinski, et al, "Project Sonar: Reduction in Cost of Care in an Attributed Cohort of Patients With Crohn's Disease," *Gastroenterology*, 2016;150(4; Suppl 1): S173, [http://www.gastrojournal.org/article/S0016-5085\(16\)30668-0/abstract](http://www.gastrojournal.org/article/S0016-5085(16)30668-0/abstract).

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.40 PROMETHEUS Payment Model

Model Name: PROMETHEUS Payment Model	
Brief Description: The PROMETHEUS payment model is a bundled payment model whereby a group of providers are eligible for an annual retrospective bonus if they deliver all of the recommended care associated with a medical procedure or condition at a cost that is less than a previously-negotiated, risk-adjusted price for that clinical episode. This price is called an Evidence-informed Case Rate (ECR), and includes the cost of some potentially avoidable complications. The main way that providers are expected to reduce the cost of services associated with an episode is to reduce the occurrence of potentially avoidable complications. Disbursal of bonuses is contingent upon adequate performance on clinical process, outcome, and patient experience measures. A study of five pilot sites that tried to implement the PROMETHEUS payment model from 2008-2011 found that three of the sites had yet to enter into a contract by the end of this period, and two sites had abandoned these efforts early on. The PROMETHEUS payment model is more of a <i>concept</i> as opposed to a <i>specific payment model</i> – implementers decide on the price of bundles, quality measures to tie to payment, how to attribute patients, etc.	
Developer: Health Care Incentives Improvement Institute (HCII)	
What is the goal of this payment model?	According to the developers, PROMETHEUS model is a way to price patient care fairly, and encourage physicians, hospitals and other clinicians to collaborate in delivering effective and efficient care. The model, developers say, encourages caregivers to work in teams, share information, and take collective responsibility for a patient’s health.
How long has this payment model been in operation? Where has it been implemented?	From 2008-2011, five health care organizations attempted to implement the PROMETHEUS payment model. By the end of this period, three sites still had yet to work out all the implementation details and enter into contracts with payers (despite having willing partner payers), and two sites had abandoned this work earlier on. The three sites that attempted to implement this model were: 1) Independence Blue Cross and Crozer Keystone Health System in Pennsylvania; 2) The Employers’ Coalition on Health in Rockford, Illinois; 3) Priority Health–Spectrum Health in Michigan. Several years later, a 2014 <i>Health Affairs</i> blog post claimed that several payers and health care systems were still in the early stages of using the model to implement bundled payment programs.
Type(s) of health care services, medical conditions, and health care settings addressed?	All covered services delivered by all providers that would typically treat a patient for a given condition (i.e., hospital, physicians, laboratory, pharmacy, rehabilitation facility, etc.). The developer of this payment model has identified sets of recommended services for 21 acute & chronic medical conditions and inpatient & outpatient procedures.
Types of patients included?	<i>Information is not currently publicly available.</i>
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: PROMETHEUS Payment Model	
Types of providers participating in the payment model?	<i>Information is not currently publicly available.</i>
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Implementers specify their own approaches for designing and implementing this payment model, but generally speaking, providers receive fee-for-service payments for services within a bundle, and then an annual retrospective reconciliation compares the costs generated to the previously-negotiated, risk-adjusted price of a bundle. If the services provided during this episode cost less than the previously-negotiated price, and if quality measure targets are met, providers receive a financial bonus. (The degree of risk sharing between payers and providers is negotiable.)
Are there any performance metrics? If so, what is being measured?	Specific measures were not available, but the developers of PROMETHEUS state that the model includes incentives to reward provider performance on clinical process, outcomes of care, and patient experience measures.
Are there any performance incentives? If so, what is being incentivized?	See row above.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This payment model is layered on top of fee-for-service payments. Providers continue to be paid on a fee-for-service basis, and are then eligible for financial bonuses if the total cost of care provided during an episode is lower than a previously-negotiated bundled price.
Has the model been evaluated? Who funded this evaluation?	A 2011 evaluation published in <i>Health Affairs</i> concluded that of the five pilot sites that attempted to implement this payment model from 2008 to 2011, three had failed to execute contracts by May 2011, and two others had abandoned their efforts early on. The researchers found that the pilots took longer to set up than expected, primarily because of the complexity of the payment model.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Other pertinent information	<i>Information is not currently publicly available.</i>
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The above information was excerpted or summarized from these sources:

“PROMETHEUS PAYMENT: Pilot Assessment and Implementation Toolkit,” Health Care Incentives Improvement Institute, <http://www.hci3.org/wp-content/uploads/files/files/PROMETHEUS%20Payment%20Toolkit%20-%20Final.pdf>; “History,” Health Care Incentives Improvement Institute, <http://www.hci3.org/programs-efforts/prometheus-payment/history>; Hussey PS, Ridgely MS, Rosenthal MB, “The PROMETHEUS Bundled Payment Experiment: Slow Start Shows Problems In Implementing New Payment Models,” *Health Affairs*, 2011;30(11):2116-2124, <http://content.healthaffairs.org/content/30/11/2116.full>; Delbanco S, “The Payment Reform Landscape: Bundled Payment,” *Health Affairs Blog*, July 2, 2014, <http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment/>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.41 SMARTCare

