Paying for Health Care: What's Working Today and What Does the Future Hold?

INTRODUCTION

Health care payment reform is critical to employers and other health care purchasers looking to contain health care costs and get greater value for their spending. The current fee-for-service model can encourage unnecessary care, driving up costs as we pay for the volume of care instead of its value. Reforms aimed at the payment side of health care can cut waste and improve quality by changing providers' incentive structure. At the same time, we need to focus on aligning incentives across consumers, health care providers, health care payers and health care purchasers, which often requires pairing payment reforms with benefit and network designs that give consumers motivation to seek higher-value care. And as we embark on changing the way we pay doctors and hospitals, we need to examine the greater health care market environment and determine what types of payment reform might work best given specific market conditions.

This report begins by defining payment reform, its penetration in the U.S. today, some of the current challenges, and the need to understand each specific market before determining an effective strategy for payment reform. The report then catalogues the payment, benefit, and network design reforms employers and others payers — including Medicare and states —are trying and how these strategies interconnect. **A complete list of all the programs and pilots reviewed in this report can be found in Appendix I**.

Whenever possible, this report contains examples of employers' and purchasers' experiences with different types of payment reform. However, where few or no examples exist, the report provides examples from Medicare and/or health plans, who often act on behalf of employers. Please note this report does not contain a comprehensive list of all examples of payment reform. Catalyst for Payment Reform (CPR) welcomes suggestions for additions or modifications to this report.

What Is Payment Reform?

While there are many different definitions of payment reform, for the purpose of this report and the other work we do, Catalyst for Payment Reform defines payment reform as follows:

- Payment that reflects or supports provider performance, especially the quality and safety of care that providers deliver;
- Payment methods that are designed to spur provider efficiency and reduce unnecessary spending.

Note: If a payment method only addresses efficiency, it is not considered value-oriented; it must include a quality component.

Payment reform typically lies at the intersection between health plans (or a government payer) and providers. This is where incentives can be created to provide higher-value care (efficient, affordable, high quality care). While it can be important for health care purchasers to provide financial incentives to health plans to encourage better performance, such as improving customer service, such incentives do not directly impact health care providers.

Where Do Things Stand Now?

In 2010, CPR and its participating members, including large private employers like The Dow Chemical Company, GE, and Wal-Mart Stores, Inc., as well as large public purchasers like the California Public Employees' Retirement System (CalPERS), set a goal that by 2020, 20 percent of commercial payments would flow through payment methods proven to enhance value. At the time, just 1 to 3 percent of payments reflected provider performance.

By 2017, Medicare will be putting 10 percent of its reimbursement to hospitals at risk based on their performance on quality and safety measures. And we now know from CPR's National Scorecard on Payment Reform that there has been meaningful progress in the commercial sector, though we are still short of CPR's 2020 goal.

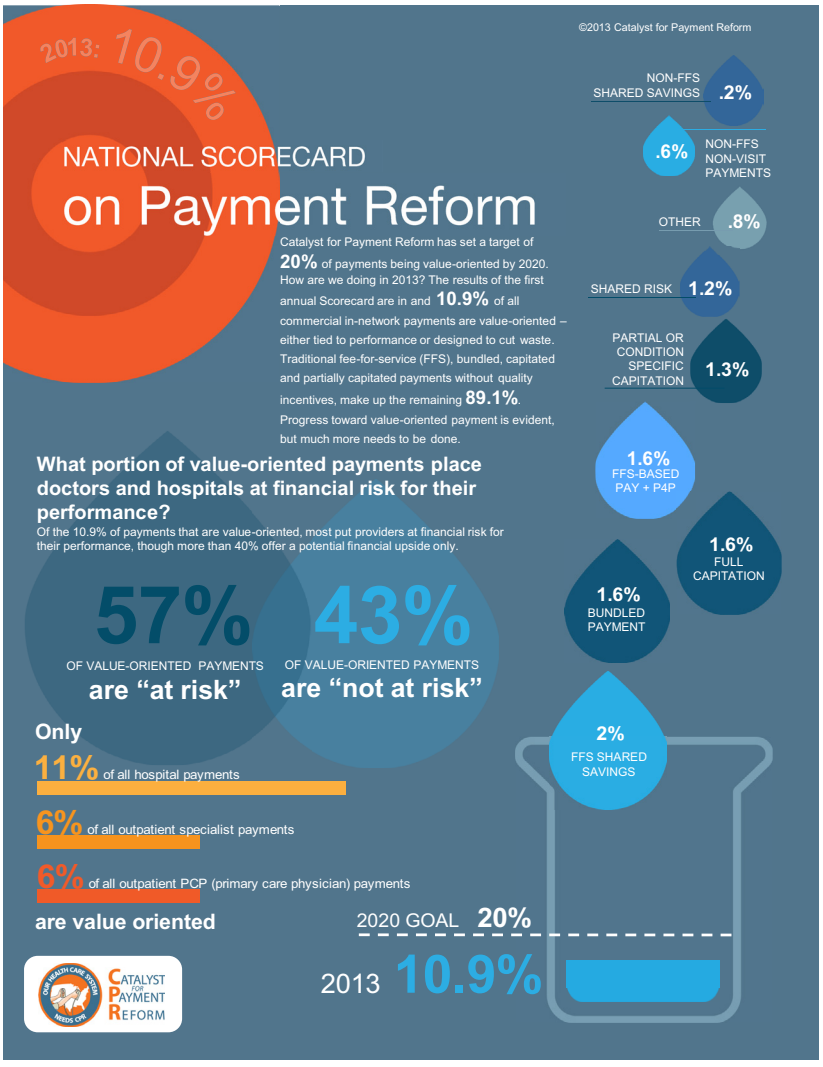
Scorecard Findings

In March 2013, CPR released its first annual National Scorecard on Payment Reform, which tracks the status of the private sector's progress from volume to value-oriented payment from a national and regional perspective. A companion National Compendium on Payment Reform, released at the same time, provides an online catalogue of payment reform pilots and programs, and serves as the basis for some of the information in this report.

Based on data collected from commercial health plans between November 2012 and February 2013, the Scorecard found that only about 11 percent of the in-network health care dollars we pay to doctors and hospitals today are value-oriented, tied to how well they deliver care or creating incentives for both improving quality and reducing waste. However, almost 90 percent of payments remain in traditional fee-for-service — paying providers for every test and procedure they perform regardless of necessity or outcome — or in bundled, capitated, or partially-capitated payments without quality incentives.

Within the 11 percent of payment that is value-oriented, the Scorecard found that 43 percent of those payments give providers financial incentives by offering a potential bonus or added payment to support higher-quality care, such as fee-for-service with shared savings. The other 57 percent of payments put providers at financial risk for their performance if they do not meet certain quality and cost goals, such as bundled payment.

The Scorecard also found just 11 percent of all hospital payments and 6 percent of all outpatient specialist and primary care physician payments are value-oriented. Currently, of the total outpatient payments made, the Scorecard found that 75 percent go to specialists and 25 percent go to primary care physicians. Hence, one figure to watch over time, as health care delivery and payment reforms aim to emphasize more primary care, will be the portion of payments that go to specialists versus primary care physicians. More detailed results from the Scorecard are on page 3.



METRIC	NATIONAL RESULTS
PROGRESS TOWARD CPR'S 2020 GOAL OF 20% OF PAYMENTS TIED TO VALUE.* This figure shows how close our nation is to achieving CPR's goal of 20% of payments tied to value by 2020, as well as the components of the current % of payment that is value-oriented. All other payment is payment without a quality component, including traditional fee-for-service.	10.9%
% OF PAYMENTS CONSIDERED "AT RISK." This figure shows the % of current value-oriented payments that put providers "at risk" for some financial downside if they don't meet quality expectations or go over budget, including: shared risk, bundled payment, capitation, partial/condition-specific capitation. Payment programs where providers are not "at risk" include pay-for-performance, shared savings, and payment for non-visit functions.	AT RISK = 57% NOT AT RISK = 43%
% OF DOLLARS PAID TO HOSPITALS, SPECIALISTS, AND PRIMARY CARE PHYSICIANS THROUGH PAYMENT REFORM PROGRAMS. These figures show the proportion of payments made to hospitals, specialists (outpatient care) and primary care doctors (outpatient care) that is value-oriented.	HOSPITAL = 11% SPECIALIST = 6% PRIMARY CARE = 6%
% OF COMMERCIAL, IN-NETWORK PLAN MEMBERS ATTRIBUTED TO A PROVIDER PARTICIPATING IN A PAYMENT REFORM CONTRACT. This figure shows the % of commercial, in-network plan members attributed to a provider participating in a payment reform contract, such as attributed members in an ACO or PCMH.	National = 2%
% OF NON-FFS PAYMENTS THAT INCLUDE A QUALITY COMPONENT. This figure shows how often quality is considered as a factor in a non-FFS-based payment. Non-FFS payment with quality includes: bundled payment with quality, capitation with quality, partial/condition-specific capitation with quality, shared savings with quality. Non-FFS payment without quality includes: bundled payment without quality, capitation without quality, partial/condition-specific capitation without quality.	NON-FFS W/ QUALITY = 35% NON-FFS W/O QUALITY = 60%
% OF HEALTH PLANS THAT OFFER MEMBERS TRANSPARENCY TOOLS AND HOW THESE TOOLS ARE OFFERED.** These figures show how many plans make certain information available to consumers through tools.	SEE SEPARATE TABLE BELOW
SHARE OF TOTAL DOLLARS PAID TO PRIMARY CARE PHYSICIANS VERSUS SPECIALISTS. This figure shows the share of payment to PCPs versus specialists. Over time, this figure will show if there is a rebalancing of payment between primary and specialty care.	PCP = 25% SPECIALISTS = 75%
% OF TOTAL HOSPITAL ADMISSIONS THAT ARE READMISSIONS FOR ANY DIAGNOSIS WITHIN 30 DAYS OF DISCHARGE FOR MEMBERS 18 YEARS OF AGE AND OLDER. This figure is the NCQA Plan All Cause Readmissions (PCR) measure. We included this measure as a quality indicator that we can track over time as a potential correlate to the changes in payment methods. (Derived from data submitted to eValue8 using NCQA's all-cause readmission measure. Not an official NCQA benchmark).	9%

*Breakdown of 10.9% Value-Oriented Payment

**Transparency Measures

PAYMENT REFORM PROGRAM	PRELIMINARY NATIONAL RESULTS
PAYMENT POSES FINANCIAL RISK FOR PROVIDERS	
Bundled Payment With Quality	1.6%
Partial or Condition-Specific Capitation With Quality	1.3%
Full Capitation With Quality	1.6%
Shared Risk With Quality	1.2%
PAYMENT DOES NOT POSE FINANCIAL RISK FOR PROVIDERS	
Fee-For-Service With Shared Savings	2%
Fee-For-Service Base Pay Plus Pay-For-Performance	1.6%
Non-Fee-For-Service, Non-Visit Function Payments (e.g. care coordination, medical home payment, or patient communication enhancements)	.6%
Non-Fee-For-Service Shared Savings	.2%
FINANCIAL RISK UNKNOWN	
Other	.8%
TOTAL	10.9%

METRIC	PRELIMINARY NATIONAL RESULTS
% OF PLANS REPORTING THAT THEY OFFER/SUPPORT A COST CALCULATOR TOOL.	98%
% OF PLANS REPORTING THAT COST INFORMATION PROVIDED TO MEMBERS CONSIDERS MEMBER BENEFIT DESIGN RELATIVE TO CO-PAYS, COST-SHARING, AND COVERAGE EXCEPTIONS.	86%
% OF UNIQUE USERS OF THE COST CALCULATOR TOOLS OF THE TOTAL ENROLLMENT.	2%
% OF PLANS WHERE COST CALCULATOR IS INTEGRATED INTO A HOSPITAL CHOOSER TOOL.	77%
% OF PLANS WHERE COST CALCULATOR IS INTEGRATED INTO A PHYSICIAN CHOOSER TOOL.	77%

To generate these results, the National Scorecard on Payment Reform uses data submitted on a voluntary, self-reported basis to eValue8, the National Business Coalition on Health's annual Request for Information to health plans. The plans responding to the Scorecard questions represent almost half of the commercially-insured lives in the U.S. While Scorecard findings are not wholly representative of health plans across the U.S., they offer a preliminary baseline against which to measure progress toward value-oriented payment in the commercial sector. CPR has made all findings, including a breakdown of payment methods, a glossary of terms, and the Scorecard methodology available online on its website.

It is important to note, because of the lack of a common definition, and health plans' tendency to look toward the categories above first, CPR did not include or measure global payment in its National Scorecard.

However, this paper includes a definition and a few examples, as some payment reform pilots do use global payment, although there is no widely-accepted definition for it.

Overall, it is important to note how little payment today flows through methods that meet CPR's definition of payment reform. While employers are increasingly interested and engaged in payment reform, there is still little of it happening in the private sector; in many cases employers have not been involved in payment reform efforts directly.

Current Challenges to Payment Reform and Related Issues

In our current health care environment, there are some longstanding barriers to payment reform, including lack of price and quality transparency. It is difficult to pay providers based on value, not volume, where there is insufficient information about provider quality. Lack of price information often means consumers can't play a role in shopping for care based on value, even in situations where providers are supposedly paid based on value, not volume. And provider market power can be an impediment to payment reform as well, pushing prices higher based on provider clout, not quality. Some of these issues can best be addressed through a combination of payment reform and benefit design and provider network strategy. More details come later in this report. Others lend themselves to regulatory interventions, which this report does not address.

Different Types of Markets Need Different Reforms

The example of provider market power highlights the need to consider a specific market's characteristics and dynamics before moving ahead with a particular payment reform strategy. While there are many variables that affect which payment reform options are best suited to a particular market, experts agree that local providers, employers and other health care purchasers, and health plans have the greatest impact. CPR developed a comprehensive Market Assessment Tool to help these and other health care stakeholders understand the type of market they operate in, and the best possible course forward for payment reform. Through a combination of an online stakeholder survey, in-depth key informant interviews, and structural data about the market, CPR's Market Assessment Tool can characterize each of these three stakeholder groups as *market shaping or non-market shaping*. The interplay of who has power in the market — who's calling the shots — may make all of the difference in what payment reform options are available or which should be tried first. Furthermore, the roles of the state and the regulatory environment also matter, as does the market's capacity and the supply and demand of specific services.

			PROVIDERS	
			MARKET-SHAPING	NOT MARKET-SHAPING
PURCHASERS	MARKET-SHAPING	HP+	Market Type 1	Market Type 2
		HP-	Market Type 3	Market Type 4
	NOT MARKET-SHAPING	HP+	Market Type 5	Market Type 6
		HP-	Market Type 7	Market Type 8

HP+ = Market-Shaping Health Plan; HP- = Not Market-Shaping Health Plan

While other nuances do exist, using providers, purchasers, and plans as the three main variables, CPR's Market Assessment Tool can categorize markets into eight types. Above, the right and left side of a schematic separates markets into those in which providers are shaping the market (left) and those in which providers are not market-shaping (right). The top and bottom of the schematic divides markets into those in which purchasers are shaping the market (top) and those in which purchasers are not (bottom). Then within those two purchaser categories, there is the added dimension of the role of the health plan in shaping the market, which further distinguishes the four main quadrants into eight separate market types. For example, Market Type 5 is one in which both the providers and plans are market shaping but where the purchasers are not.

Many elements go into determining whether or not each of these three stakeholder groups is a true market shaper. Through structural data and information from stakeholders, we can examine a combination of factors in making this determination, including but not limited to: market share; reputation; willingness to participate in payment reform; and capability of providing or accepting new forms of payment. Once the market type and market shapers have been identified, the various payment reform options available become much clearer. An overview of how CPR derives its recommendations can be found here.

Review of Payment Reform Options

While the possibilities for payment reform are broad, most changes to payment generally fall into one of three categories:

1. Upside only Payment reforms in which the payment changes give health care providers the chance for a financial upside, but no added financial risk, or downside. Common examples include pay-for-performance bonuses or care coordination fees for physicians serving as medical homes.
2. Downside only Payment reforms in which the payment changes give health care providers the possibility of being at financial risk in the event that added resources (which could have been avoided) are used to care for a patient. The most commonly referred to examples pertain to hospitals, such as non-payment for preventable hospital-acquired conditions or readmissions.
3. Two-sided risk Payment reforms in which health care providers have both a possible financial upside and downside. One illustration of this would be a risk-sharing payment arrangement in an Accountable Care Organization (ACO) type of setting in which there is shared savings potential, but also the risk that the provider will have to absorb costs if they spend over budget or do not meet quality targets.

We also include two additional categories, even though neither would be viewed strictly as payment reform. However, both are important options to be paired with payment reform or in the absence of viable payment reform strategies.

4. Consumer Shift Provider contracting and/or benefit design arrangements that encourage consumers to seek care from higher-value providers. Tiered or narrow networks are two such examples.
5. Regulatory Options Intervention by a federal, state or local regulatory agency or other governmental body to reform health care payment or the dynamics in the market that surround it. This paper does not address regulatory options.

PAYMENT REFORM STRATEGIES

The following is a comprehensive list of payment reform strategies in the market today, including examples of efforts by employers and other health care purchasers to use the models, as well as any known results. In some cases, a health plan may be leading the payment reform program, acting in the interest of its own fully-insured business and/or on behalf of self-insured employers or purchasers who work with that plan to provide coverage. When possible, employer and purchaser examples are shown first; otherwise, we provide examples from health plans, states, and Medicare. The examples below are listed according to the categories measured by the National Scorecard (with the addition of global payment). Categories with upside-only risk appear first.

The table in **Appendix I** provides a summary view of all the examples below by category, and where these categories fall on the spectrum of financial risk for providers. The table also summarizes details CPR was able to ascertain about the performance measures being used and any known results of the pilot or program.

CPR's National Compendium on Payment Reform provides further details on some of these examples as well. CPR encourages health plans, providers, and other sponsors of payment reforms to add details about their programs to the Compendium so that their efforts can be part of this robust, online resource.

1. PAY-FOR-PERFORMANCE/BONUS PAYMENTS FOR QUALITY/EFFICIENCY

A pay-for-performance (P4P) model provides incentives (typically financial) to providers to achieve improved performance by increasing quality of care and/or reducing costs. Incentives are typically paid on top of fee-for-service.

Health Plan Initiatives

Bridges to Excellence Housed at the Health Care Incentives Improvement Institute (HCI3), Bridges to Excellence (BTE) is a collection of physician recognition programs based on national quality measures; participating physicians can earn both peer recognition and additional revenue from participating health plans. BTE's recognition programs cover all major chronic conditions, plus preventive care, office systems, and a medical home measurement scheme to promote comprehensive care delivery. Research has shown that physicians participating in BTE outperform their peers, providing more appropriate care and using resources more efficiently. For example, BTE recognized-physicians performed significantly better than their non-recognized peers on measures of cervical cancer screening, mammography, and glycosylated hemoglobin testing.[1]

California Value Based P4P The California P4P program, managed by the Integrated Healthcare Association (IHA) on behalf of eight health plans representing 10 million insured persons, is the largest non-governmental physician incentive program in the United States. IHA is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in nearly 200 physician groups.

Since 2001, the program has offered financial incentives via health plans for physicians who achieve certain quality measures, and provided Californians with public quality data available through the State of California Office of the Patient Advocate. Between 2011 and 2015, the P4P Program is expanding to include both quality and cost in the form of Value Based Pay-for-Performance (Value Based P4P). This will help hold physician organizations accountable for the costs of all care provided to their HMO members, as well as the quality of this care, and will help to align physician organizations and health plans toward a more price-competitive HMO product.[2] Data collection has shown that the P4P program steadily raises care quality scores for participating physician organizations[3] and encourages physicians to use information technology and enhance efficiency.[4]

State Initiatives

According to a 2010 report issued by the National Conference on State Legislatures (NCSL), an estimated 85 percent of state Medicaid programs were expected to operate some type of pay-for-performance program by 2011 (the most recent estimate available).[5] Below is one example.

SoonerCare Choice SoonerCare Choice is a Primary Care Case Management (PCCM) program in which the state contracts with primary care providers/case managers throughout Oklahoma to provide health care for low-income, Medicaid-eligible, pregnant women; children; and the SSI-eligible population. Its P4P program provides bonus payments, averaging approximately $2,800 per provider, to physicians for completing early periodic screening, diagnostic, and treatment requirements (EPSDT) for children. The state funds its program by designating $1 million per year for bonus payments.[6] Since program implementation in 1997, the state has seen its EPSDT rates improve by more than 20 percent. According to an evaluation by the Pacific Health Policy Group, the State of Oklahoma has saved $139.2 million since it implemented the SoonerCare Choice program in February 2008.[7] The 2012 report found that the SoonerCare achieved an ROI of $6 for every $1 in administrative expenditures, in addition to reduced risk scores and gaps in care, high member satisfaction scores, cost decreases resulting from cost avoidance, and a significant increase in compliance rates for chronic conditions in the 88 provider practices that serve SoonerCare.[8]

Centers for Medicare and Medicaid Services (CMS) Initiatives

Hospital Value-Based Purchasing Program The Hospital Value-Based Purchasing (VBP) Program is a CMS initiative that rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare patients. Hospitals participating in the Hospital Value-Based Purchasing Program began to receive incentive payments for providing high-quality care or improving care after October 1, 2012. The incentive payments are based on a hospital's performance during the period from July 1, 2011, to March 31, 2012.[9] There are not yet any results available on its impact on quality or costs. A similar program, the Premier Hospital Quality Demonstration, which ran from 2003 to 2009, also utilized value-based payment and showed only small improvements in quality and no effect on expenditures.[10]

Physician Group Practice Demonstration Running from 2005 to 2010, this CMS demonstration rewarded physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Ten large (200+ physicians) group practices across the country participated. These groups received their regular Medicare payments for services they provided to beneficiaries, but they could also share in the savings generated as long as they met certain quality metrics and exceeded a savings threshold of 2 percent. The program contained 32 quality goals, most of them process measures related to coronary artery disease, diabetes, heart failure, hypertension, and preventive care. The savings threshold was calculated by using the per capita expenditures for a comparison group in the same geographic area and adjusting for the case mix and severity of illness.[11] Results indicate that participating physician groups scored well on quality metrics during all five years of the demonstration. However, only two groups were able to exceed a 2 percent savings threshold in the first year, and only half met the threshold after three years.[12]

2. NON FEE-FOR-SERVICE, NON-VISIT PAYMENTS

This payment model gives providers financial incentives and support to coordinate patient care, such as an extra per member per month (PMPM) fee layered on top of another payment model (e.g. fee-for-service) already in place. However, this payment is not fee-for-service, and is not dependent on patient office visits or the delivery of care in other venues.

Purchaser/Employer Initiatives

The Maryland Multi-Payer Pilot Program (MMPP) This program, described in greater detail in the Shared Savings section below, allows self-funded employers to work with their third party administrator and the Maryland Health Care Cost Commission to develop a program whereby the employer makes a fixed payment to primary care practices that care for its employees. The "fixed payment" is based on the quality of care and size of the practice and is a dollar amount per member per month. The annual "fixed payment" paid by employers per employee is $50-60. The fixed payment helps the primary care practice make the changes necessary to provide advanced primary care. The program has a shared savings component and well documented results described in greater detail below.[13]

State Initiatives

South Carolina's Healthy Connections Program South Carolina Medicaid beneficiaries have the option to join a managed care plan or a case management program called the Medical Homes Network Program. In this program, created in 2011, the state contracts with Care Coordination Service Organizations (CSOs) to create medical homes. In turn, these organizations contract with physicians to provide medical homes for patients. Physicians are paid fee-for-service by Medicaid, but may also receive a care coordination fee at the discretion of the CSO. Quality of care is measured by an annual survey.[14] There are no results available to report at this time.

Illinois Health Connect Bonus Payment Programs Illinois Health Connect, launched in July 2006, is the state's primary care case management (PCCM) program for certain populations covered by Medicaid, CHIP, and the state-funded program for children who would otherwise be uninsured. Participating primary care providers (PCPs) sign an agreement to provide better care/better care access in exchange for an enhanced fee schedule and ongoing monthly PMPM care management fees. They are also eligible for performance incentives. In April 2010, the Illinois Department of Healthcare and Family Services announced that Illinois Health Connect saved the state approximately $150 million in fiscal year 2009.[15]

3. CONDITION-SPECIFIC CAPITATION WITH QUALITY

Condition-specific capitation is a fixed dollar payment to providers for the care that patients may receive for a specific condition (or set of conditions) in a given time period, such as a month or year. Non-specified conditions remain reimbursed under fee-for-service or other payment methods.

Historically, some states have used this payment method in their Medicaid programs for beneficiaries with specific conditions, such as HIV/AIDS, or for those needing care for chronic illnesses or mental health. Below we include an example from CMS; we were unable to find public written descriptions of its use elsewhere.

Centers for Medicare and Medicaid Services (CMS) Initiatives

Medicare Health Support (formerly Chronic Care Improvement Program) The Medicare Modernization Act of 2003 (MMA) authorized development and testing of voluntary chronic care improvement programs, now called Medicare Health Support, to improve the quality of care for people living with multiple chronic illnesses. The programs were overseen by CMS and operated by health care organizations chosen through a competitive selection process (called Medicare Health Support Organizations or MHSOs). The program consisted of two phases. During the first six months of each outreach period, the MHSOs received a monthly management fee for each beneficiary in their assigned intervention group until such time that the beneficiary became ineligible or declined to participate. Beyond the initial six-month period, management fees were paid only for confirmed participants and eligible pilot periods. MHSOs were also held at risk for fees based on the performance of the intervention group relative to beneficiaries overall; fees were also at risk for several clinical processes of care and one patient satisfaction measure. Findings from the first 18 months of the pilot were not encouraging, as none of the eight MHSOs achieved gross savings rates that were statistically different from zero.[16]

4. PARTIAL CAPITATION WITH QUALITY

This capitation model involves a fixed dollar payment to providers for specific services (e.g. payments for carve-outs for high-cost items such as specific drugs or medical devices, like prosthetics) that patients may receive in a given time period, such as a month or year. Non-specified services remain reimbursed under fee-for-service. While we understand that some health plans have these relationships with provider systems, we were unable to identify any publicly available details about them.

5. FULL CAPITATION WITH QUALITY

Full capitation with quality is considered to be a fixed dollar payment to providers for all of the care that patients may receive in a given time period, such as a month or year, with payment adjustments based on measured performance and patient risk. Full capitation plus P4P is considered full capitation with quality.