Model Name: SMARTCare	
Brief Description: The SMARTCare (Smarter Management And Resource use for Today’s complex cardiac Care) program is a care delivery intervention that combines clinical decision support, shared decision-making, patient engagement, and provider feedback tools designed to improve care for patients with stable ischemic heart disease. Funded by a \$15.9 million dollar Health Care Innovation Award (HCIA) from CMMI, the program’s main goal is to deliver better, more appropriate care at a lower cost to patients experiencing chest pain due to heart disease. The developers of SMARTCare have proposed two payment models that could fund this intervention: (1) a bundled payment for diagnosis and treatment of stable ischemic heart disease, and (2) a care management fee that could be used in the interim, which would be increased or decreased based on past performance on cost and quality metrics.	
Developer: The Florida and Wisconsin Chapters of the American College of Cardiology	
What is the goal of this payment model?	SMARTCare is designed to give better, more appropriate care at lower cost to patients experiencing chest pain due to heart disease. Its three main goals are to: improve care for patients with stable ischemic heart disease; decrease costs of health care through reduction of unnecessary procedures; and engage patients in their care management.
How long has this payment model been in operation? Where has it been implemented?	Beginning in May 2014, this care delivery model is being implemented over a 3-year period in 5 sites in Florida and 5 sites in Wisconsin. The sites include a mix of private practices and academic hospital centers, and cover a diverse demographic landscape. The two payment models that have been proposed to accompany this care delivery intervention do not appear to have been adopted yet.
Type(s) of health care services, medical conditions, and health care settings addressed?	This care delivery intervention focuses on improving the appropriateness of care delivered to patients with stable ischemic heart disease (e.g., the care that might lead up to an angioplasty). This model aims to improve clinical decision-making in three key areas: 1) the appropriateness of noninvasive cardiac imaging, 2) the treatment choice between medical therapy, stenting, and bypass surgery, and 3) medication and lifestyle-change adherence.
Types of patients included?	Patients with stable ischemic heart disease served by the 10 participating sites. Under a description of a proposed bundled payment approach that could be used to pay for this care delivery model, the following patients would be included: patients with either (a) previously diagnosed coronary artery disease (for example, those who have had a previous heart attack, bypass surgery, or cardiac catheterization documenting the presence of disease) who are experiencing significant worsening of symptoms, or (b) patients without known coronary artery disease but who are experiencing stable symptoms such as chest pain that suggest coronary artery disease might be present. Excluded patients would be primarily those with unstable ischemic heart disease and those whose symptoms may represent impending myocardial infarction (“heart attack”). The reason for excluding these patients is that current evidence suggests that routine use of invasive procedures is warranted in these patients, and that nationwide the appropriateness of such high-cost but highly effective procedures is already greater than 90- 95%. Also, patients who have had heart surgery to correct birth defects within the heart will be excluded.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: SMARTCare	
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Cardiologists and other types of providers.
The entity accountable to the payer?	<i>Information is not currently publicly available.</i>
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	<p>This care delivery intervention is being funded through a grant from CMMI.</p> <p>The developers of SMARTCare have proposed two payment models that could support the delivery of this care delivery model: (1) a bundled payment for diagnosis and treatment of stable ischemic heart disease; and (2) a care management fee that would be adjusted based on past cost and quality performance and could be temporarily used to facilitate the transition to the bundled payment model.</p> <p>(1) The bundled payment: This payment model would consist of a single condition-based payment, paid to a SMARTCare provider for each patient requiring evaluation and treatment of new or significantly changed symptoms of stable ischemic heart disease. This payment would replace all current physician fees and facility-based payments for evaluation and management, testing, and PCI procedures for these patients during the six month period from the time they first seek care. The amount of the payment would be expected to be lower than what Medicare or a private health plan currently spends on current fees and payments for evaluation and management, testing, and PCI procedures for the patients, yet generous enough to cover the costs the SMARTCare provider will incur to (a) implement the new decision-support tools and (b) deliver the appropriate care, tests, and procedures to the patients. The amount would be risk-adjusted based on the severity of the patient’s symptoms and risk factors.</p> <p>(2) The transitional care management fee: This fee would be paid monthly or as a single lump sum for each patient, in addition to fee-for-service payments for services provided. The fee would be increased or decreased based on a provider’s past cost and quality performance. A target spending level would be defined in advance, based on average total spending for similar patients in the most recent year, and adjusted downward by a pre-defined amount to offset the additional spending on the SMARTCare management fee. The amount of that this fee would be increased or decreased would be proportional to (a) the amount by which the risk-adjusted total spending for the SMARTCare provider’s patients was above or below the target spending level, and (b) the amount by which the SMARTCare provider’s risk-adjusted performance on quality measures was above or below average compared to other cardiac care providers. Specific pricing, risk adjustment, and inclusion/exclusion criteria would be defined similarly to what was described above for the bundled payment model.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: SMARTCare	
Are there any performance metrics? If so, what is being measured?	As part of the care delivery intervention being implemented, SMARTCare physicians are collecting and reporting on measures of patient experience and clinical quality.
Are there any performance incentives? If so, what is being incentivized?	In the proposed bundled payment model, providers would have an incentive to reduce the quantity of services they provide to patients in order to generate a profit from their bundled payment. No quality measures appear to be tied to the receipt or size of these payments. In the proposed care management fee payment model, providers would have an incentive to reduce the cost of care provided to patients covered by this model and to increase the delivery of any services measured by the quality measures that would be used to adjust the size of care management fees.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	The proposed bundled payment model would be used instead of fee-for-service payments, while the proposed care management fee would be layered on top of fee-for-service payments.
Has the model been evaluated? Who funded this evaluation?	No formal evaluation appears to be available.
Other pertinent information	<p>The SMARTCare program “offers a chance for physicians to align their clinical practice with the best evidence-based recommendations, reduce unnecessary invasive procedures, and provide a streamlined mechanism for physicians and patients to collaborate in the health care process through shared decision making.”</p> <p>The registries and tools used in SMARTCare include:</p> <ul style="list-style-type: none"> - Non-invasive decision support (FOCUS) - Invasive decision support Shared (ePRISM) - Treatment based on individualized risk profile (INDIGO) - Performance benchmarking (PINNACLE) - The National Cardiovascular Data Registry (NCDR) - Immediate Feedback to Clinicians: (Dashboard)

The above information was excerpted or summarized from these sources:

Wisconsin Chapter of American College of Cardiology, SMARTCare, available at: <http://www.wcacc.org/aboutsmartcare/aboutsmartcare.html>; Florida Chapter, American College of Cardiology, Wisconsin Chapter, American College of Cardiology, Wisconsin Medical Society, Partnership for Healthcare Payment Reform, SMARTCare (Version 2), available at: http://www.chqpr.org/downloads/SMARTCare_Overview-of-Payment-and-Care-Changes.pdf; CMS, Health Care Innovation Awards Round Two: Project Profile: American College of Cardiology Foundation, available at <https://innovation.cms.gov/initiatives/Participant/Health-Care-Innovation-Awards-Round-Two/American-College-Of-Cardiology-Foundation.html>; and Marshall A, “SMARTCare holds potential to save billions in heart care costs,” *Cardiovascular Business*, June 2, 2014, available at: <http://www.cardiovascularbusiness.com/topics/healthcare-economics/smartcare-holds-potential-save-billions-heart-care-costs>; American College of Cardiology, “SMARTCare: Implementation of ACC State Chapter Initiatives Supported by a Major Grant from the Center for Medicare and Medicaid Innovation,” April 15, 2016, available at: <http://www.acc.org/about-acc/leadership/features/bog/2016/04/0415>.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.42 Tufts Health Plan Coordinated Care Model

Model Name: Tufts Health Plan Coordinated Care Model	
Brief Description: The Tufts Health Plan Coordinated Care Model (CCM) was developed to address the challenge of controlling healthcare costs while expanding healthcare coverage. The model intends to achieve the Triple Aim of reduced cost, improved quality and improved population health through three main elements: 1) value-based global budget contract models that pay providers for their ability to manage overall cost and quality of care and also provide them with analytic and consulting support; 2) a tiered product design that places hospitals and affiliated physicians (primary care providers and specialists) into two or three tiers based on cost and quality information, and provides plan members with cost-sharing incentives to select efficient, high-quality providers that provide the best value; and 3) the use of predictive modeling to identify certain subgroups of plan members and target them for care management activities across the spectrum of health care services to manage costs and quality.	
Developer: The Tufts Health Plan	
What is the goal of this payment model?	The goal of the CCM is to achieve the Triple Aim of reducing healthcare costs, improving quality, and improving population health. Strategy is to align financial and health quality incentives of plan, providers, and patients.
How long has this payment model been in operation? Where has it been implemented?	This payment model was conceived subsequent to the passage of Massachusetts’s health care reform law in 2006, when coverage expanded but costs were continuing to rise. Tufts Health Plan serves over 1 million members in Rhode Island and Massachusetts, and consists of 91 hospitals and nearly 29,000 primary care providers and specialists.
Type(s) of health care services, medical conditions, and health care settings addressed?	Health care settings span the care continuum from primary care providers and specialists, acute care hospitals, and post-acute providers.
Types of patients included?	The types of patients include commercial, Medicare, and Medicaid patients covered by the various plans offered by Tufts Health Plan.
Method of attributing patients to participating providers	The Tufts Health Plan is trying to attribute all members to a primary care provider; the Plan attributes members prospectively in their contracts, using a claims-based methodology. Their system also allows for members to self-select a primary care provider.
Types of providers participating in the payment model?	Providers across the care continuum including primary care providers, specialists, and acute care hospitals participate in the model.
The entity accountable to the payer?	All providers participate in the model.
The entity receiving payment from the payer (if different from above)?	<i>Information is not currently publicly available.</i>
How are providers paid under the payment model?	Value-based, global budget contracts pay providers for their ability to manage the overall cost and quality of care; including enhanced analytic and consultative support.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Tufts Health Plan Coordinated Care Model	
Are there any performance metrics? If so, what is being measured?	Metrics include providers’ overall quality relative to their network and peer group using quality metrics from HEDIS, CMS Process of Care Measures, Leapfrog, and HCAHPS.
Are there any performance incentives? If so, what is being incentivized?	Providers are paid based on their ability to manage the overall cost and quality of care delivered to plan members, and each participating provider’s baseline is reset every year based on their prior year’s performance.
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	<i>Information is not currently publicly available.</i>
Has the model been evaluated? Who funded this evaluation?	<i>Information is not currently publicly available.</i>
Other pertinent information	In addition to global budgets, the plan includes product designs that align incentives for members and providers, and clinical management programs that help providers reduce costs.