Health Plan Initiatives

Kaiser Permanente Kaiser Permanente provides one of the best known examples of full capitation with quality. Comprising the Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Permanente Medical Groups in eight regions, Kaiser Permanente is the largest nonprofit, integrated

health care delivery system in the United States. The health plan pays regional medical groups on a capitated basis. Some of the regional health plans also give performance bonuses to medical groups for improvements in quality standards and member satisfaction.[17] Several studies have documented the success of Kaiser's capitated model in improving health outcomes and in reducing medical spending. For example, various Kaiser regions have had documented success reducing smoking rates among patients, improving patient safety, reducing readmissions, and reducing heart attacks.[18]

Centers for Medicare and Medicaid Services (CMS) Initiatives

Medicare Advantage In 2013, approximately one quarter of Medicare beneficiaries were enrolled in Medicare Advantage, Medicare's capitated arrangement with health plans. Under the Affordable Care Act, these health plans will receive bonus payments for quality performance. Historically, Medicare Advantage plans were paid relatively high rates—the Affordable Care Act brings their rates more in line with average costs for traditional Medicare beneficiaries. A recent study found enrollment in Medicare Advantage is associated with reduced hospitalizations.[19]

Medicaid Managed Care A number of states have at least some portion of their Medicaid program in managed care, whereby they pay health plans and related entities on a capitated basis to care for beneficiaries. A quality component is baked in, as federal law requires states to review their managed care plans to ensure they meet basic quality and patient access guidelines.[20] A paper by the Robert Wood Johnson Foundation synthesizing research on Medicaid managed care reveals some states have had more success than others when it comes to using managed care to reduce costs and improve quality.[21]

The Minnesota Senior Health Options Program Under the Minnesota Senior Health Options program, first implemented in 1997, participating plans contract directly with CMS and the state Medicaid program. They receive capitated payments from both organizations that cover all Medicare and Medicaid-eligible services. Under this arrangement, participating plans have a financial incentive to manage all aspects of the individual's health, with no incentive to shift responsibilities and costs to the "other" program. Enrollment is voluntary, and those who choose to enroll in the program receive a standard set of services — including a uniform health assessment, customized care plan, and care coordination — designed to meet their health care needs and help them remain as independent as possible. To align incentives, the state encourages plans to pay providers using some sort of value-based payment system (and will require this in the future). In addition, the state and CMS put in place various requirements and support structures to encourage the provision of high quality, low-cost services.[22]

As a result, the Minnesota Senior Health Options program has enhanced access to care, reduced preventable hospital and nursing home admissions, and generated high levels of satisfaction among beneficiaries and participating providers. In terms of enhanced access to care, 98 percent of dual eligibles (those enrolled in Medicare and Medicaid) enrolled in the program have had a primary care visit within the last year. By comparison, among Medicare beneficiaries nationally with six or more chronic conditions, 92 percent had a physician office visit in 2010. Though dual eligibles have more chronic illnesses, those enrolled in the program are less likely to be admitted to the hospital than traditional Medicare beneficiaries or Medicare HMO members in the state, and were also less likely to use nursing homes.[23]

6. GLOBAL PAYMENT

As discussed previously, due to lack of a widely-accepted definition, CPR's National Scorecard on Payment Reform did not measure the use of global payment. Many plans and payers define global payment the same way they define capitation. However, several payers describe their payment models as global payment, so we provide examples of it below. In most cases, global payment refers to a "next generation capitation" that incorporates more quality measures as well as risk adjustment.[24] Other experts make a distinction between capitation and global payment, with the latter more applicable to

large health care systems responsible for all the care of a specific population — inpatient, outpatient, as well as ancillary care.[25] Global payment can be administered either prospectively, with providers receiving a prospective PMPM fee to manage patient care, or retrospectively, in which case providers submit claims and are paid on a fee-for-service basis, but then payments are reconciled against a global budget at the end of the year.[26]

Purchaser/Employer Initiatives

Buyers Health Care Action Group Starting in 1997, the Buyers Health Care Action Group, a coalition of large Minnesota employers (now called Minnesota Health Action Group), created "Choice Plus," which organized providers into discrete care systems based on cost and quality, combined with greater transparency, consumer choice, and a modified form of global payment. The "modified" global payment paid fee-for-service (FFS) claims, and then adjusted future reimbursement rates based on total cost performance. A quarterly "look back" at claims cost compared expenditures to the bid target. Providers then had an increase in fee levels or a reduction in their fee schedule. Unlike traditional global payment, every service was reimbursed and providers did not receive a prospective pool of dollars. BHCAG spun off Choice Plus in 2001 and renamed it Patient Choice (it is offered today by Medica, a Midwestern health plan).[27] A 1997 assessment of the Choice Plus model found: availability of 90 to 95 percent of community primary care physicians (with almost twice the delivery sites as previous offerings); extensive consumer information about providers and the care systems in which they participate; and a cost reduction of 9 percent against expected claims.[28]

Health Plan Initiatives

BCBSMA Alternative Quality Contract (AQC) Since 2009, Blue Cross Blue Shield of Massachusetts (BCBSMA) has engaged an increasing share of the physicians and hospitals in its network in a payment reform model called the Alternative Quality Contract (AQC). While the model contains several features, it is predominately based on global payment. The AQC model combines a global budget for a patient population with significant performance incentives based on nationally-accepted quality measures. Providers participating in the AQC are paid FFS and have a pre-negotiated, per member per month (PMPM) budget. Provider organizations participating in AQC include large multi-specialty groups, independent practice associations, and physician–hospital organizations (PHOs). In addition, providers are exposed to both an upside (shared savings when costs are below budget) and downside risk (sharing in losses with BCBSMA when costs are higher than budgeted). There is also a separate financial incentive based on quality of care. The bonus system is based on absolute (as opposed to relative) performance; it is the same for all groups for the contract period, and depends on an overall quality score that is created by aggregating quality scores from each measure.[29]

In a 2012 study, Harvard researchers analyzed claims data from the AQC and found the program lowered total medical spending while improving the quality of care. On average, groups in the AQC spent 3.3 percent less than fee-for-service groups in the second year. Provider groups that entered AQC from a traditional fee-for-service contract model achieved even greater spending reductions of 9.9 percent in year two, up from 6.3 percent in the first year. In comparison, groups that entered from contracts that were already similar to the AQC achieved fewer savings in both years. The researchers also found that the improvements in quality of chronic care management, adult preventive care, and pediatric care associated with the AQC grew in the second year.[30]

State Initiatives

Oregon's Coordinated Care Organizations Oregon Medicaid has begun experimenting with global payment, creating "Coordinated Care Organizations" (CCO) to manage all the services required by a given geographic Medicaid population for a fixed global amount. CCOs are responsible for managing all care — physical health, mental health, and dental health. There is also an option for potential shared

savings. The program, started in 2012, is still very new.[31] However, a report looking at first year data shows that per capita spending on Medicaid dipped by more than 1 percent, and emergency room visits by CCO clients fell by 9 percent.[32]

7. BUNDLED PAYMENT WITH QUALITY

Bundled payment, also known as "episode-based payment," means a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition, or to provide a given treatment. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications. Reimbursement is paid to the provider on the basis of expected costs for clinically defined episodes that may involve several practitioner types, several settings of care, and several services or procedures over time. An example is payment to obstetricians for the ongoing management of pregnancy, delivery, and postpartum care.

Purchaser/Employer Initiatives

California Maternity Episode Payment Project The Pacific Business Group on Health, in collaboration with the California Maternity Quality Care Collaborative and Cynosure, launched a three-year maternity care project that combines a blended hospital payment and a physician pay-for-performance program, as well as targeted quality improvement support to reduce unnecessary cesarean deliveries at full-term. The project is scheduled to run from 2012-2015. The pilot developed a delivery-only bundle with a "super case rate" set to reflect a reasonable rate of cesarean delivery. The blended rate is for facility fees only, and there is a corresponding pay-for-performance program for physicians.

Hoag Hospital and a large medical group are working with Cigna to implement the program. Memorial Care is implementing this program with Aetna. A third hospital in Northern California is expected to implement the program in 2014.[33]

Health Plan Initiatives

PROMETHEUS PROMETHEUS, short for Provider Payment Reform for Outcomes Margins Evidence Transparency Hassle-reduction Excellence Understandability and Sustainability, may be the most well known of the performance-based bundled payment programs. Developed by PROMETHEUS Payment Inc. in 2006, now housed at HCI3, it assigns evidence-based case reimbursement rates (ECRs) to common conditions including depression, type 2 diabetes, and congestive heart failure, as well as common procedures such as total joint replacements and deliveries. A single ECR covers all inpatient and outpatient care associated with a given condition. Clinical Working Groups composed of experts in a particular field of medicine determine the ECRs based on treatment regimens consistent with current care standards. Costs are empirically determined and are risk-adjusted based on the severity and complexity of each patient. In addition, costs of potentially avoidable complications are calculated for each ECR and used both as an incentive to reduce total case costs as well as to improve quality. Under the PROMETHEUS plan, performance incentives can account for as much as 10 to 20 percent of the total bundled payment. Like many payment innovation programs, PROMETHEUS has the potential to exert additional pressure on providers by publicly reporting their rankings based on their quality and patient satisfaction scores.[34]

Several payers and health care systems are still in the early stages of using the Prometheus model to implement bundled payment programs; to date no widespread study has been completed about the savings derived from using the model, and data are still being gathered at specific sites (see one specific example below). The Commonwealth of Massachusetts issued a report in late 2013, estimating that had it used the model in 2009 for seven medical conditions (as compared to traditional fee-for-service payments), total payments would have decreased from $201 million to an estimated $175 million, saving the state $26 million primarily through a $17.4 million reduction in the cost of potentially avoidable complications.[35]

BCBSNC and CaroMont Health Bundled Payment Program In 2011 CaroMont Health and North Carolina's largest health insurer, Blue Cross and Blue Shield of North Carolina (BCBSNC), implemented a bundled payment arrangement based on the PROMETHEUS payment model for entire knee replacement. The bundle includes the pre-surgical period of 30 days prior to hospitalization, the surgery itself, and most follow-up care within 180 days after discharge from the hospital. BCBSNC saved about 8 to 10 percent on the average per episode cost in their one year pilot with CaroMont.[36]

United Healthcare and Oncology In 2010, UnitedHealthcare began a pilot with oncology groups to offer a single episode fee for an entire course of cancer treatment (for 19 different cancer scenarios). The oncology group chooses a treatment regimen and commits to 85 percent compliance with the therapy; UnitedHealthcare calculates the profit the group would make under the traditional mode of payment, and adds on a case management fee, before arriving at an agreed price for the payment. Participating oncology groups meet regularly to discuss and compare quality measures. The goal of the pilot is to help hold costs steady while improving care quality.[37] Formal results are not yet available, though the goal is to contain costs and improve the quality of care.[38]

Geisinger's ProvenCare Geisinger Health System has implemented a unique performance-based bundled payment system called ProvenCare, developed as a way to reimburse providers for coronary artery bypass graft surgery (CABG). Under this payment plan, physicians agree to follow 40 preoperative, perioperative, and postoperative treatment guidelines, such as prescribing preoperative antibiotics, in exchange for a flat rate of reimbursement. The premise is that closely followed guidelines will result in fewer complications and lower costs. However, physicians have the ability to deviate from a guideline if they document their reasoning. To develop the bundled payment, Geisinger calculated all costs associated with their standards of care for CABG surgeries and added half of the average historical cost of care related to complications.[39]

Geisinger Health Center's ProvenCare Program has achieved notable results, including a 10 percent reduction in readmissions, shorter average length of stay, and reduced hospital charges for CABG surgery.[40] The program achieved a 44 percent drop in readmissions over a course of 18 months.[41] The Atlantic reported that through the strict standardization process of ProvenCare, Geisinger significantly lowered mortality rates and complication rates for patients that underwent CABG in 2011.[42] Since the program's inception in 2006, the following other diagnoses have been added to ProvenCare: elective coronary angioplasty (PCI); bariatric surgery for obesity; perinatal care; and treatment for chronic conditions.[43]

State Initiatives

Arkansas Health Care Payment Improvement Initiative In 2012, Arkansas created the Arkansas Health Care Payment Improvement Initiative for both Medicaid and commercial payers for five episodes: perinatal; attention deficit hyperactivity disorder; upper respiratory infection; total joint replacement for both hips and knees; and congestive heart failure. Medicaid and commercial insurers will use data to identify the providers responsible for a patient's care and then reimburse them for the cost of the episode. Quality data will be collected as well with an opportunity for shared savings and shared risk depending upon their performance. The program is just beginning and results are not yet available.[44]

Centers for Medicare and Medicaid Services (CMS) Initiatives

CMS Bundled Payments for Care Improvement (BPCI) Initiative Under the Bundled Payments for Care Improvement initiative started in 2013, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher-quality, more-coordinated care at a lower cost to Medicare. The Bundled Payments initiative is comprised of four broadly defined models of care (described in **Appendix II**), which link payments for multiple services that beneficiaries receive during an episode of care.

Participants of the initiative were given 48 episodes to select from, ranging from acute conditions to chronic. The 99 participants among the various models include health care facilities including hospital systems, free-standing hospitals, integrated health care delivery systems, nursing homes, and stand-alone ambulatory centers. Appendix II reviews each model and the number of participating facilities. Over the course of the three-year initiative, CMS will work with participating organizations to assess whether the models result in improved patient care and lower costs to Medicare.

Medicare Acute Care Episode (ACE) Demonstration A three-year pilot that started in 2009, the Medicare ACE demonstration engaged five provider systems in a program wherein they received bundled payments for inpatient episodes of care. The episodes comprised cardiovascular and orthopedic procedures; ACE sites would also reward providers who achieve quality and efficiency improvements. Early results are promising with participating systems reporting savings.[45]

Medicare Participating Heart Bypass Center Demonstration Under Medicare's Participating Heart Bypass Center Demonstration, four hospitals in the 1990s were paid a single amount covering both hospital and physician services for CABG surgery. The Health Care Financing Administration (HCFA), now called CMS, originally negotiated contracts with four applicants (1991). In 1993, the government expanded the demonstration to include three more participants.[46] The program ran from 1991 through 1996. The evaluation by Health Economics Research showed that an all-inclusive bundled payment arrangement can provide an incentive to physicians and the hospital to work together to provide services more efficiently, improve quality, and reduce costs. Over the life of the program, Medicare saved $42.3 million on bypass patients treated in the demonstration hospitals. The average discount amounted to roughly 10 percent on the $438 million in expected spending on bypass patients, including a 90-day post-discharge period.[47] In addition, beneficiaries (and their insurers) saved another $7.9 million in Part B co-insurance payments, so total Medicare savings were estimated as $50.3 million in five years.[48] Overall, there were no systematic differences in self-reported health outcomes between demonstration and non-demonstration patients.[49] But the bundling of the physician and hospital payments did not have a negative impact on the post-discharge health improvements of the demonstration patients.

8. SHARED SAVINGS MODEL

This arrangement provides an incentive for providers or provider entities to reduce unnecessary health care spending for a defined population of patients, or for an episode of care, by offering providers a percentage of any realized net savings (e.g. upside risk only). "Savings" can be measured as the difference between expected and actual cost in a given measurement year, for example, and may vary based on provider performance. Shared savings programs can be based on a fee-for-service payment system and can be applied to some or all of the services that are expected to be used by a patient population. Some examples of shared savings are based on patient-centered medical homes, while some others are ACOs.

Purchaser/Employer Initiatives

CalPERS and PG&E (IOCP Model) Working with health plans and providers, Boeing first piloted the Intensive Outpatient Care Program (IOCP) for its Seattle employees with the Everett Clinic in 2007. The IOCP model focuses on care management for individuals with medically-complex conditions. Initially, under this model Everett Clinic providers were paid a PMPM fee for case management. The model has been shown to reduce health care costs by 20 percent and improve patient functionality.[50] Today, PG&E and CalPERS are using the model, working with the Pacific Business Group on Health (PBGH). The model now includes shared savings for the employer-purchasers, health care providers, and the health plan; 50 percent of savings goes to the employer, 45 percent to the medical group and 5 percent to the health plan. PBGH is now expanding the model to both the Medicare population and to other commercial plans and employers.