The above information was excerpted or summarized from these sources:

“Rewarding High Quality: Practical Models for Value Based Physician Payment” http://www.achp.org/wp-content/uploads/ACHP-Report_Rewarding-High-Quality_4.20.16.pdf

“Investing in Outcomes, Creating Value: Tufts Health Plan” <http://www.achp.org/wp-content/uploads/Tufts-Health-Plan-Innovation-Profile-ACHP1.pdf>

“Tufts Associated HMO Inc., Responses to Testimony Questions, September 16, 2013” <http://www.mass.gov/anf/docs/hpc/tufts.pdf>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.43 UnitedHealthcare Oncology Episode Pilot Program

Model Name: UnitedHealthcare Oncology Episode Pilot Program	
Brief Description: From 2009-2012, UnitedHealthcare partnered with 5 US oncology practices to pilot an episode payment model for treating nineteen discrete “episodes” in breast, colon, and lung cancer with evidence-based treatment regimens. Apart from using proven treatment regimens, the objective of the “episode” model was to use the least expensive combination of medications, thus attempting to discourage oncologists from using high priced drugs to potentially increase their margins of reimbursement. After physicians register the patients, the episode fee is paid immediately. During treatment, the physician is paid the average sales price for the drugs he or she administers (part of the overall episode). All other services such as physician office visit and chemotherapy administration are billed and paid for on a fee-for-service basis. The program saw a 34% decrease in predicted medical costs (nearly \$33 million) but saw 179% increase (than projected costs) in cost of drugs administered within the episodes.	
Developer: UnitedHealthcare	
What is the goal of this payment model?	<p>The two objectives of this program were:</p> <ul style="list-style-type: none"> - to decrease the total medical cost by using aligned financial incentives supported by actionable use and quality information - to remove the linkage between drug selection and medical oncologists’ income
How long has this payment model been in operation? Where has it been implemented?	<p>The pilot was tested from October 2009 – July 2012 in 5 oncology practices across the country. Midway in 2011, one practice was acquired by an academic medical center and left the program while another practice replaced it in the program. The practices were:</p> <ul style="list-style-type: none"> - Northwest Georgia Oncology, Atlanta, GA - Center for Cancer and Blood Disorders, Fort Worth, TX - Kansas University, Kansas City, KS - Dayton Physicians, Dayton, OH - West Clinic, Memphis, TN - Advanced Medical Specialties, Miami, FL
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>19 episodes in breast, colon and lung cancer were identified for this program (they are listed below). UnitedHealthcare established time limits for each episode based on the chemotherapy regimen selected by the medical group. There are two types of episode time limits.</p> <ul style="list-style-type: none"> - Chemotherapy regimens that are intended to treat patients after surgery for cure—rather than for palliative care—are called adjuvant regimens. These treatments are given for a defined period of time and then discontinued. UnitedHealthcare added sixty days to the scheduled regimens to define the episode time period. - For the patients with relapsed cancer that cannot be cured, UnitedHealthcare used an arbitrary episode time limit of four months. The episode is renewed for additional four-month periods if the physician is still providing care to the patient.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: UnitedHealthcare Oncology Episode Pilot Program																																														
	The following table lists the 19 episodes in breast, colon and lung cancer that were included in this program.																																													
	<table border="1"> <thead> <tr> <th>Cancer Type</th> <th>Episode No. and Description</th> <th>Duration (months)</th> </tr> </thead> <tbody> <tr> <td rowspan="10">Breast</td> <td>1. Stages 0, I; no chemotherapy</td> <td>6</td> </tr> <tr> <td>2. Stages I, II; HER2 overexpression, ER/PR negative</td> <td>12</td> </tr> <tr> <td>3. Stages I, II; HER2 overexpression, ER/PR positive</td> <td>12</td> </tr> <tr> <td>4. Stages I, II; HER2 underexpression, ER/PR negative</td> <td>6</td> </tr> <tr> <td>5. Stages I, II; HER2 underexpression, ER/PR positive</td> <td>6</td> </tr> <tr> <td>6. Stage III; HER2 overexpression, ER/PR negative</td> <td>12</td> </tr> <tr> <td>7. Stage III; HER2 overexpression, ER/PR positive</td> <td>12</td> </tr> <tr> <td>8. Stage III; HER2 underexpression, ER/PR negative</td> <td>6</td> </tr> <tr> <td>9. Stage III; HER2 underexpression, ER/PR positive</td> <td>6</td> </tr> <tr> <td>10. Stage IV; anti-estrogen therapy only</td> <td>4</td> </tr> <tr> <td rowspan="3">Colon</td> <td>11. Stage IV; treatment with all other medications</td> <td>4</td> </tr> <tr> <td>12. Stages I, II; no chemotherapy</td> <td>6</td> </tr> <tr> <td>13. Stages II, III</td> <td>9</td> </tr> <tr> <td rowspan="6">Lung</td> <td>14. Stage IV</td> <td>4</td> </tr> <tr> <td>15. Small-cell, any stage</td> <td>4</td> </tr> <tr> <td>16. Non-small-cell, stages I, II</td> <td>4</td> </tr> <tr> <td>17. Non-small-cell, stage III</td> <td>4</td> </tr> <tr> <td>18. Non-small-cell, stage IV, nonsquamous histology</td> <td>4</td> </tr> <tr> <td>19. Non-small-cell, stage IV, squamous histology</td> <td>4</td> </tr> </tbody> </table>	Cancer Type	Episode No. and Description	Duration (months)	Breast	1. Stages 0, I; no chemotherapy	6	2. Stages I, II; HER2 overexpression, ER/PR negative	12	3. Stages I, II; HER2 overexpression, ER/PR positive	12	4. Stages I, II; HER2 underexpression, ER/PR negative	6	5. Stages I, II; HER2 underexpression, ER/PR positive	6	6. Stage III; HER2 overexpression, ER/PR negative	12	7. Stage III; HER2 overexpression, ER/PR positive	12	8. Stage III; HER2 underexpression, ER/PR negative	6	9. Stage III; HER2 underexpression, ER/PR positive	6	10. Stage IV; anti-estrogen therapy only	4	Colon	11. Stage IV; treatment with all other medications	4	12. Stages I, II; no chemotherapy	6	13. Stages II, III	9	Lung	14. Stage IV	4	15. Small-cell, any stage	4	16. Non-small-cell, stages I, II	4	17. Non-small-cell, stage III	4	18. Non-small-cell, stage IV, nonsquamous histology	4	19. Non-small-cell, stage IV, squamous histology	4	
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Types of patients included?	Breast, cancer and colon cancer patients insured by UntiedHealthcare seeking care at the 5 participating oncology centers and being treated by one of the 19 episodes listed above.																																													
Method of attributing patients to participating providers	Patients were included based on being cared for by participating oncologists.																																													
Types of providers participating in the payment model?	Oncologists at the 5 participating oncology practices.																																													
The entity accountable to the payer?	Participating practices.																																													

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: UnitedHealthcare Oncology Episode Pilot Program	
The entity receiving payment from the payer (if different from above)?	[Same]
How are providers paid under the payment model?	<p>Each physician identified eligible patients during their initial consultation, and his or her office registered the patient with UnitedHealthcare. The episode fee is paid immediately. During treatment, the physician is paid the average sales price for the drugs he or she administers. All other services are billed and paid for on a fee-for-service basis</p> <p>The “episode” bundled the following three components:</p> <ul style="list-style-type: none"> - Physician hospital care - Hospice management - Case management - <p>All other services (i.e. physician office visit, chemotherapy administration, diagnostic radiology, laboratory) were paid as per the pre-existing FFS arrangement. For drugs, UnitedHealthcare calculated the drug margin for each selected regimen by subtracting the average sales price—the price determined by Medicare—from the group’s usual reimbursement for the drug using the existing fee schedule. Average sales price was used as a proxy for the physician’s actual acquisition price for the drug.</p>
Are there any performance metrics? If so, what is being measured?	<p>The main focus of the performance measures include patients’ survival, relapse-free survival, hospitalizations for complications and the total cost of care for an episode.</p> <p>Specifically, the quality and use measures used in the program include:</p> <ul style="list-style-type: none"> - Total cost of care - Emergency room and hospitalization rates - Parenteral drug costs per episode - Average drug cost per episode - Admissions for cancer symptoms - Admissions for treatment-related symptoms - Time to first progression for relapsed patients - No. of lines of therapy for relapsed patients - Hospice days for patients who died - Days from last chemotherapy to death - Costs in the last 30 days of life - Survival from date of condition enrollment (relapsed patients only) - Cost per admission and length of stay - Diagnostic radiology use - Laboratory service use - Durable medical equipment use - Surgical services, use and cost - Febrile neutropenia occurrence rate - Granulocyte colony-stimulating factor usage rate - Erythropoetin use

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: UnitedHealthcare Oncology Episode Pilot Program	
Are there any performance incentives? If so, what is being incentivized?	[No link between measures and payment stated]
How do incentives operate?	<i>Information is not currently publicly available.</i>
Is this a stand-alone payment model or is it used with other payment models?	This episode payment model is used in addition to the traditional FFS model and replaces payment only for few of the services under FFS.
Has the model been evaluated? Who funded this evaluation?	An evaluation funded and led by authors from UnitedHealthcare was published in the Journal of Oncology Practice in July 2014. The predicted fee-for-service total cost for the episodes cohort was \$98 million but the actual total medical cost for this cohort was \$65 million, representing a net savings of \$33 million. The predicted chemotherapy drug cost was \$7.5 million but the actual cost turned out to be \$21 million with a net increase in spending of \$13.5 million. (\$ figures are approx.) The decline in total costs, despite unexpected level of drug costs, was due to decline in hospitalizations and use of therapeutic radiation.
Other pertinent information	<i>Information is not currently publicly available.</i>

The above information was excerpted or summarized from these sources:

Newcomer, L et al, “Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Model”, Journal of Oncology Practice, July 8, 2014, available online:

<http://jop.ascopubs.org/content/early/2014/07/08/JOP.2014.001488.full> ; Newcomer, L, “Changing Physician Incentives For Cancer Care To Reward Better Patient Outcomes Instead Of Use Of More Costly Drugs Health Affairs 31, no.4 (2012):780-785, available online at: <http://content.healthaffairs.org/content/31/4/780.full.pdf+html>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.44 Washington State Health Care Authority’s Accountable Care Program