Health Plan Initiatives

Medica and Fairview Health Services Medica (a health plan) and Fairview Health Services (a provider system) partnered in 2009 to develop their approach to shared savings in Minnesota and select counties in Wisconsin, North Dakota, and South Dakota, for a pilot covering 800,000 to 900,000 individuals. Both Medica and Fairview rely on fee-for-service claims to pay provider groups their base payments and then additionally award a PMPM management fee to participating practices. These practices are expected to hire a disease care coordinator. Medica and Fairview award shared savings to each practice based on its performance on all services compared with a control group, including a comparison on quality measures that serve as a qualifying gate for practices to receive savings. A confidential algorithm then determines the shared savings pool based on health care quality, cost, efficiency, patient experience, and provider collaboration. Fairview takes 75 percent of the calculated savings, while Medica receives the other 25 percent. Fairview then distributes its share as follows: one-third to the hospital, one-third to care management infrastructure, and one-third to providers in the system.[51]

The Medica and Fairview Health Services shared savings experiment expanded quickly, and by 2011, all of Fairview's 40 primary care clinics were using the medical home model.[52] In addition, Fairview Health Services began writing shared savings contracts with all commercial health care purchasers.[53] Evaluation found that care quality increased significantly. For example, optimal vascular care went up from 35 percent in 2009 to 52.3 percent in mid-2013, and COPD testing rose from 44 percent in 2012 to 58 percent in mid-2013.[54] In addition, the cost of care in this program was better than the market average in 2012, while patient satisfaction remained high, even during the transition period.[55]

HealthPartners – Total Cost of Care Model Total Cost of Care (TCOC) contracting is a payment reform effort launched in 2010 by HealthPartners, the largest consumer-governed, non-profit health care organization in the nation, covering more than 1 million members. HealthPartner's TCOC approach was endorsed by the National Quality Forum in 2012.[56] To determine and distribute savings, HealthPartners compares each care system's performance to a jointly negotiated target. HealthPartners calculates savings by comparing the performance of participating practices to the costs of all health care services in the target. The organization calculates shared savings for commercially-insured and Medicaid patients separately. Providers and the plan share any cost savings equally. Unlike some shared savings arrangements, HealthPartners does not recapture plan costs associated with the arrangement, require reinsurance to protect against high-cost outliers, or have a minimum savings threshold.[57] Overall, by using TCOC, payers in the Minneapolis metropolitan area estimate providers are beating trends by 2 percent.[58]

Geisinger "ProvenHealth Navigator" The Geisinger Health Plan implemented a patient-centered medical home program in 2006, known as the ProvenHealth Navigator initiative.[59] By 2009, 38 primary care physician practices had been converted to medical homes serving as the main point of contact for more than 30,000 Medicare recipients and 3,000 commercial patients.[60] Each medical home site has a registered nurse case manager who gets to know patients and their families and can visit them in the hospital or nursing home, and a disease manager that can support patients by answering questions on chronic disease management. The medical home can also earn shared savings for meeting cost and quality targets. This model is a "quality-gated shared savings model" because, after meeting financial targets, the portion of cost savings that each practice receives is dictated by the number of quality standards it attains. The quality metrics are created annually for each practice across categories of chronic disease care, preventive care, care transition, patient experience, professional experience, and continuous improvement.[61]

Preliminary data on the first two medical home pilot sites found that the ProvenHealth Navigator model cut hospitalization rates by 20 percent and lowered costs overall by 7 percent. A study published in the American Journal of Medical Quality analyzed the "longer term 'hard' outcomes" experienced by patients in the ProvenHealth Navigator model in rural Pennsylvania, finding that there were reduced incidences of amputations among diabetic patients and end-stage renal disease, across four years

of claims data.[62] While there was no reduction in incidence of stroke or myocardial infarction among the medical home patients, Geisinger expects to see reductions in longer-term measures like 10-year cardiovascular risk.[63] Further analysis needs to be completed to identify which specific interventions and strategies incur the greatest impact or whether the impact comes from the different aspects of the ProvenHealth Navigator model working in tandem.[64]

State Initiatives

Maryland Multi-Payer Patient-Centered Medical Home Program (MMPP) Maryland began a three-year program to test patient-centered medical homes in 2011, with 52 primary and multi-specialty practices and federally qualified health centers (FQHCs) located across the state. Maryland law requires the five major carriers of fully-insured health benefit products (Aetna, CareFirst, CIGNA, Coventry, and UnitedHealthcare) to participate in the MMPP. However, the Federal Employee Health Benefit Plan (FEHBP), the Maryland state employee health benefits plan, TRICARE, and private employers such as Maryland hospital systems have also elected voluntarily to offer this program to their employees.[65] Based on a patient-centered medical home (PCMH) model, participating primary care practice sites can earn a percentage of the savings they generate through improved care and better patient outcomes. Practices also earn incentive payments based on meeting quality targets. The first of these shared savings payments took place in fall 2012, based on performance during 2010 and 2011.

Recognizing the comprehensive impact of the PCMH approach, the shared savings calculations include all patient costs, including the approximately 94 percent of costs that occur outside the primary care practice (e.g., in hospitals, with specialist physicians, etc.). To generate savings, practices must limit the growth of their patients' overall costs so that it is lower than the statewide average for non-MMPP practices. Using the state's all-payer claims database, the MMPP calculated each practice's total cost of care in 2010 to create a baseline, and then compared the expected costs to the practice's actual costs for 2011. If actual 2011 costs were less than expected (2010 baseline costs plus inflation), the practice achieved savings. Practices can earn between 30 and 50 percent of the savings by complying with quality requirements. Practices that reported performance on more quality measures earned a larger share of the savings they generated. In future years, practices will also need to meet utilization and performance targets to earn the maximum share of savings.[66]

The Maryland initiative has shown signs of early success. Of 52 participating providers, 22 earned savings in the first year, meaning they incurred "savings against expected 2011 total care costs and report[ed] on up to 21 measures that gauge the quality of care at the practice."[67] In addition to the shared savings received by the participating providers, the MMPP gave out $2.1 million to providers to invest in re-engineering their practices to a more advanced form of primary care.[68]

Centers for Medicare and Medicaid Services (CMS) Initiatives

Medicare Shared Savings Program (ACO Model) Beginning in 2012, CMS established a Medicare Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service (FFS) beneficiaries and to reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). ACOs demonstrate savings if assigned patient population expenditures are below the established benchmark, and the performance year expenditures meet or exceed the minimum savings rate (MSR). The MSR takes into account normal variations in expenditures. Under the one-sided model, the MSR varies based on the size of the ACO's population. This risk model also has a maximum share of savings of 50 percent for quality performance with a cap on shared savings at 10 percent of the benchmark. We describe a two-sided risk model in the shared risk section below. What began as 27 ACO organizations in the Shared Savings program in 2012 has now grown to 106 ACOs contracting with Medicare.[69] Federal savings are estimated to amount to $940 million by 2017.[70] However, there are no published results as of yet.

9. SHARED RISK

This model refers to arrangements in which providers accept some financial liability for not meeting specified financial and/or quality targets; examples include loss of bonus, baseline revenue loss, or loss for costs exceeding global or capitation payments, withholds that are retained, and adjustments to fee schedules. We include shared risk programs with a shared-savings component in the shared risk category (e.g. includes both upside and downside risk). Shared risk programs can be based on a fee-for-service payment system. With the rapid proliferation of ACOs supported by Medicare and commercial health plans, more providers today are entering into shared risk arrangements. While there are now hundreds of ACOs nationwide, most of them start with shared savings. A few documented examples of ACOs with shared risk payment arrangements are below.

Purchaser/Employer Initiatives

California Public Employees Retirement System (CalPERS) Shared Global Risk ACO In 2010, Blue Shield of California (BSC), Dignity Health (a hospital system), and Hill Physicians Medical Group jointly formed an Accountable Care Organization (ACO) that operates under an annual global budget reflecting total expected health spending for a defined population of around 41,000 individuals covered by CalPERS. Members receive a range of health services which are divided into "cost categories" for the purpose of assigning risk to BSC and the participating providers. The pilot has a global spending target and offers shared risk and savings among BSC and the two participating providers. The organizations operate under a three-way per member per month budget; each shares in the savings achieved under the target, and each bears financial risk for spending in excess of the target. However, risk was not evenly distributed among the organizations for all services; each partner assumed greater risk for cost categories over which it had the most influence on per member per month (PMPM) costs. The underlying reimbursement mechanisms for participating providers did not change during the pilot. The hospitals were still paid on a fee-for-service basis and the participating physician group was still paid on a capitated basis.[71]

BSC estimates that the project resulted in savings of about $20 million in 2010. The $5 million over the $15 million saving target is being shared among all three players. The ACO has generated a 22 percent reduction in patient readmissions compared with 2009, a half-day reduction in inpatient length of stay, a nearly 14 percent drop in total inpatient days per thousand, and a 50 percent reduction in the number of inpatient stays per thousand of 20 or more days. Translated into real dollars, the ACO achieved savings of more than $400 per member per year. Inpatient costs per day declined about $240 for the pilot population, compared to a $200 increase in cost per day for the control group.[72]

Intel Corporation and Presbyterian Health Services In early January 2013, Intel Corporation partnered directly with Presbyterian Healthcare Services (PHS) to offer its employees an accountable care-style benefits plan. Intel is working directly with the system (rather than through a health plan) to administer benefits for members in the arrangement. Intel and PHS developed a value-based compensation structure that includes both shared costs and pay for performance, and addresses both cost and quality factors. This compensation system is based on a global PMPM target, with shared savings. Intel and PHS share risks and rewards if results exceed or fall short of a designated target.[73] Given the newness of the arrangement, no results have been published yet.

Health Plan Initiatives

Blue Cross Blue Shield of Illinois (BCBS IL) and Advocate Health Care ACO (AdvocateCare)
BCBS IL and Advocate Health Care, the largest health system in the state of Illinois, may have one of the largest commercial ACOs in the U.S.[74] Providers can earn up to 50 percent in shared savings based on their performance compared to a control group. Advocate and its physicians must reduce costs and achieve quality outcomes to earn savings. For the first requirement, BCBS IL compares baseline medical

costs for the attributed population to the medical costs of patients served by the rest of BCBS IL's PPO network. To qualify, Advocate's trend must be lower than the risk-adjusted trend of the nonparticipating PPO network by more than a predefined amount. After Advocate has fulfilled this requirement, participating physicians must also meet minimum quality thresholds. [75] For the first six months of 2011, AdvocateCare's hospital admissions per member fell 10.6 percent compared with 2010 results, and emergency room visits were down 5.4 percent. Medical cost trend was 6.1 percent below market.[76]

Horizon Blue Cross Blue Shield of New Jersey ACO Pilot Horizon Blue Cross Blue Shield of New Jersey's (BCBS NJ) ACO Pilot comprises a large multispecialty group and several of Horizon's national accounts. The ACO pilot arrangement contains upside and downside payment risk for providers. Horizon Health Care Innovation (HHI), a subsidiary of Horizon BCBS NJ, leads the ACO pilot and provides a base fee schedule aligned against a projected total cost of care. If the ACO pilot exceeds the projected total cost of care, it is responsible for reimbursing a pre-negotiated percentage of the excess costs to HHI and participating accounts. HHI did not disclose the exact percentage that must be returned, but noted it is in the double digits. To protect the providers, the total cost of care is risk-adjusted. The amount of money at risk is also capped, so it is guaranteed a certain baseline of revenue. If the ACO is able to provide care at a reduced cost while meeting a quality threshold, it is eligible to share in the savings. The savings are shared between the participating accounts, HHI, and the ACO. The ACO is also eligible for additional payment if it performs within the top 10 percent of all quality metrics.[77]

To date, costs per patient, per month averaged almost $100 less than the statewide costs for patients not in the patient-centered medical home program. Quality results have also been positive, with lower readmission rates, among other measures.[78]

Medica Health Plan's Total Cost of Care Contracts Medica's Total Cost of Care contracts were conceived as a long-term, evolving payment model. Each of the six Total Cost of Care contracts is unique in its payment methodology, but follows a similar structure that includes shared savings and some amount of revenue at risk based on performance. There are currently six providers — five integrated health systems and one physician clinic — in the Twin Cities participating. Medica is anticipating expansion to other parts of Minnesota and North Dakota. The Total Cost of Care contracts entail a "risk and reward pool" funded through a withheld amount (which is held either by Medica or by the provider) or through prospective adjustments to providers' fee-for-service payment schedule. A given amount is withheld at the beginning of the contract year, and providers must achieve an established cost and quality threshold to receive payment from the withheld amount. Cost performance (80 percent) and quality performance (20 percent) determine eligibility for some or all of the withheld amount. Between 2 and 8 percent of provider revenue is at risk under these arrangements. Providers are also eligible to keep up to 50 percent of any savings they earn.[79]

Since 2008, Medica has seen lower fee-for-service rate increases as a result of their Total Cost of Care contracts, and they have recently initiated similar contracts that involve the Medicaid population. There have been challenges with the withhold method of payment, including a concern that it does not adequately support Medica's goal to eliminate overuse. In some cases, Medica found providers deliver more care under FFS systems with large withhold arrangements. There is also an administrative burden associated with processing individual checks to self-funded groups in situations when providers earn only a portion of the withhold. As an alternative and as a means of funding the risk and reward pool, Medica is exploring a per member per month fee (similar to a medical home payment) that could be increased or decreased based on the provider's cost and quality performance. Another alternative could include a network management fee that would be assessed as part of the premium.[80]

State Initiatives

Maine State Employee Health Commission and MaineGeneral Since early 2010, MaineGeneral Health (a non-profit provider system) and the Maine State Employees Health Commission (SEHC)

have collaborated to advance quality and reduce costs, using shared risk. To align incentives across stakeholders, the two have recently announced a partnership to collaborate on an ACO-like arrangement, with shared risk, and quality benchmarks. The collaboration will begin holding PMPM for 2013 to 2011 levels.[81] The partnership is moving towards a full global payment model in FY2014 with MaineGeneral committed to taking on greater risk for SEHC.[82]