Model Name: Washington State Health Care Authority’s Accountable Care Program	
Brief Description: Since Jan. 2016, a small subset of Washington state’s public employees residing in western Washington can opt in or be attributed to one of two local ACOs. These two ACOs are eligible to receive shared savings bonuses if their patients’ expenditures are lower than a specified spending target, and are at risk of paying back a share of any cost over-runs above this spending target. (Specific percentages are not available publicly.) Performance on quality measures is also used when calculating the size of bonuses or penalties. ACOs are expected to deliver integrated physical, mental health, and substance use disorder services, and implement and report on specific evidence-based, care transformation strategies listed below. The state plans to work with private and public employers to try to replicate this payment model in 2017.	
Developer: Washington State Health Care Authority	
What is the goal of this payment model?	This model is designed to reward achievement of the triple aim: better health, better care, and lower costs.
How long has this payment model been in operation? Where has it been implemented?	<p>This plan was launched in January 2016 in the Puget Sound region of the state (i.e., Snohomish, Kitsap, King, Thurston and Pierce counties).</p> <p>The two participating ACOs (known as “UMP Plus networks”) are:</p> <p>(1) Puget Sound High Value Network LLC - led by Virginia Mason Medical Center and including Edmonds Family Medicine, EvergreenHealth Partners and Hospital, MultiCare Connected Care, Overlake Medical Center, Seattle Cancer Care Alliance, and Seattle Children’s Hospital, and</p> <p>(2) University of Washington (UW) Accountable Care Network - led by UW Medicine (Seattle) and including Capital Medical Center; Cascade Valley Hospital & Clinics; MultiCare Connected Care; Overlake Medical Center; Seattle Cancer Care Alliance; Seattle Children’s Hospital; and Skagit Regional Health.</p> <p>The third-party administrator of the UMP Plan is Regence BlueShield.</p>
Type(s) of health care services, medical conditions, and health care settings addressed?	<p>ACOs are expected to deliver integrated physical, mental health, and substance use disorder services.</p> <p>They are expected to offer timely and convenient access to both primary care and specialty providers, as well as expanded service hours for primary care and urgent care, and 24/7 consulting nurse and tele-urgent care services. The ACOs are expected to provide enhanced communications to members, including plan-specific websites, dedicated contact centers for scheduling, prescriptions, and additional support services, and proactive member engagement through printed and electronic materials.</p>
Types of patients included?	<p>Public employees (i.e., employees of state government, higher education institutions, and school districts enrolled through the Public Employees Benefits Board) residing in the Puget Sound region are eligible to participate in this plan. Currently, 11,000 of the state’s 350,000 public employees and dependents are enrolled in this plan.</p> <p>These individuals can participate in one of two ways:</p> <ul style="list-style-type: none"> (1) Designated ACO Participants – members who enroll themselves in the plan. (2) Attributed ACO Participants – members who have not enrolled themselves in the plan, but who are attributed to one of the two ACOs based on their overall health care utilization patterns.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Washington State Health Care Authority’s Accountable Care Program	
Method of attributing patients to participating providers	<p>For members that are attributed to an ACO based on their health care utilization, utilization is based on utilization observed across all participating hospitals and providers in an ACO. Members must have a minimum of two qualifying visits with an ACO within a 24-month period to be attributed. Members are attributed using the following hierarchy:</p> <ol style="list-style-type: none"> 1. Highest number of qualifying visits 2. If a tie for highest number of qualifying visits, highest total RVUs for qualifying visits 3. If a tie for qualifying visits and RVUs, most recent date of service. <p>Members are attributed to the ACO with which they have the majority of their qualifying visits to <i>primary care specialists</i>. Or, if a member cannot be attributed based on qualifying visits to primary care specialists, the member will be attributed based on qualifying visits to both <i>primary care</i> and <i>chronic care specialists</i>.</p>
Types of providers participating in the payment model?	<i>Information is not currently publicly available.</i>
The entity accountable to the payer?	<p>The state has entered into contracts with each of the two ACOs:</p> <ol style="list-style-type: none"> 1) Puget Sound High Value Network LLC 2) University of Washington (UW) Accountable Care Network
The entity receiving payment from the payer (if different from above)?	Same as above.
How are providers paid under the payment model?	<p>The two participating ACOs’ approaches for paying providers in their network is unknown.</p> <p>Payments to each ACO are determined as follows. On an annual basis, a financial reconciliation is conducted separately for two cohorts: 1) Designated members (who opt in to the UMP Plus plan), and 2) Attributed members. ACOs are eligible to receive shared savings bonuses if their patients’ expenditures are lower than a specified spending target, and are at risk of paying back a share of any cost over-runs above this spending target. (Specific percentages are not available publicly.) Net savings can be achieved for both the Attributed and Designated Cohort, while net deficits can only be achieved for the Designated Cohort.</p> <p>Performance on quality measures is also used when calculating the size of bonuses or penalties.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Washington State Health Care Authority’s Accountable Care Program	
<p>Are there any performance metrics? If so, what is being measured?</p>	<p>A “quality improvement score” is calculated and used to determine the percentage of the savings or losses that an ACO will be paid or owe the state. These measures are a subset of the measures in the Washington Statewide Common Measure set, and measure the following five categories of care:</p> <ul style="list-style-type: none"> • Chronic conditions • Behavioral management • Client experience (CG-CAHPS) • Medical screenings and immunizations • Obstetrical care <p>Each measure is assigned a weight, reflecting its degree of influence on overall QI score. The state also requires the two ACOs to implement and report their progress on various evidence-based, care transformation strategies:</p> <ul style="list-style-type: none"> • Invest in infrastructure to advance primary care medical home (PCMH) standards across all network partners (as defined by 2011 National Committee for Quality Assurance (NCQA) PCMH Level III standards or equivalent). • Adopt clinical policies of HCA and coverage decisions of the Washington State Technology Clinical Committee. • Adopt certified health information technology infrastructure, including electronic health records, and participate in the Washington State Health Information Exchange. • Develop quality improvement plans that include implementation of Bree Collaborative recommendations across all partners for various high cost, high utilization, and high variation procedures: <ul style="list-style-type: none"> ○ Care coordination for high-risk members ○ Potentially avoidable hospital readmissions ○ Obstetrics ○ Total knee and total hip replacement surgery bundle ○ Spinal fusion bundle ○ Cardiology ○ Low back pain ○ End of life care ○ Addiction and substance dependence treatment • Participate in shared-decision making pilots and Accountable Communities of Health, Healthier Washington initiatives. • Participate in the cardiac, obstetrics and low back pain quality improvement programs of the Foundation for Health Care Quality, a trusted, independent organization based in Seattle.
<p>Are there any performance incentives? If so, what is being incentivized?</p>	<p>Organizationally, the two ACOs have an incentive to reduce the total cost of care provided to designated and attributed members, while also delivering high rates of the services measured using the 19 quality measures referenced above, and engaging in the activities measured by the patient experience survey used in this model. They also have an incentive to complete the various evidence-based, care transformation strategies listed above.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Washington State Health Care Authority’s Accountable Care Program	
How do incentives operate?	Each ACO has agreed to annual targets for financial “trend guarantees” (spending targets). If the ACO’s patients’ total health care expenditures are <i>below</i> the ACO’s trend guarantee (resulting in more savings than the targeted spending level would have created), the state pays the ACO a share of these savings. If the ACO’s patients’ expenditures <i>exceed</i> the ACO’s trend guarantee (resulting in less savings than the target would have created), the ACO must pay the state a share of the deficit (for “designated” patients only – not for “attributed” patients). The share of the savings (or deficit) to be paid to or collected from the ACO is determined based on the ACO’s performance on the quality measures described above.
Is this a stand-alone payment model or is it used with other payment models?	This payment model requires participating providers to continue to submit fee-for-service claims, so that the payer can annually retrospectively calculate participating ACOs’ cost and quality performance and determine the size of shared savings or shared deficits.
Has the model been evaluated? Who funded this evaluation?	<i>Information is not currently publicly available.</i>
Other pertinent information	Public employees who opt in to the UMP Plus plan pay 30% lower monthly premiums, and face lower medical and prescription drug deductibles and no cost-sharing for primary care office visits; if they complete a wellness assessment and earn a wellness incentive they pay no or a reduced medical deductible.

The above information was excerpted or summarized from these sources:

Washington State Health Care Authority, Paying for Value: Accountable Care Networks for Washington State Public Employees, September 2015, available at: <http://www.hca.wa.gov/assets/program/acpfactsheet.pdf>; Washington State Health Care Authority, Request for Application (RFA) No. 14-031, available at: http://www.hca.wa.gov/assets/program/acp_final_rfa_0.pdf; and Washington State Health Care Authority, Paying for Value, 2016, available at: <http://www.hca.wa.gov/about-hca/healthier-washington/paying-value>; Washington State Health Care Authority, Better Health. Better Care. Lower Costs.: The Facts, available at: <http://www.hca.wa.gov/assets/program/payingforvaluefactsheet.pdf>; personal email communication from J.D. Fischer, Washington State Health Care Authority, Aug. 10, 2016; Washington State Health Care Authority, Contract: HCA Contract Number K1471, available at: http://www.hca.wa.gov/assets/program/acp_pshvn_contract.pdf; Washington State Health Care Authority, Contract: HCA Contract Number K1469, available at: http://www.hca.wa.gov/assets/program/acp_uwmedcontract.pdf.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

1.45 WellPoint’s Patient-Centered Medical Home Pilot

Model Name: WellPoint’s Patient-Centered Medical Home Pilot	
Brief Description: This was the pilot program for WellPoint’s PCMH approach from 2007-2011 which paid primary care physicians an enhanced fee layered on top of traditional FFS. Two specific payment approaches that WellPoint followed in this program initially included: (1) a multi-payer initiative which consisted of incentive payments for care coordination and quality improvement on top of a traditional fee-for-service payment (such as in Colorado and New Hampshire) and (2) a single-payer initiative led by WellPoint to pay doctors an enhanced fee that is tied to achievement of quality levels (such as in New York).	
Developer: WellPoint, Inc. (now Anthem, Inc.) and partner provider organizations.	
What is the goal of this payment model?	The goal of the payment model was to reengineer primary care to improve outcomes and affordability.
How long has this payment model been in operation? Where has it been implemented?	Wellpoint began its patient-centered medical homes pilot in 2007, in ten patient-centered medical home pilots in Colorado, Connecticut, Maine, New Hampshire, New York, and Ohio. The pilots have served 134,000 WellPoint-affiliated health plan members and 255,000 participants across all payers, inclusive of WellPoint membership. After the pilots concluded, WellPoint expanded the program to all of its plans in a total of 14 states.
Type(s) of health care services, medical conditions, and health care settings addressed?	The main focus of this model is for physicians to support care coordination and preventive activities that improve the health of patients.
Types of patients included?	WellPoint and affiliated plans’ insured members seeking care from primary care physicians and associated specialists in the PCMH setting.
Method of attributing patients to participating providers	<i>Information is not currently publicly available.</i>
Types of providers participating in the payment model?	Primary care physicians working in a medical home setting.
The entity accountable to the payer?	Participating primary care practices
The entity receiving payment from the payer (if different from above)?	[Same]
How are providers paid under the payment model?	Different sites in the pilot program had slightly different features, for example: 1) In Colorado: The WellPoint plan paid both fee-for-service, in the form of a baseline payment for services provided by the physician, and pay-for-performance, with a care coordination fee and a payment based on the achievement of quality and cost or utilization measures.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: WellPoint’s Patient-Centered Medical Home Pilot	
	<p>The CO coordinating organization, Colorado Clinical Guidelines Collaborative, received grant funding to pay for practices to apply for the NCQA medical home recognition and helped practices improve their ability to function as medical homes. NCQA recognition level affected level of financial incentives.</p> <p>2) In New Hampshire: Each participating health plan in the New Hampshire pilot paid a per patient per month care coordination payment on top of a fee-for-service reimbursement. Each insurer set its own payment amounts and paid physicians twice a year, based on the number of patients attributed to that physician. The average care management payment was \$4 (the WellPoint payments were \$2, \$4, or \$6 for practices with level 1, 2, or 3 recognition, respectively)</p> <p>3) In New York: In New York, WellPoint’s affiliated health plan implemented an enhanced fee-for-service initiative that provided physicians with reimbursement in addition to standard fee-for-service payments if they achieve certain quality thresholds.</p>
Are there any performance metrics? If so, what is being measured?	<p>Strong incentives to meet NCQA measures. Other specific examples of performance metrics measured are:</p> <p>(1) Utilization measures such as: acute inpatient admissions, emergency room visits, specialty visits, etc.</p> <p>(2) Clinical Quality measures such as: glucose control, blood pressure control and lipid control for diabetes patients, appropriate antibiotic prescribing.</p>
Are there any performance incentives? If so, what is being incentivized?	<p>Cost, utilization and quality were incentivized, although the particular approach differed across sites.</p>
How do incentives operate?	<p>In Colorado: The WellPoint plan paid additional quality-based reimbursements to participating practices twice a year. Practices could earn level 1, 2, or 3 recognition from the National Committee for Quality Assurance based on their record of delivering various elements of care. Practices that earned level 3 recognition, the highest level, earned an extra \$7.50 per patient per month from the WellPoint plan. Fourteen of sixteen practices earned this highest level of recognition. The other two practices achieved level 2 recognition and received additional monthly payments of \$6 per patient.</p> <p>In addition, beginning in the second year, WellPoint included a pay-for-performance payment based on quality and efficiency measures such as improving care for chronic illness, encouraging appropriate emergency department use, and reducing unnecessary hospitalizations. The first performance payment was based entirely on quality improvement, with the amount hinging on the degree of improvement in the quality measures. The second performance payment, for the third year, will be based on both quality and cost efficiency.</p> <p>In New Hampshire: The WellPoint-affiliated health plan rewarded high-performing physicians by increasing payments for subsequent years. Practices could receive a 2 percent, 4 percent, or 6 percent increase in their evaluation and management payments. Representatives of participating practices met monthly to share their experiences with office process flow and their challenges and successes.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: WellPoint’s Patient-Centered Medical Home Pilot	
	In New York: “Enhanced” fee-for-service payments resulted in payments that were roughly equivalent to \$3 per patient per month for practices that achieved NCQA level 1 recognition, \$5 for those with level 2 recognition, and \$7 for those with level 3 recognition
Is this a stand-alone payment model or is it used with other payment models?	The incentive payments for care coordination and quality improvement were on top of a traditional fee-for-service payment.
Has the model been evaluated? Who funded this evaluation?	The Colorado pilot was evaluated by WellPoint and a researcher from the Harvard School of Public Health, and the New Hampshire pilot was evaluated by WellPoint and a group from the Heller School for Social Policy and Management at Brandeis University. In each case, WellPoint performed a “pre-post” analysis. HealthCore, WellPoint’s health outcomes subsidiary, conducted a baseline analysis of the New York pilot using insurance claims data from WellPoint’s affiliated health plan in New York. Analysis of the baseline data was published by WellPoint as a Health Affairs paper in September, 2012.
Other pertinent information	Wellpoint has implemented the model in all of its plans (14 states)

The above information was excerpted or summarized from these sources:

Raskas et al, “Early Results Show WellPoint’s Patient-Centered Medical Home Pilots Have Met Some Goals For Costs, Utilization, And Quality”, Health Affairs, September 2012 vol. 31 no. 9 2002-2009, available online at: <http://content.healthaffairs.org/content/31/9/2002.full>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

2. INTERNATIONAL MODELS

This section includes profiles for two sample payment models

2.1 Netherland’s Bundled Payments for Certain Chronic Conditions

Model Name: Netherlands’ Bundled Payments for Certain Chronic Conditions	
Brief Description: Dutch private health insurance companies are permitted to pay a single fee to a “care group,” which is a new legal entity formed by multiple providers (often exclusively primary care providers). For patients with diabetes, COPD, or needing vascular risk management, care groups deliver or subcontract with other preferred providers (e.g., specialists, labs, dieticians) to deliver a negotiated bundle of services associated with a particular type of chronic condition. The prices of these bundled payments are negotiated between each insurer and each care group, and fees paid to subcontracted providers are also negotiated between these providers and each care group. In 2007 (the first year that 10 care groups were allowed to be paid bundled payments for diabetes, under a pilot), bundled payments ranged from €258-€474 per patient per year; this range diminished in later years. In 2010, when bundled payments for type 2 diabetes, chronic obstructive pulmonary disease (COPD), and cardiovascular risk management, began to be allowed on a permanent basis, 100 care groups were accepting bundled payments for diabetes nationwide, and 7 care groups were accepting bundled payments for cardiovascular risk management in the southern part of the country.	
Developer: The Dutch minister of health approved the introduction of bundled payments for diabetes on a trial basis, and the Dutch parliament later voted to adopt bundled payments for 3 chronic conditions on an ongoing basis.	
What is the goal of this payment model?	The developer’s goals were publicly unavailable.
How long has this payment model been in operation? Where has it been implemented?	Bundled payments for diabetes started on a trial basis in Jan. 2007, and began being offered on an ongoing basis for type 2 diabetes and cardiovascular risk management in Jan. 2010. In July 2010, bundled payments for COPD began to be allowed. The initial diabetes pilot involved 10 care groups. In 2010, 100 care groups were accepting bundled payments for diabetes nationwide and 7 care groups were accepting bundled payments for cardiovascular risk management in the southern part of the country.
Type(s) of health care services, medical conditions, and health care settings addressed	Care groups are responsible for providing a negotiated bundled of services associated with diabetes, COPD, or cardiovascular risk management (including primary and specialty care). Care groups can negotiate with private insurers to only provide bundled services for one or some of these chronic conditions.
Types of patients included	Patients with diabetes, COPD, or needing cardiovascular risk management.
Method of attributing patient to participating providers	Unknown.
Types of providers participating in the payment model	Care groups are primarily made up of primary care providers, who then subcontract with other providers (e.g., specialists, labs, dieticians) to ensure the delivery of all of the health care services included in a particular bundle.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Netherlands' Bundled Payments for Certain Chronic Conditions	
The entity accountable to the payer	The care group.
The entity receiving payment from the payer (if different from above)	Same as above.
How are providers paid under the payment model?	<p>Private health insurance companies pay a single fee to a “care group” for a bundle of negotiated services associated with a particular chronic condition. Care standards recommending (but not requiring) what services to include in bundles are jointly developed by caregiver organizations, patient associations, and public health authorities in consultation with insurers.</p> <p>The prices of bundled payments are negotiated between each insurer and each care group, and fees paid to subcontracted providers are also negotiated between these providers and each care group. In 2007 (the first year bundled payments were permitted for diabetes), bundled payments ranged from €258-€474 per patient per year; this range diminished in later years. Care groups are free to distribute bundled payments to participating providers however they see fit.</p>
Are there any performance metrics, if so, what is being measured?	Unknown.
Are there any performance incentives, if so, what is being incentivized?	Physicians are incentivized to provide the negotiated bundle of services at a cost that is less than the negotiated price for this bundle – for example, by having specialists, primary care providers, and nurses all work at the top of their license.
How do incentives operate?	If a care group can deliver all of the negotiated services in a bundle for less than the negotiated price of this bundle, they can keep these savings.
Is this a stand-alone payment model or is it used with other payment models?	Bundled payments are just one of several sources of income for physicians in the Netherlands, and only cover the cost of services delivered to patients with qualifying chronic conditions. (See “Other pertinent information” at bottom of table for description of other payment approaches used in this country.)
Has the model been evaluated? Who funded this evaluation?	The Dutch health minister charged the National Institute for Public Health and the Environment with evaluating care groups receiving bundled payments. A government-funded report released in 2012 presented analyses of medical records, claims data, patient experience survey data, and interviews with care groups, but did not include any data from a comparison group. Specific assigned research questions are unknown, but some results follow: for 9 diabetes care groups studied, researchers found modest improvements on most process measures (which was partly attributed to better record keeping), and improvements on most outcomes measures. Patients’ and providers’ experiences were also positive. Providers felt that coordination improved, clinical guideline adherence improved, and attendance at multi-disciplinary consultations increased. The evaluation also found that the model led to health professionals working more at the top of their license, with primary care providers (rather than specialists)