Centers for Medicare and Medicaid Services (CMS) Initiatives

Medicare Shared Savings This model described in the Shared Savings section above also has a two-sided risk model. Under the two-sided model, the minimum savings rate is 2 percent of the benchmark for all ACOs. Shared loss calculation is one minus final sharing rate as a function of quality performance (not to exceed 60 percent). All ACOs share in the first dollar saved once they meet or exceed the minimum savings rate.[83]

CMS Pioneer ACO Model The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. It allows these provider groups to move more rapidly from shared savings to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Services Program. And it is designed to work in coordination with private payers by aligning provider incentives. The payment models being tested in the first two years of the Pioneer ACO Model are a shared savings payment policy with generally higher levels of shared savings and risk. In year three of the program, participating ACOs that have shown a specified level of savings over the first two years will be eligible to move a substantial portion of their payments to a population-based model. These models of payments will also be flexible to accommodate the specific organizational and market conditions in which Pioneer ACOs work.[84]

By reducing hospital admissions and readmissions, the CMS Pioneer ACO generated substantial savings, according to a 2012 CMS press release. Costs for the more than 669,000 beneficiaries aligned to Pioneer ACOs grew by only 0.3 percent in 2012 where as costs for similar beneficiaries grew by 0.8 percent in the same period.[85] Generating a gross savings of $87.6 million in 2012 and saving nearly $33 million to the Medicare Trust Funds, 13 out of 32 pioneer ACOs produced shared savings with CMS. Pioneer ACOs earned over $76 million by providing coordinated, quality care. Only two Pioneer ACOs had shared losses totaling approximately $4 million.[86] Banner Health Network, based in Phoenix, realized $13 million in savings in the first year of the program.[87] Despite these successes, nine out of the initial 32 Pioneer ACOs have dropped out of the program; seven of these did not produce savings through the program.[88]

10. Policies of Non-Payment to Providers

Policies of non-payment to providers arise when there is substantial medical evidence stating that a particular service is harmful to the patient and/or does not contribute to the care process in any meaningful way. These payment policies mean providers are no longer reimbursed for rendering such services, shifting the focus away from volume and onto appropriateness, while cutting wasted dollars in the system. Policies of non-payment send a strong signal to the health care industry, but can only be implemented under specific conditions.

State Activity

Pennsylvania Medicaid Non-Payment for Preventable Hospital Readmissions Policy Beginning June 2011, Pennsylvania Medicaid stopped paying for hospital readmissions occurring within 14 days of discharge (extended to 30 days in September 2011) "for the treatment of conditions that could or should have been treated during the previous admission."[89] Exceptions to the non-payment policy include payment for readmissions that qualify as outliers and readmissions due to complications of the original diagnosis with a different and more costly diagnosis as the result (in this case, Medicaid

shall pay the hospital the higher payment rather than the original payment). Readmissions unrelated to the original admission will be viewed as new admissions for billing purposes.[90] Typical scenarios of readmission non-payment include treating hospital-acquired conditions, like surgical site infections, untimely discharge after the original admission, and failing to provide necessary services during the initial hospitalization.[91] The state estimated the policy would save the Medicaid program $826,000 in fiscal year 2011-2012.[92]

South Carolina Birth Outcomes Initiatives The South Carolina Birth Outcomes Initiative (BOI) is a partnership involving South Carolina Medicaid, the state's Hospital Association, BlueCross BlueShield of South Carolina (BCBSSC), and other stakeholders to improve birth outcomes in South Carolina through a variety of program and policy changes.[93] In September 2012, BOI engaged all 43 birthing hospitals in South Carolina to sign a pledge to reduce voluntarily the number of early elective deliveries.[94] Then, in January 2013, through BOI, South Carolina Medicaid and BCBSSC, who together pay for 85 percent of all births in the state, implemented a policy that stopped reimbursement to hospitals and physicians for elective, non-medically indicated inductions and cesarean deliveries before 39 weeks gestation. The American College of Obstetricians and Gynecologists strongly advises against early elective deliveries.[95] The focus of the Birth Outcomes Initiative on reducing elective, non-medically indicated inductions and cesarean deliveries before 39 weeks gestation has helped to reduce by half the non-medically indicated inductions prior to 39 weeks. By the first quarter of 2013, total savings amounted to $6 million, a result of the increased engagement around early electives deliveries as well as the non-payment policy introduced in January 2013.[96] Preliminary data also show a decline in early elective inductions.[97]

Texas Medicaid Non-Payment for Early Elective Deliveries Texas Medicaid changed its benefit criteria for obstetric deliveries in 2011 to deny claims for any cesarean deliveries, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary. Texas Medicaid currently restricts these services to one of the following additional criteria: gestational age of the fetus should be determined to be at least 39 weeks or fetal lung maturity must be established before delivery, and when the delivery occurs prior to 39 weeks, maternal and/or fetal conditions must dictate medical necessity for the delivery. Records are subject to retrospective review and payments made for non-medically indicated caesarean sections, labor inductions, or any deliveries following labor induction, which fail to meet medical necessity criteria, will be subject to recoupment. Recoupment may apply to all services related to the delivery, including additional physician fees and hospital fees.[98] The policy change is still new and specific data has yet to be collected and analyzed. Savings for the Medicaid program were predicted to be approximately $36.5 million.[99] However, Leapfrog Group data shows that the Texas early elective delivery rate for 2012 — 18.3 percent — was well over the Leapfrog Group target of 5 percent or less.[100]

Centers for Medicare and Medicaid Services (CMS) Initiatives

Medicare Hospital-Acquired Condition Payment Policy Medicare no longer pays hospitals for additional costs associated with 10 conditions considered to be preventable medical errors (also known as health care-acquired conditions, or HACs). Since October 2007, affected hospitals have been required to submit a Present on Admission (POA) Indicator with each claim. As of October 2008, if a Medicare claim includes a selected HAC that was not identified on the POA Indicator, the hospital will not receive a higher resulting DRG payment.[101] Based on 2008 CMS predictions, the federal government would have realized savings of $50 million per year for the first three years beginning October 2008, then, beginning in FY 2012, federal government savings are predicted to come in at $60 million per year.[102] However, according to the New England Journal of Medicine, the policy change has not reduced HACs in a statistically significant way.[103]

Medicare Hospital Readmissions Reduction Program The Hospital Readmissions Reduction Program penalizes hospitals with high 30-day readmission rates for three conditions.[104] Penalties are determined based on a comparison of a hospital's performance to the national average, adjusting for clinically-relevant factors. The program began October 2012 and the maximum penalty was 1 percent of total Medicare reimbursement; in 2013, it increased to 2 percent, and in 2014, will increase to 3 percent. By 2017, hospitals will have up to 6 percent of their Medicare payments at risk.[105] Early data show readmission rates are declining, from a steady 19 percent to 17.8 percent in the last quarter of 2012; however it may be too early to say definitively whether the decline was caused by the policy change.[106] More than 2,200 hospitals faced some penalty in the first year. The penalties amounted to an average $125,000 per hospital and $280 million total.[107]

BENEFIT AND NETWORK DESIGN STRATEGIES

In addition to payment reform, strategies centered on benefit and network design can also have a significant impact on value in the health care system. Payment reform and benefit and network design strategies can go hand in hand to align incentives across consumers, purchasers, plans, and providers. As the emphasis of this paper is on payment reform, the following section seeks to document activities around benefit and network design and identify the payment reform programs, identified in the previous section, that best complement them.

SURVEY DATA HIGHLIGHTED ON THE FOLLOWING PAGES ARE TAKEN FROM "HEALTH CARE CHANGES AHEAD SURVEY: EMPLOYERS' ACTIONS TODAY AND PLANS FOR THE FUTURE," TOWERS WATSON, SPETEMBER, 2013

1. PRICE AND QUALITY TRANSPARENCY

Price transparency is defined as "the availability of provider-specific information on the price for a specific health care service or set of services to consumers and other interested parties," while price is defined as "an estimate of a consumer's complete health care cost on a health care service or set of services that 1) reflects any negotiated discounts; 2) is inclusive of all costs to the consumer associated with a service or services, including hospital, physician, and lab fees; and, 3) identifies the consumer's out-of-pocket costs (such as co-pays, co-insurance and deductibles)."[108] Quality transparency is the ability of consumers and other interested parties to see data on providers including outcomes, patient satisfaction, provider designation, etc. To gauge quality, the Institute of Medicine's "six aims" identify the major aspects of quality that are important to measure: safety, effectiveness, timeliness, patient-centeredness, equity, and efficiency.[109]

Seventy three percent of surveyed employers provide, or plan to provide, price and hospital-quality transparency tools, purchased through their health plans or vendors, between now and 2016.

While efforts centered on price and quality transparency are not considered to be benefit and network design strategies themselves, they are nonetheless key building blocks and foundations for these programs. Much of this is explained in greater detail in CPR's 2013 paper with the University of Michigan VBID Institute, A Potent Recipe for Higher-Value Health Care, found here. Both price and quality transparency allow for meaningful comparisons across providers and give purchasers access to the cost and quality information they need to implement strategies such as reference pricing, centers of excellence, and Consumer-Directed Health Plans. In addition, when purchasers develop benefit designs that motivate consumers to shop based on price and quality information — including information or incentives tied to clinical necessity—they can enhance the quality of care and reduce health care spending. The creation of benefit designs that explicitly encourage consumers to act on price and quality information is a step in this direction. These can begin to shift toward a system that provides and rewards high-value care, while simultaneously driving waste from the health care system.[110]

Purchaser/Employer Activity

Health plans are heeding the call from purchasers to share price and quality information with consumers and are developing transparency tools for their patient members to help them access and understand these data. A growing number of independent vendors are also joining their ranks. CPR examined the features common in most tools as well as cutting edge strategies in our 2013 paper, The State of the Art of Price Transparency Tools and Solutions.

Life Technologies, The Container Store, and other employers Several dozen if not hundreds of employers now rely on transparency solutions available from their plan, an independent vendor or both. Many have reported significant employee engagement and savings from using these tools — especially those available from independent vendors. For example, independent vendors such as Castlight Health report employer customers like Life Technologies have an anticipated 13 percent reduction in medical spend,[111] while Compass Health Professionals reports The Container Store had an excess of $1 million savings from using its transparency solution.[112]

A recent white paper by Thomson Reuters estimated the typical savings an employer could expect to incur using price transparency tools and solutions. The paper explains, *"Even more conservative models on the impact of price transparency yield impressive savings results. Consider an employer with 20,000 employees and a healthcare cost trend of 6.1 percent — which is the median faced by employers today. It's unlikely that all consumers will use healthcare information to inform and change their decisions about where to seek treatment … In the first year, we assumed that approximately 10 percent of employees would use the information provided to change their behavior and move to median-priced providers for the targeted procedures. In years two and three, we assumed adoption rates of 25 percent and 50 percent respectively. As a result, this employer could uncover a potential savings of $715,000 in the first year and $6.8 million by the third year."* [113]

Payment Strategies to Combine With Transparency

As mentioned previously, price and quality transparency provide the foundation for many benefit and network design strategies, and create a strong base for many payment reform strategies. Price and quality transparency should be paired with benefit and network designs, such as consumer directed health plans, which encourage consumers to use the information and become savvy shoppers. Price and quality transparency may be more meaningful to consumers if it's presented for episodes of care, rather than for each individual office visit, procedure and service within an episode. Consumers may have an easier time understanding bundled payment — one transparent price for an episode of care — compared to multiple prices in the fee-for-service context. Some of the more robust price transparency tools available today allow consumers to shop for an episode of care — such as pregnancy through delivery — using price and quality information. Bundled payment with a quality component also ensures providers have the right financial incentives to provide that care efficiently and effectively.

Transparency can also complement a pay-for-performance strategy. By making quality and price information available to consumers, they can select higher-value providers, who in turn are rewarded for their performance financially through the pay-for-performance approach, as well as through increased volume.

2. REFERENCE PRICING

Reference pricing establishes a standard "reference price" for a drug, service, or bundle of services, and generally requires that plan members pay any allowed charges beyond this amount. This may make patients more sensitive to the price of a service and more likely to choose cost-effective hospitals or physicians for their care. However, the success of reference pricing depends on certain factors. Reference pricing is most likely to be effective for elective procedures, allowing time to "shop" for the best value, and available from multiple providers in selected geographies. Additionally, prices must be transparent to enable consumers to make informed decisions.

When quality is taken into consideration as well as price, reference pricing becomes "value pricing." Reference pricing will likely need to incorporate quality more fully in the future, particularly for more complex procedures where price and quality vary significantly, such as hip and knee replacement and back surgery.[114]

> Thirty seven percent of surveyed employers use, or plan to use, reference pricing in their medical plan between now and 2016.

Purchaser/Employer Activity

Safeway Inc. Safeway Inc. provided employees with Castlight's price and quality transparency tools to create "smart shoppers" in its workforce. The company set a limit on how much they will pay for commodity services, such as colonoscopies, for both in- and out-of-network providers. Employees can shop for imaging and labs, and other commodity services.