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Netherlands’ Bundled Payments for Certain Chronic Conditions	
	<p>now managing well-controlled diabetics, nurses now conducting most diabetes check-up tasks and care management tasks, and optometrists and others doing many tasks previously done by ophthalmologists. Disappointingly, a separate 2012 analysis of national claims data found that total annual health care costs for patients treated by diabetes care groups increased by €288 more than a comparison group from 2008 to 2009. (For reference: total expenditures generated per diabetic patient in a care group was €4,872 in 2009.)</p>
Other pertinent information	<p>Contextual information about the Dutch health care system, which is not solely related to the bundled payments described above, follows:</p> <ul style="list-style-type: none"> -Residents of The Netherlands are required to purchase subsidized, community-rated, private health insurance covering a basic benefits package. In 2006, the average annual price of coverage for consumers was €1,050. -Employers are required to pay 7.75% of the first €51,414 of an employee’s salary to the government on the employee’s behalf. Employees pay tax on this income. Self-employed people pay 5.4% of their income. The government redistributes these contributions to private insurers using a risk-adjusted capitation formula. -The government pays premium subsidies to 5 million residents in this country of 16.8 million, ranging from €2.00-€72.00 per month, depending on income. -All patients register with a primary care provider of their choice. Full-time primary care providers have panels of approximately 1,900 patients. -Patients can only access specialists and hospital care (other than ER care) upon referral from a primary care provider. -Once they have a referral, patients can pick their specialist, but their insurer has the right to require a co-pay for out-of-network specialists. -Insured adults pay an annual deductible of €360 (as of 2014) to their insurer. Primary care visits and children’s health care are fully covered without a deductible and without cost-sharing. -Providers are not allowed to balance-bill (i.e., charge patients for costs beyond those paid by insurers). -Most primary care providers are self-employed; only 11% are employed by another primary care provider. -Payment for primary care providers includes: capitation fees for registered patients (which make up ~37% of their income, and are higher if the patient is older or from a “deprived” area, and ranged from €4.33-€5.73 per month in 2009); fee-for-service payments for office visits, home visits, phone calls, emails, vaccines, and drug refills (which make up ~33% of these providers’ income, and ranged from €4.50-€22.50 in 2009); payments for activities that increase efficiency or substitute for specialist care; bundled payments (described above); pay-for-performance payments; and hourly pay for after-hours care (€50.20/hour in 2009). -Primary care providers are required to provide 50 hours of after-hours care per year. Most provide after-hours care in hospital-run “General practitioner posts” which are on-site, after-hours clinics staffed by primary care providers and assistants; assistants

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Netherlands’ Bundled Payments for Certain Chronic Conditions	
	<p>triage phone calls and providers decide whether patients need to be referred to the hospital. Patients can also proceed directly to the ER or call an ambulance without a referral (though medical transportation is subject to patient cost-sharing).</p> <p>-Hospitals are primarily private, non-profit and receive a majority of their income from case-based DRGs (which cover inpatient, outpatient, and specialist costs). The prices of 70% of DRGs are negotiable by hospitals and insurers, while 30% are set nationally. Hospitals also negotiate budgets based on formulas that take into account # of beds, # of specialists, patient volume, etc.</p> <p>-Specialist fees are included in hospital DRGs, and almost all specialists work in hospitals (and are either paid on a fee-for-service basis as part of a private group practice, or are employed by the hospital and paid a salary). FFS specialists can negotiate an hourly rate with a hospital within a prescribed range (€132.50/hour, +/- €6.00), which must cover their practice expenses. These specialists are expected to earn €129,500 and have €75,760 in practice expenses, and work 1,555 billable hours per year. In reality, these specialists earn more than this. Salaried specialists employed by hospitals earn less (€64,416-€118,212).</p> <p>-85% of people buy voluntary, unregulated, supplementary health insurance to cover drug co-pays and services not included in the basic benefits package, such as physiotherapy, dental care, eyeglasses, contraceptives, and alternative medicine.</p> <p>-Legal residents are automatically enrolled in long-term care insurance, which is also subsidized by the government.</p>

The above information was excerpted or summarized from these sources:

Reinhard Busse and Juliane Stahl, “Integrated Care Experiences and Outcomes in Germany, The Netherlands, And England,” *Health Affairs*, 2014: 33(9): 1549-1558; JN Struijs, JT de Jong-van Til, LC Lemmens, et al. *Three years of bundled payment for diabetes care in the Netherlands: Impact on health care delivery process and the quality of care*. Bilthoven: National Institute for Public Health and the Environment, 2012; Struijs JN, Mohnen SM, Molema CCM, de Jong-van Til JT, Baan CA, *Effects of bundled payment on curative health care costs in the Netherlands: An analysis for diabetes care and vascular risk management based on nationwide claim data, 2007-2010*. Bilthoven: National Institute for Public Health and the Environment, 2012; Joost Wammes, Patrick Jeurissen, and Gert Westert, “The Dutch Health Care System, 2014,” in Elias Mossialos, Martin Wenzl, Robin Osborn, Chloe Anderson (eds.), *International Profiles of Health Care Systems, 2014*. New York: Commonwealth Fund, 2015; Niek Klazinga, “The health system in the Netherlands,” *Eurohealth*, 2008: 14(1): 8-10; Willemijn Schafer, Madelon Kroneman, Wienke Boerma, et al. *The Netherlands: Health System Review*. Copenhagen: World Health Organization, 2010.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