Kroger Kroger implemented a reference or "target pricing" program in two areas. The first is non-emergent, adult-only diagnostics, including MRI and CT scans. Krogers' plan administrator set a target price for each service and requires employees and their families to go through a precertification process. The second area is for drugs, including statins, PPIs, glucose test strips, and ARBs. Kroger educated members about significant price variation in these classes of drugs and the availability of generic equivalents, and communicated to members six months in advance that the plan would pay only a certain amount for these drugs. If they chose a higher-cost, alternative drug, the member would pay the difference.[115]

The two reference pricing programs initiated by Kroger in 2012 have already provided significant savings to the company and its employees. For six non-emergent diagnostic services, Kroger has accumulated $5,700,000 in year-to-date savings, based on a report at the end of the third quarter of 2013. For example, the unit price for abdomen CT scans went down by 32 percent in states where target pricing was implemented compared to the 10 states without it.[116] The Rx target price program has also seen impressive year-to-date savings, with $1,700,000 in savings reported and a mixed change in utilization impact. By focusing solely on education at point-of-sale, the Rx target price program was effective at steering employees toward higher-value medications without significantly reducing utilization rates, as utilization of statins increased by more than 5 percent.[117]

California Public Employees' Retirement System (CalPERS) Hip and knee replacements are commonly targeted for reference pricing because they are costly and often elective. In 2011, CalPERS created a Value Based Purchasing Design (VBPD) along with a Value Based Site of Care for its 1.3 million state and local employees, retirees, and their dependents. In partnership with Anthem, CalPERS set its reference price for both hip and knee replacements at $30,000 or less for the hospital stay as well as the device. Forty-six hospitals met the volume and quality standards within the reference price; 16 hospitals are deemed "centers of expertise." CalPERS reimburses travel expenses for employees who live 50 miles or farther from a center. Preliminary results show this strategy saved CalPERS $5.5 million in 2011 and 2012.[118] In 2012, CalPERS built is reference pricing program with colonoscopy at $1,500, cataract surgery at $2,000, and arthroscopy at $6,000.[119]

Payment Strategies to Complement Reference Pricing

Creating member risk through reference pricing can result in plan members shifting to lower-priced providers, as well as some providers lowering their prices. These are highly desirable behavior changes in the current health care market. However, for high-cost procedures such as knee replacements, potential member liability — even when going to providers whose average is below the reference price — can be significant, and the provider typically bears no risk for exceeding the reference price. As such, instituting reference pricing with bundled payment can create significant alignment among the consumer, employer, and provider. This powerful marriage is outlined in greater detail in a recent (2013) report issued by CPR and HCI3, Reference Pricing and Bundled Payments: a Match to Change Markets. For consumers, bundled payments can limit their out-of-pocket financial liability, thereby encouraging them to seek care from providers accepting bundled payment. Employers can expect greater cost predictability. For providers, pairing reference pricing with bundled payment creates accountability for defined outcomes (e.g., quality of care metrics) and financial liability for costs above the predetermined price for the bundle. This promotes a focus on delivering only appropriate services within the episode, optimizing outcomes, and avoiding preventable adverse events that lead to increased care delivery, including readmissions.[120] Because bundled payment can make out-of-pocket costs more predictable for consumers, a willingness to accept bundled payment for the services targeted by reference pricing may become a competitive advantage for providers.

3. CENTERS OF EXCELLENCE (COE)

Centers of Excellence (COEs), often associated with high-performance networks, are provider organizations that contract with an employer to act as a COE for specific, usually expensive, procedures or services. COEs have generally shifted from a focus on low-frequency, high-cost events like transplants, to addressing moderate frequency, mid- to high-cost services, including knee replacements and spinal surgery.[121] In addition, while COEs may excel in a specific surgery or procedure, they are unlikely to be high-performers on all procedures within a general category of services like orthopedics or cardiac care.[122] While the employers listed below have only recently begun their COE programs and no formal studies of their impact have been completed to date, some research has shown COEs do improve health outcomes. For example, a study examining COEs for hip replacements found that patients receiving surgery at a COE had statistically significantly lower rates of complications.[123]

Twenty five percent of surveyed employers contract, or *plan to* contract, directly with physicians, hospitals, accountable care organizations or patient-centered medical homes between now and 2016.

Purchaser/Employer Activity

Wal-Mart Stores, Inc. Starting in late 2012, Wal-Mart began piloting a COE program that offers its associates heart, spine, and transplant surgeries at six of the leading hospital and health systems in the U.S. with no out-of-pocket costs. These are the Cleveland Clinic, Geisinger Medical Center, Mayo Clinic, Mercy Hospital, Scott & White Memorial Hospital, and Virginia Mason Medical Center. The program is voluntary and adults age 18 and over are eligible. Wal-Mart's associates (and their dependents) enrolled in the company's medical plans will receive consultations and care covered at 100 percent without a deductible or co-insurance, plus travel, lodging and food for the patient and a caregiver. Patients must be healthy enough to travel for the surgeries. In contrast, care from out-of-network providers is only covered at 80 percent after the deductible.[124]

Lowe's Companies, Inc. Starting in 2010, Lowe's Companies, Inc. encouraged employees to go to the Cleveland Clinic for qualifying cardiac surgeries, including triple bypass surgery and mitral valve repair. Full-time employees and dependents covered by the self-funded medical plans are eligible to receive these qualifying heart surgeries and procedures at no cost. Lowe's also fully covers travel and lodging expenses associated with traveling to the Cleveland Clinic for the patient and an adult companion. To date, 66 medical plan members (both adult and pediatric) have sought heart care from the Cleveland Clinic. Although the numbers are small, the impact on employee engagement is significant — employees feel fortunate that their employer offers such a rich benefit, even if they never have to use it. In addition, as the program has evolved, Lowe's and the Cleveland Clinic have worked to ensure it functions in a patient-focused manner, including attention to "at home" care which can be important in recovering from surgery.[125]

PepsiCo, Inc. Starting in late 2011, PepsiCo, Inc. began offering incentives to employees to seek care at Johns Hopkins Medicine in Baltimore, Maryland, for certain cardiac surgeries and revisions of joint replacements — procedures that have wide variation in both cost and outcomes. By waiving deductibles and co-insurance, and by covering the cost of travel and lodging for the patient and a companion, PepsiCo steers employees to seek care from a high-quality provider. In the future, PepsiCo may cover additional procedures under this program.[126]

Kroger Kroger launched an effort in January 2012 to give its roughly 60,000 insured associates and their dependents — 130,000 people in all — an option for hip, knee, or spinal fusion surgery at one of 19 designated medical centers across the country. Krogers has some very preliminary results; 36 employees took advantage of the program last year. The workers got a higher rate of reimbursement

for the operation (up to 90 percent) and Kroger saved money as well. Those 36 procedures cost $30,000, on average — a savings of roughly 25 percent, or $10,000, over what they would cost at other facilities, even factoring in the cost of travel.[127]

Collective Efforts Wal-Mart, Lowe's and other large employers joined the Pacific Business Group on Health Negotiating Alliance (PBGH-NA) in the fall of 2013 to launch a national Employers Centers of Excellence Network that will offer no-cost knee and hip-replacement surgeries for employees at four hospital systems in the United States: Johns Hopkins Bayview Medical Center in Baltimore, Maryland; Kaiser Permanente Orange County in Irvine, California; Mercy Hospital in Springfield, Missouri; and Virginia Mason Medical Center in Seattle, Washington.[128]

PBGH, working with health care management company Health Design Plus, will oversee the new national Employers Centers of Excellence Network (ECEN), which will include treatment for the more than 1.5 million employees and their dependents enrolled in Wal-Mart's, Lowe's, and other large employers' medical plans. Employees will receive consultations and care covered at 100 percent without deductible or co-insurance, plus travel, lodging, and living expenses for the patient and a caregiver. Patients must be healthy enough to travel for the surgeries. The program is voluntary and employees or their covered dependents can still choose to receive care from local providers and incur routine costs.[129] Due to the newness of the program, it is too early to assess its impact.

Payment Strategies to Combine With Centers of Excellence

The Centers of Excellence strategy pairs well with bundled payments. COEs are often designated for procedures or services that lend themselves to bundled payment and bundled payments bring added predictability to purchasers, consumers and providers. In return for volume, providers may be willing to accept bundled payment for specific services, saving the employer money while increasing quality of care.

4. EVIDENCE-BASED PLAN DESIGNS & VALUE-BASED INSURANCE DESIGNS (V-BID)

Value-based insurance designs (V-BID), also called evidence-based plan designs, use a system of targeted financial incentives and disincentives to encourage consumers to utilize high-value care, while reducing the utilization of care not supported by medical evidence. In addition to this incentive-disincentive structure, V-BID is also commonly coupled with other plan designs including wellness plans or disease management programs, to promote further lifestyle and behavioral changes on the part of the consumer.

> Fifty two percent of employers surveyed said they use, or plan to use value-based benefit designs, or provide different levels of coverage based on cost or quality, or evidence-based practice, between now and 2016.

Purchaser/Employer Activity

The majority of employers now use some form of VBID. Below are a few well known examples.

Pitney Bowes In 2007, Pitney Bowes decided to cut co-payments for two essential heart drugs in order to improve quality of care and curb health spending by ensuring that patients adhere to their treatment and avoid more serious and costly health problems. As a result, employees who needed the drug Clopidogrel to prevent another heart attack or stroke began filling their prescriptions more regularly, were less likely to visit the doctor, end up in the ER, or be admitted to a hospital, thus slashing their out-of-pocket expenses beyond the co-pay reductions.[130] An academic study found that the policy resulted in an immediate 2.8 percent increase in adherence to statins relative to controls, which was maintained for the subsequent year. For clopidogrel, the policy was associated with an immediate stabilizing of the adherence rate and a four-percentage-point difference between intervention and control subjects a year later.[131]

Perdue Farms, Inc. In 2011, Perdue Farms developed a new, evidence-based plan design called BestHealth that combined VBID with a narrow network and a health improvement program. To guide plan participants away from low-value or harmful interventions, Perdue Farms differentiates cost sharing for services valued at different levels. The company identified seven potentially harmful interventions (medical interventions such as cardiac stents that can be risky and unnecessary) that they cover at 70 percent rather than the standard 90 percent. In cases where the patient or physician feels that the intervention is appropriate, Perdue offers a second opinion process through the Cleveland Clinic "e-consult" service. If the consultation corroborates the need for the procedure, it is covered at the higher level.[132]

The results from the first year showed that the plan was successful at driving desired behaviors — BestHealth participants had 30 percent fewer low-value interventions (done per one thousand) as compared to those in other plan offerings. Additionally, there was higher participation in the health improvement program in the BestHealth group than the rest of the population and the health scores of participants in BestHealth became progressively higher throughout the year compared to participants in other plans. As a result, the total cost for BestHealth participants was substantially lower than for the rest of the population. In its second year, enrollment in the plan doubled to around 38 percent of associates and Perdue hopes to see additional evidence that BestHealth drives effective care and appropriate health management in the future.[133]

Oregon Public Employees Benefits Board and Oregon Educators Benefits Board The Oregon Health Leadership Council, a consortium of health care leaders, developed a model for value-based benefit design, currently in use by purchasers and plans. The model uses three tiers: the first tier reduces financial barriers to management of chronic conditions; the second tier has standard cost sharing for services not covered in tier one or three; and the third tier increases cost sharing for interventions that are overused or are driven by provider preference or supply. The Public Employees (PEBB) and Oregon Educators (OEBB) Benefit Boards continue to see positive outcomes in health status from using this model. Employees covered by PEBB showed evidence of several significant health improvements in 2012 compared with 2007. These include a 59 percent decrease in smoking and a 55 percent decrease in all tobacco use. Several other health measures also appear to be improving, including screening for high cholesterol, high blood pressure, and diabetes. OEBB employees showed significant health improvements in two important areas in 2011 compared with 2009, including a 21 percent decrease in obesity and an increase of 13 percent in appropriate screening for colorectal cancer.[134]

Marriott International In 2005, Marriott International implemented a value-based insurance design to reduce cost barriers to care for employees and their dependents with chronic conditions. Marriott reduced co-payments for prescribed medications used in the treatment of common chronic diseases such as asthma, cardiovascular disease, and diabetes. It also offered a disease management program. A study examining medication adherence in the group with reduced co-pays found a statistically significant increase in adherence — an increase from 4 to 7 percent for angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), beta blockers, diabetic therapies, and HMG-CoA reductase inhibitors (statins).[135]

Payment Strategies to Combine With VBID

Value-Based Insurance Designs compliment a wide variety of payment reform strategies. For example, VBID could encourage patients with a chronic illness to seek regular care and take the medications they need, while a shared savings payment arrangement could incentivize providers to deliver the right care to chronically ill patients as part of a patient centered medical home. VBID can encourage consumers to seek preventive care, for example through offering zero co-pays for mammograms, while providers can be incentivized to offer preventive care to a population using capitation with quality or global payment.

5. CONSUMER-DIRECTED HEALTH PLANS

A Consumer-Directed Health Plan, or CDHP, is a type of plan that can be paired either with an individual plan, or with a group plan through an employer. What all CDHPs have in common is a personal account — either a Health Savings Account (HSA) or a Health Reimbursement Account (HRA) — used to pay for medical expenses and incentivize consumers to shop for care and use care wisely, because of a significant deductible. When paired with an HSA, CDHPs are also called Account Based Health Plans. These plans give the consumer more control of and responsibility for their health care dollars and quality of care. While research has demonstrated some benefits from CDHP, including lower premiums, and employees switching to generic drugs, more research is needed.[136]

Today, 66 percent of companies have an Account Based Health Plan (ABHP) in place and another 13 percent expect to add one by 2014. Total-replacement ABHPs are also on the rise. Nearly 15 percent of respondents with an ABHP use a total-replacement ABHP, up from 7.6 percent in 2010.

Purchaser/Employer Activity

The majority of large employers now rely on CDHPs, some offering them as the only option to employees. Below are a few examples.

Safeway Inc. In January 2006, Safeway offered its non-union workers a CDHP structured with a $2,000 annual deductible and out-of-pocket costs limited to $3,000 for family coverage. The annual deductible is offset by a company contribution of $1,000 to a Health Reimbursement Account (HRA), and unused funds in the HRA roll over to the next plan year. The CDHP/HRA covers all preventive care services at 100 percent and provides a 24-hour nurse advice line staffed by registered nurses to help people manage chronic conditions. Safeway's CDHP/HRA is designed to give employees incentives to promote healthier lifestyles and lower the cost of insurance for employees and the company.[137] Safeway has been able to hold health care spending relatively flat, in part due to consumer directed health care. Safeway's all-inclusive health care costs per capita did not change from 2005 to 2011. Over the same period, national health care costs increased more than 60 percent.[138]

GE In 2010, all of GE's salaried workers moved into CDHPs as part of a companywide initiative for health-care innovation designed to make employees better health-care consumers and to coincide with GE's "Healthymagination" strategy. Employees have three choices of deductibles and can save pre-tax dollars in health savings accounts. GE will fund up to $1,000 for two of the three choices. While GE's plans offer free preventive care, smokers pay extra. The benefit design could save the company over $1 billion over the next decade.[139]

6. TIERED AND NARROW NETWORKS

In a tiered plan, members pay different levels of co-payments, co-insurance, and/or deductibles depending on their plan design and the tier of the provider delivering a covered service or supply. Employees may be grouped into different payment tiers based on marital status, family, and/or dependents, while providers can be grouped into tiers based on comprehensive cost and quality information. While there is wide variation in narrow network products, health plans typically select hospitals and other providers for cost-efficiency based on case-mix-adjusted costs and utilization. They select for quality based on process measures and external certification, such as National Committee for Quality Assurance recognition. Some plans build their networks only around physicians, typically specialists, but in some cases primary care physicians as well. Other plans also select hospitals. Some narrow-network products, like HMOs, only cover in-network services. Others, like PPOs

Thirty one percent of employers have or plan to use differential cost sharing to encourage employees to use high-performing networks, by 2014.

and point-of-service plans, offer tiered coverage, with significantly higher patient cost-sharing for services received outside the preferred network.

Purchaser/Employer Activity

Group Insurance Commission (GIC), Commonwealth of Massachusetts The GIC is a purchaser of health benefits for approximately 300,000 state employees, retirees and dependents in Massachusetts. Since 2004, GIC worked with Massachusetts' 12 health plans to evaluate the efficiency and quality of specialists and some PCPs to create a standard set of performance measures that could be used to steer patients toward high-value providers and encourage low-value providers to improve.[140] Each health plan used a standard set of performance measures to implement a tiered network design, placing preferred, high-performance providers in higher tiers and more poorly performing providers in lower tiers. Since 2007, GIC has offered active state employees an array of tiered network plans. Once within the tiered network, enrollees can save more money in co-pays by selecting top-tier providers, though the difference in co-payment amounts across tiers is modest: seeking care from a tier two physician instead of a tier one physician costs the enrollee $5 to $10 more. About 20 percent of physicians are rated in the least expensive tier one category, 65 percent in tier two, and 15 percent in the highest cost tier three.[141]

According to a Commonwealth Magazine report in 2011, the tiered networks program carried out by the GIC had increased cost-savings with each year of implementation.[142] One piece of evidence for this success is that the GIC held its average premium increases to single-digits between FY 2006 and FY 2009 while other Massachusetts public employers saw an average increase of 10 percent.[143], [144] Enrollment in the tiered networks reached an all-time high of 31 percent when the GIC offered a three-month premium holiday to enrollees that selected the lower-cost tiered network option.[145]

Intel Corporation As described previously in the section on shared risk, Intel has partnered directly with Presbyterian Health System (PHS) to create an accountable care arrangement. Presbyterian has taken on potential shared savings as well as financial risk. In return, PHS providers know that Intel employees who select this benefit option will seek care only from them. Intel projected the company could save $8 to $10 million through 2017 as better care improves population health, though they expect costs initially to rise.[146]

CalPERS and the University of California The University of California and the California Public Employees' Retirement System have offered their members the option of "slimmer" plans sold by Health Net Inc. and Blue Shield of California. The University of California reports that employees who select the narrow network option provided by HealthNet can save 50 percent on their premiums.[148]

Wal-Mart Stores, Inc., The Home Depot, and Imagine Health's SmartCare EPN Program In early 2013, around 29,000 Wal-Mart and Home Depot employees in Illinois were offered the chance to enroll in an employer-driven narrow network through Imagine Health's SmartCare Employer Performance Network (EPN) program. The narrow network for Wal-Mart and Home Depot spans six markets, including Chicago, and is anchored by Presence Health. Imagine Health developed the network to ensure adequate access for these employers' enrollees to physicians meeting both quality and cost criteria. It's too early to know the impact of this program, but on its website, Imagine Health reports that its EPN offering brings in over $1.2 million in savings for every 1,000 employees.[150]

Payment Strategies to Combine With Narrow and Tiered Networks

Pay-for-performance programs can complement narrow or tiered networks as only those providers that meet certain quality standards should be included in the high-performance network or top tier. Per the Intel example, it may make sense to pair tiered and narrow networks with shared savings or

global payment arrangements. When patients have financial incentives to use the network, physicians and other providers can be assured enough volume to make it worthwhile to take on financial risk and invest in managing patient care through new models of delivery, such as patient centered medical homes or ACOs.

7. MANAGING PHARMACY BENEFITS

An employer can influence prescription drug utilization and the associated costs by determining what pharmaceuticals to cover, at what price, by whom, and through what delivery channel. Employers are currently using pharmacy benefit design to encourage the use of low-cost, high-efficacy drugs, creating cost differentials between generic and brand-name drugs, mandating generic substitution, and permitting employees to get 90-day supplies for chronic disease medications from a retail pharmacy at the same cost as through mail-order. Employers and purchasers typically rely on pharmacy benefit managers (PBMs) to help them implement these strategies.

Many employers are exploring financial and clinical management approaches to mitigate drastic cost increases for drugs, including prior authorization (65 percent by 2014), step therapy (68 percent by 2014) and formulary management (40 percent by 2014).

Purchaser/Employer Activity

Visant Corporation To increase its generic utilization rate, Visant Corporation worked with its PBM to implement a program that requires a participant to try a generic medication before filling a prescription for a brand-name drug in the same class. This approach is called the "high-performance generic step therapy program." In addition, the plan design uses co-insurance to encourage participants to choose the lower cost generic drug. Employees can also purchase a 90-day supply of maintenance medications at their local CVS pharmacy at the same discount offered by mail-order pharmacy. Visant has found these approaches encourage utilization of generic drugs.

Pitney Bowes Pitney Bowes commissioned an analysis to identify population-based risk factors associated with high-cost utilization of health benefits (>$10,000) per year, and discovered poor medication adherence. The company redesigned its pharmacy benefits; in the new system, all medications for asthma, diabetes, and hypertension were moved to tier one with only 10 percent co-insurance. Blood glucose testing supplies were also moved to tier one.[151] As a result, pharmacy costs declined by 50 percent and medication adherence improved significantly.[152]

US Airways CVS Caremark has a program called "Maintenance Choice" that allows plan sponsors to give plan members the choice of receiving their 90-day maintenance medication refills either at home, by mail, or in person at the pharmacy. Regardless of which channel members select, they pay the lower mail co-pay and the plan sponsor receives the lower mail rate. Previously, US Airways had required its plan members to receive their maintenance medications by mail, but home delivery was not a good fit for the workforce. The airline reports better medication adherence with this program.[153]

Payment Strategies to Combine With Pharmacy Benefit Design

A variety of other network and benefit designs work well with pharmacy benefit design such as VBID or case management, described below. A variety of payment reform strategies complement pharmacy benefit design too. For example, shared savings, shared risk, or global payment can incentivize providers to take good care of patients with a chronic illness, while pharmacy benefit management can encourage those chronically ill patients to take needed medication. Payers who identify COEs for cardiac care, for example, may want to use pharmacy benefit management to make access to heart medications simple and inexpensive.

8. HIGH-COST CASE MANAGEMENT PROGRAMS AND CLAIMANTS

Case management programs help patients with expensive health conditions obtain the most appropriate and cost-effective care, something patients may not be able to do on their own. Although case management programs share common elements, the components of these programs, their delivery model, and the ability for employers to tailor these programs, vary. Other distinct differences between these programs include how they identify and engage patients, the clinical processes and workflows they use, the ratio of case managers to patients, and the conditions these programs address. For example, programs may address all or some of the following conditions: cancer; cardiovascular disease; HIV/AIDS; high-risk pregnancy; catastrophic illnesses or injuries; and organ transplants. However, some programs may require separate specialty case management programs for certain conditions such as cancer, transplantation, and neonatal intensive care unit (NICU) cases.[154]

> "Best performers" (employers with successful benefits strategies) took a number of significant steps in 2013 to improve the efficiency of their health care programs, including investing in case management to manage their high-cost cases more proactively and effectively.

Purchaser/Employer Activity

A large percentage of employers and purchasers now rely on some type of case management strategy for their employees — even if only working with their health plan to offer disease management strategies. Below are just a few examples.

The Boeing Company As described previously, the Boeing Company worked with the Everett Clinic and its health plan to complete a two-and-a-half year pilot project focused on improving the care of complex patients. Starting in 2007, the pilot enrolled 740 non-Medicare Boeing patients in an Intensive Outpatient Care Program (IOCP). Patients were connected to a multi-disciplinary care team that included a dedicated nurse care manager and a supervising physician. Each IOCP-enrolled patient received a comprehensive intake interview, physical exam, and diagnostic testing. A care plan was developed in partnership with the patient and executed through intensive in-person, phone, and email contacts. The care plan included ongoing outreach by the nurse, education in self-management of chronic conditions, and care coordination by the IOCP team. Daily team planning "huddles" were used to plan patient interactions and specialists were directly involved when needed.[155] Providers were paid a per member per month fee; supplemental monthly per capita fees paid to the physician groups for primary care intensification were included in the spending attributed to IOCP-enrolled patients.[156] As a result, functional status scores, HEDIS intermediate outcomes scores, depression scores, patients' experience of care scores, and employees' absenteeism scores improved compared to baseline. Unit price-standardized per capita spending dropped by an estimated 20 percent, primarily due to lower spending on ER visits and hospitalizations (in comparison to a control group of Boeing's enrollees in Puget Sound that did not receive their primary care from one of the three physician groups).[157]

CalPERS, PG&E and the IOCP Model Through the California Quality Collaborative, The Pacific Business Group on Health (PBGH) is currently providing technical assistance to 20 delivery systems in California and Arizona to spread intensive care management services for high-risk Medicare beneficiaries and commercially-insured members. The new model uses a combination of PMPM payments plus shared savings for employers and providers.

Quad/Graphics Quad/Graphics uses a combination of worksite clinics and employee wellness programs to improve employee health. Diabetic employees can participate in the "Well You for Diabetes" program that provides consultations with a certified diabetes educator who works closely with physicians to manage care. In addition, co-pays for supplies and medications are waived if

participants meet certain goals. More than 200 of the 732 diabetic patients in Quad/Graphics' workforce are participating in the program and have reduced their hemoglobin A1c levels (a measure of blood glucose control) from an average 8 percent to 7.5 percent. Data shows the company may spend less per employee on health care costs than other comparable employees as well.[158]

Johnson & Johnson Company employees and their partners covered under the "Healthy People" health reimbursement arrangement (HRA) plan are offered financial incentives for participating in the case management program. These incentives are deposited into the HRA fund. One example is a $500 incentive for employees or their partners to enroll in the maternity program. If the employee or their partner enroll by the end of the 16th week of pregnancy and remain continuously engaged in the maternity program, including participating in a postpartum discussion (within two months of the delivery date) with their case manager, they will receive a $500 incentive. If the employee or their spouse enroll in the program after the 16th week of pregnancy and remain continuously engaged in the program, including participating in the postpartum discussion, they will receive a $250 incentive.[159]

Payment Strategies to Combine With Case Management

High-cost case management programs can pair well with a wide variety of payment reform strategies that give providers financial incentives to improve care for the most expensive, medically-complex patients. For example, capitation and condition-specific capitation can encourage provider systems to manage the care of patients with chronic illness. Shared savings, shared risk and global payments can incentivize providers to care for specific populations of patients in patient centered medical homes or ACO-type arrangements. In the example above of case management for expectant mothers, providers could be offered a comprehensive bundled maternity payment to incentivize the right care.

CONCLUSION

As health care costs continue to rise without a commensurate improvement in the quality of care, the major purchasers of health care, including employers, health plans, and state and federal government, are looking for ways to get better value for every health dollar they spend. There is tremendous variation in the approaches they pursue. Local market dynamics impact the reforms most likely to succeed. In charting a path forward, purchasers must consider a range of payment reforms, and benefit and network designs and how they can work together. Given how little we still know about what works, experimentation and rigorous evaluation are critical, as well as sharing lessons as we learn them.