2.2 Physician Payment in Denmark

Model Name: Physician Payment in Denmark (as of 2014)	
<p>Brief Description: Publicly-financed health care is available to all legal residents in this country of 5.6 million. Primary care providers are privately-employed and contract with their regional government to receive payment using a hybrid approach that includes fee-for-service payments for services like office visits, diagnostic tests, minor surgery, etc. (making up 66-70% of their income) and capitated payments for patients who choose to register with their practice (making up 30-33% of their income).</p> <p>Specialists who work in office settings are also privately-employed, but are paid entirely on a fee-for-service basis, and after they deliver a certain threshold of services, subsequent fees are reduced by 40%. Specialists who work in hospital settings are publicly-employed and paid a salary based on the number of hours worked during regular hours and after-hours.</p> <p>Primary care providers and specialists can charge co-pays to the 2% of Danish patients who choose not to register with a primary care provider; the remaining 98% of patients face no cost-sharing from primary care providers, specialists, or hospitals.</p> <p>Payment rates are negotiated between the relevant professional association (for primary care providers, specialists, nurses, etc.) and a collective of regional governments, who are the entities that manage and pay for most health care.</p> <p>About 40% of the population has supplementary private health insurance to cover the cost of co-pays, services not fully covered by the state (e.g., physiotherapy), and to provide access to the small private hospital sector (97% of all hospitals services are provided by public hospitals). Separate plans are available to provide patients with a lump sum in case of critical illness.</p>	
Developer: Unknown	
What is the goal of this payment model?	<p>The goal of the fee-for-service component of Denmark’s payment model is to increase primary care providers’ productivity by incentivizing them to treat patients themselves, rather than referring them to specialists, and to incentivize the delivery of politically high-priority services, such as preventive services. Meanwhile, the capitated portion of this payment model is intended to provide remuneration for general services for which fees are not available, and to reduce providers’ incentives to provide unnecessary services to increase their incomes.</p> <p>Primary care providers’ role as gatekeepers ensures that primary care providers are patients’ first point of contact, and supports the principle that continuity of care should be provided by a family doctor and health care professionals should operate at the top of their license.</p>
How long has this payment model been in operation?	Unknown.
Where has it been implemented?	Unknown.
Type(s) of health care services, medical conditions, and health care settings addressed	Services provided by outpatient primary care physicians, outpatient specialists, and inpatient (hospital) physicians.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Physician Payment in Denmark (as of 2014)	
Types of patients included	All legal residents of Denmark (not including undocumented immigrants and visitors).
Method of attributing patient to participating providers	Patients register with a primary care provider of their choosing. Once these providers have 1,600 patients in their panel, they can refuse to take additional patients.
Types of providers participating in the payment model	Privately-employed primary care physicians, privately-employed office-based specialists, and publicly-employed hospital-based specialists.
The entity accountable to the payer	The physician (for privately-employed outpatient primary care physicians and specialists), and the hospital (for publicly-funded outpatient specialists and inpatient physicians).
The entity receiving payment from the payer (if different from above)	Same as above.
How are providers paid under the payment model?	<p>Primary care providers enter into contracts with their regional government to receive a combination of fee-for-service payments for services like office visits, home visits, electronic consultations, blood tests, wounds, minor surgery, diagnostic tests (which make up 66-70% of their income) and capitated payments for patients who register with their practice (making up 30-33% of their income). Their payment rates are set through national agreements negotiated between a collective body of regional governments and their professional association. Agreements specify office hours, are renegotiated every 2 years, and contain clauses about rate reductions if overall expenditures exceed given levels; regions monitor the activity level of individual practices and may intervene if they are significantly above average (though regions cannot order a primary care provider to reduce their productivity, or pay back money). In addition to services specified in national agreements, additional <i>regional</i> agreements can specify additional services to be delivered on a fee-for-service basis in certain areas (e.g., specific care coordination functions, participation in meetings, services to a particular institution). A small share of primary care providers' income derives from fees for non-covered services (e.g., certifying that a patient is healthy enough to have their driver's license renewed). One source estimated that 95% of primary care providers' income comes from public funds.</p> <p>After-hours care is generally provided by collectives of primary care providers who rotate on-call duties and are paid by regional governments on an enhanced fee-for-service basis (i.e., fees are higher for care delivered after hours). The exception is Copenhagen, which employs <i>salaried</i> staff (including specialized nurses). Patients call after-hours phone lines and speak with the on-call provider (or nurse, in Copenhagen), who decides whether to have a roaming mobile primary care provider unit conduct a home visit or to refer the patient to their after-hours clinic. After-hours clinics are often co-located at (but independent of) hospital emergency departments.</p> <p>The 98% of Danish patients who choose to register with a primary care provider face no co-pays, but must obtain referrals from this provider to access specialists.</p>

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Physician Payment in Denmark (as of 2014)	
	<p>The 2% of Danes who choose not to register with a primary care provider agree to pay co-pays for primary and specialty visits but can access specialists without a referral.</p> <p>All patients can only access public hospitals for inpatient or outpatient care if referred by a primary care provider. (A referral is not needed to access emergency care.)</p> <p>Specialists can be privately-employed and work in office settings without hospital privileges or can be government-employed and work in hospital-based ambulatory clinics.</p> <p>Privately-employed office-based specialists are paid entirely on a fee-for-service basis, receiving payments from: regional governments for referred public patients; private supplemental health insurers that provide voluntary wrap-around coverage of patients’ co-pays; and private individuals paying out-of-pocket. Allowable services and rates are specified for each medical specialty in national agreements negotiated by a collective of all 5 regional governments and the specialty physician association. If a specialist reaches a specified level of activity (“turnover”), fees for further services are reduced by 40%. Specialists can set their own fees for private patients, who typically pay out-of-pocket for minor interventions, and separately negotiate rates with voluntary supplemental health insurance companies for major (i.e., inpatient) interventions sought by privately-insured patients.</p> <p>Publicly-employed hospital-based specialists who provide inpatient or outpatient care are employed by regional governments. These specialists are paid a salary based on the number of hours worked. Salaries are negotiated by a collective of the country’s regional governments and the relevant employees’ union. Publicly-employed physicians are not allowed to see private patients in the hospital. (Separate private hospitals exist, but 97% of hospital services are provided by public hospitals.)</p>
Are there any performance metrics, if so, what is being measured?	No measures are used when calculating payments, to our knowledge.
Are there any performance incentives, if so, what is being incentivized?	See “What is the goal of this payment model?” above.
How do incentives operate?	See “How are providers paid under the payment model?” above.
Is this a stand-alone payment model or is it used with other payment models?	These are stand-alone payment models.
Has the model been evaluated? Who funded this evaluation?	Unknown.

EXAMPLES OF HEALTH CARE PAYMENT MODELS BEING USED IN THE PUBLIC AND PRIVATE SECTORS

Model Name: Physician Payment in Denmark (as of 2014)	
Other pertinent information	<ul style="list-style-type: none"> -Denmark’s publicly-financed health care system fully covers all primary, preventive, specialist, hospital, mental health, long-term, and child dental care, and subsidizes outpatient prescription drugs, home care, physiotherapy, optometry services, and adult dental care. -Patients can choose which hospital they go to, but must get a referral from a primary care provider to seek inpatient or outpatient hospital care. -Primary care providers’ agreements with regional governments require them to be open from 8am to 4pm on 4 weekdays per week (with the first hour reserved for phone consultations), and to stay open until 6pm or 7pm on 1 weekday per week. -Danish academics writing about this payment model report that the prevailing opinion in Denmark is that too large a share of primary care providers’ income derives from fee-for-service payments, potentially leading to shorter visits.

The above information was excerpted or summarized from these sources:

Karsten Vrangbaek, “The Danish Health Care System, 2014,” in Elias Mossialos, Martin Wenzl, Robin Osborn, and Chloe Anderson (eds.), *International Profiles of Health Care Systems, 2014*, New York: The Commonwealth Fund, 2015. Available at: <http://www.commonwealthfund.org/publications/fund-reports/2015/jan/international-profiles-2014>; Maria Olejaz, Annegrete Juul Nielsen, Andreas Rudkjobing, et al, *Denmark: Health System Review*. Copenhagen, Denmark: World Health Organization, 2012. Available at: http://www.euro.who.int/_data/assets/pdf_file/0004/160519/e96442.pdf?ua=1; Kjeld Moller Pedersen, John Sahl Andersen, Jen Sondergaard. “General Practice and Primary Health Care in Denmark,” *J Am Board Fam Med*, 2012, 25:S34-38.