APPENDIX I Snapshot of Payment Reform Programs and Pilots by Payment Category

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Upside Only	Pay-for-Performance	Bridges to Excellence (BTE)	Physician recognition and reward programs using quality measures for chronic conditions, preventive care, office systems, and medical homes.	Physicians participating in BTE outperform their peers, providing more appropriate care and using resources more efficiently.
	Pay-for-Performance	California Pay-for-Performance (P4P)	Program for health plan to measure and reward physician quality; uses common quality measures (now expanding to measure cost).	Participation raises quality scores for physician organizations and encourages physicians to use information technology and enhance efficiency.
	Pay-for-Performance	SoonerCare Choice	Pay-for-performance to encourage physicians to complete early periodic screening, diagnostic, and treatment requirements.	ROI of $6 for every $1 in administrative expenditures in addition to reduced risk scores and gaps in care, high member satisfaction scores, cost decreases resulting from cost avoidance, and a significant increase in compliance rates for chronic care.
	Pay-for-Performance	CMS Hospital Value-Based Purchasing Program	Rewards acute care hospitals for quality.	No results available yet.
	Pay-for-Performance	CMS Physician Group Practice Demonstration	Five year long pilot to pay-for-performance in FFS Medicare for participating physician groups; 32 quality goals were used, most of them process measures related to coronary artery disease, diabetes, heart failure, hypertension, and preventive care. Groups could share in savings if they exceeded a 2 percent savings threshold.	Participating physician groups scored well on quality metrics during all five years of the demonstration. However, only two groups were able to exceed a 2 percent savings threshold in the first year and only half met the threshold after three years.
	Non FFS, Non-Visit Payments	The Maryland Multi-Payer Pilot Program (MMPP)	Employers can make a fixed payment for medical homes for employees (plus other components—see below). Payment is based on care quality, size of practice.	See below.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Upside Only *continued*	Non FFS, Non-Visit Payments	South Carolina Healthy Connections Program	The state contracts with Care Coordination Service Organizations (CSO) to create medical homes for Medicaid beneficiaries. In turn, these organizations contract with physicians to provide the medical homes. Physicians are paid fee-for-service by Medicaid, but may also receive a care coordination fee, at the discretion of the CSO.	No results available yet.
	Non FFS, Non-Visit Payments	Illinois Health Connect Bonus Payment	Illinois Health Connect is the state's primary care case management (PCCM) program for certain populations under public coverage. Participating primary care providers (PCPs) sign an agreement to provide better care/better care access in exchange for an enhanced fee schedule and ongoing monthly per member per month (PMPM) care management fees. They are also eligible for performance incentives.	Illinois Health Connect saved the state approximately $150 million in fiscal year 2009.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Two-sided risk	Condition-Specific Capitation With Quality	Medicare Health Support Organizations (MHSOs)	The MHSO program gives providers a monthly management fee for caring for chronically ill beneficiaries; MHSOs were also held at risk for fees based on the performance of the intervention group relative to beneficiaries overall; fees were also at risk for several clinical processes of care and one patient satisfaction measure.	18 months of data found no savings.
	Partial Capitation With Quality	No specific examples		
	Full Capitation With Quality	Kaiser Permanente	Capitated payments to medical groups with some pay-for-performance.	Several studies document improved health outcomes.
	Full Capitation With Quality	Medicare Advantage (MA)	Capitated payments to plans to care for Medicare beneficiaries; under ACA, bonus payments available too.	Study shows reduced hospitalizations for beneficiaries in MA compared to FFS Medicare.
	Full Capitation With Quality	Medicaid Managed Care	Capitated payments to plans to care for Medicaid beneficiaries; under law, states must review quality performance.	Data are mixed, results vary by state.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Two-sided risk *continued*	Full Capitation With Quality	Minnesota Senior Health Options Program	Participating plans contract directly with CMS and the state Medicaid program. They receive capitated payments from both organizations that cover all Medicare and Medicaid-eligible services. Under this arrangement, participating plans have a financial incentive to manage all aspects of the individual's health.	Program enhanced access to care, reduced preventable hospital and nursing home admissions, and generated high levels of satisfaction among beneficiaries and participating providers.
	Global Payment	Buyers Health Action Group (BHAG) (now Minnesota Health Action Group)	The Buyers Health Care Action Group created “Choice Plus," which organized providers into discrete care systems based on cost and quality, combined with greater transparency, consumer choice, and a modified form of global payment. The "modified" global payment paid fee-for-service (FFS) claims, and then adjusted future reimbursement rates based on total cost performance. A quarterly “look back” at claims cost compared expenditures to the bid target. Providers then had an increase in fee levels or a reduction in their fee schedule.	Improved consumer information, and a cost reduction of 9 percent against expected claims.
	Global Payment	BCBSMA Alternative Quality Contract (AQC)	The AQC model combines a global budget for a patient population with significant performance incentives based on nationally accepted quality measures. Providers participating in the AQC are paid FFS and have a pre-negotiated, per-member-per month (PMPM) budget.	Provider groups who entered AQC from a traditional fee-for-service contract model achieved even greater spending reductions of 9.9 percent in year two, up from 6.3 percent in the first year; improvements in quality of chronic care management, adult preventive care, and pediatric care associated with the AQC grew in the second year.
	Global Payment	Oregon Coordinated Care Organizations	Oregon Medicaid has begun experimenting with global payment, creating “Coordinated Care Organizations” (CCOs) to manage all the services required by a given geographic Medicaid population for a fixed global amount. CCOs are responsible for managing all care—physical health, mental health, and dental health. There is also an option for potential shared savings.	Per capita spending on Medicaid dipped by more than 1 percent, and emergency room visits dropped by 9 percent.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Two-sided risk *continued*	Bundled Payment With Quality	California Maternity Episode Payment Project (PBGH)	Three year maternity care project that combines a blended hospital payment, a physician pay-for -performance program, and targeted quality improvement support to reduce unnecessary cesarean deliveries at full-term.	No results available yet.
	Bundled Payment With Quality	PROMETHEUS	Performance-based bundled payment programs used by providers and plans.	See specific example below.
	Bundled Payment With Quality	BCBSNC and CaroMont Health Bundled Payment Program	In 2011 CaroMont Health and Blue Cross and Blue Shield of North Carolina (BCBSNC) implemented a bundled payment arrangement based on the PROMETHEUS Payment model for entire knee replacement. The bundle includes the pre-surgical period of 30 days prior to hospitalization, the surgery itself, and most follow-up care within 180 days after discharge from the hospital.	BCBSNC saved about 8 to 10 percent on the average per episode cost in its one year pilot with CaroMont.[1]
	Bundled Payment With Quality	United Healthcare and Oncology	In 2010, UnitedHealthcare began a pilot with oncology groups to offer a single episode fee for an entire course of cancer treatment.	No results publicly available.
	Bundled Payment With Quality	Geisinger ProvenCare	ProvenCare was developed by Geisinger as a way to reimburse providers for coronary artery bypass graft surgery (CABG). Under this payment plan, physicians agree to follow 40 preoperative, perioperative, and postoperative treatment guidelines, such as prescribing preoperative antibiotics, in exchange for a flat rate of reimbursement.	These results include a 10 percent reduction in readmissions, shorter average length of stay, and reduced hospital charges for CABG surgery. The program achieved a 44 percent drop in readmissions over a course of 18 months.
	Bundled Payment With Quality	Arkansas Health Care Payment Improvement Initiative	In 2012, Arkansas created the Arkansas Health Care Payment Improvement Initiative, for both Medicaid and commercial providers with five episodes: perinatal; attention deficit hyperactivity disorder; upper respiratory infection; total joint replacement for both hips and knees; and congestive heart failure.	No results publicly available.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Two-sided risk *continued*	Bundled Payment With Quality	CMS Bundled Payments for Care Improvement (BPCI) Initiative	Under the Bundled Payments for Care Improvement initiative started in 2013, organizations will enter into payment arrangements that include financial and performance accountability for episodes of care. The Bundled Payments initiative is comprised of four broadly-defined models of care.	No results publicly available.
	Bundled Payment With Quality	Medicare Acute Care Episode (ACE) Demonstration	A three-year pilot that started in 2009, the Medicare ACE demonstration engaged five provider systems in a program wherein they received bundled payments for inpatient episodes of care.	Early results show savings.
	Bundled Payment With Quality	Medicare Participating Heart Bypass Center Demonstration	Under Medicare's Participating Heart Bypass Center Demonstration, four hospitals in the 1990s were paid a single amount covering both hospital and physician services for CABG surgery.	From the start of the demonstration in 1991 through its conclusion in 1996, the Medicare program saved $42.3 million on bypass patients treated in the demonstration hospitals.
	Shared Savings	CalPERS and PG&E (IOCP Model)	The Intensive Outpatient Care Program uses intensive care management for medically complex patients, with shared savings for providers, plans, and employers.	Savings of 20 percent; improvements in patient outcomes.
	Shared Savings	Medica and Fairview Health Services	Both Medica and Fairview rely on fee-for-service claims to pay provider groups their base payments and then additionally award a per-member, per-month (PMPM) management fee to participating practices. Medica and Fairview award shared savings to each practice based on its performance on all services compared with a control group, including a comparison on quality measures that serve as a qualifying gate for practices to receive savings.	Better quality outcomes and savings.
	Shared Savings	HealthPartners – Total Cost of Care Model (TCOC)	TCOC is a shared savings model; HealthPartners compares each care system's performance to a jointly negotiated target. HealthPartners calculates savings by comparing the performance of participating practices to the costs of all health care services in the target. The organization calculates shared savings for commercially insured and Medicaid-insured patients separately. Providers and the plan share any cost savings.	Payers in the Minneapolis metropolitan area estimate TCOC providers are beating trends by 2 percent.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Two-sided risk *continued*	Shared Savings	Geisinger "ProvenHealth Navigator"	This patient-centered medical home model is a "quality-gated shared savings model" because, after meeting financial targets, the portion of cost savings that each practice receives is dictated by the number of quality metrics it attains. The quality metrics are created annually for each practice across categories of chronic disease care, preventive care, care transition, patient experience, professional experience, and continuous improvement.	Preliminary data on the first two medical home pilot sites found that the ProvenHealth Navigator model cut hospitalization rates by 20 percent and lowered costs overall by 7 percent.
	Shared Savings	Maryland Multi-Payer PCMH Program (MMPP) (Patient-Centered Medical Home)	Based on a patient-centered medical home (PCMH) model, participating primary care practice sites can earn a percentage of the savings they generate through improved care and better patient outcomes.	Of 52 participating providers, 22 earned savings in the first year, meaning they incurred savings against expected 2011 total care costs and report[ed] on up to 21 measures that gauge the quality of care at the practice.
	Shared Savings	Medicare Shared Savings Program (ACO Model)	Beginning in 2012, the Centers for Medicare & Medicaid Services (CMS) established a Medicare Shared Savings Program; eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). ACOs demonstrate savings if assigned patient population expenditures are below the established benchmark, and the performance year expenditures meet or exceed the minimum savings rate (MSR).	No results available yet.
	Shared Risk	CalPERS Shared Global Risk ACO	In 2010, Blue Shield of California (BSC), Dignity Health (a hospital system), and Hill Physicians Medical Group jointly formed an Accountable Care Organization (ACO) that operates under an annual global budget reflecting total expected health spending for a defined population of around 41,000 individuals covered by the California Public Employees Retirement System (CalPERS). The pilot has a global spending target and offers shared risk and savings among BSC and the two participating providers.	BSC estimated that the project resulted in savings of about $20 million in 2010. The ACO has generated a 22 percent reduction in patient re-admissions compared with 2009, a half-day reduction in inpatient length of stay, a nearly 14 percent drop in total inpatient days per thousand.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Two-sided risk *continued*	Shared Risk	Intel Corporation and Presbyterian Health Services	In early January 2013, Intel Corporation partnered directly with Presbyterian Healthcare Services (PHS) to offer its employees an accountable care-style benefits plan. Intel is working directly with the system (rather than through a health plan) to administer benefits for members in the arrangement. Intel and PHS developed a value-based compensation structure that includes both shared costs and pay-for-performance.	No results available yet.
	Shared Risk	Blue Cross Blue Shield of Illinois (BCBS IL) and Advocate Health Care ACO (AdvocateCare)	BCBS IL and Advocate Health Care have created one of the largest commercial ACOs in the U.S. Providers can earn up to 50 percent in shared savings, based on their performance compared to a control group. Advocate and its physicians must reduce costs and achieve quality outcomes to earn savings.	For the first six months of 2011, AdvocateCare's hospital admissions per member fell 10.6 percent compared with 2010 results, and emergency room visits were down 5.4 percent. Medical cost trend was 6.1 percent below market.
	Shared Risk	Horizon Blue Cross Blue Shield of New Jersey ACO Pilot	Horizon Blue Cross Blue Shield of New Jersey's (BCBS NJ) ACO Pilot comprises a large multispecialty group and several of Horizon's national accounts. The ACO pilot arrangement contains upside and downside payment risk for providers.	To date, costs per patient per month averaged almost $100 less than the cost statewide for patients not in the patient centered medical homes. Quality results have also been positive, with lower readmission rates, among other measures.
	Shared Risk	Medica Health Plan's Total Cost of Care Contracts	A given amount is withheld at the beginning of the contract year, and providers must achieve an established cost and quality threshold to receive payment from the withheld amount.	Since 2008, Medica has seen lower fee-for-service rate increases as a result of its Total Cost of Care contracts.
	Shared Risk	Maine State Employee Health Commission and MaineGeneral	To align incentives across stakeholders, MaineGeneral Health (a non-profit provider system) and the Maine State Employees Health Commission (SEHC) have have recently announced a partnership to collaborate on an ACO-like arrangement, with shared risk, and quality benchmarks.	No results available yet.
	Shared Risk	Medicare Shared Savings	Under the two-sided model, the minimum savings rate is two percent of the benchmark for all ACOs. Shared loss calculation is one minus final sharing rate as a function of quality performance.	No results available yet.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Two-sided risk *continued*	Shared Risk	CMS Pioneer ACO Model	The CMS Pioneer ACO model allows provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Services Program.	Generating a gross savings of $87.6 million in 2012 and saving nearly $33 million to the Medicare Trust Funds, 13 out of 32 pioneer ACOs produced shared savings with CMS. Pioneer ACOs earned over $76 million by providing coordinated, quality care.

RISK	PAYMENT MODEL	PROGRAM	DESCRIPTION/MEASURES	RESULTS
Downside only	Non-Payment	Pennsylvania Medicaid Non-Payment for Preventable Hospital Readmissions Policy	Beginning June 2011, Pennsylvania Medicaid stopped paying for hospital readmissions occurring within 14 days of discharge (extended to 30 days in September 2011) "for the treatment of conditions that could or should have been treated during the previous admission."	No results available yet.
	Non-Payment	South Carolina Birth Outcomes Initiative	Medicaid and the largest commercial insurer deny claims for any cesarean deliveries, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary.	Preliminary data show a decline in inductions before 39 weeks and a decline in NICU admissions.
	Non-Payment	Texas Medicaid Non-Payment for Early Elective Deliveries	Medicaid denies claims for any cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to 39 weeks of gestation and are not considered medically necessary.	No results available yet.
	Non-Payment	Medicare Hospital-Acquired Condition Payment Policy	Medicare no longer pays hospitals for additional costs associated with 10 conditions considered to be preventable medical errors (also known as health care-acquired conditions, or HACs).	According to the New England Journal of Medicine, the policy change has not reduced HACs in a statistically significant way.
	Non-Payment	Medicare Hospital Readmissions Reduction Program	The Hospital Readmissions Reduction Program penalizes hospitals with high 30-day readmission rates for three conditions by withholding a percent of their Medicare reimbursement	Early data show readmission rates are declining, from a steady 19 percent to 17.8 percent in the last quarter of 2012. More than 2,200 hospitals faced some penalty in the first year.

APPENDIX II More Detail: CMS Bundled Payments for Care Improvement (BPCI) Initiative Models

	MODEL 1	MODEL 2	MODEL 3	MODEL 4
Episode	All acute patients, all DRGs	Selected DRGs, hospital plus post-acute period	Selected DRGs, post-acute period only	Selected DRGs, hospital plus readmissions
Service Included in the Bundle	All Part A services paid as part of the MS-DRG payment	All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions	All non-hospice Part A and B services during the post-acute period and readmissions	All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective
Number of Participants	1	48	17	33

More Detail: CMS Bundled Payments for Care Improvement (BPCI) Initiative Models excerpted from http://innovation.cms.gov/initiatives/bundled-payments

Under Model 1 (Retrospective Acute Care Hospital Stay Only) the episode of care is defined as the inpatient stay in the acute care hospital. Medicare will pay the hospital a discounted amount based on the payment rates established under the Inpatient Prospective Payment System used in the original Medicare program. Medicare will continue to pay physicians separately for their services under the Medicare Physician Fee Schedule. Under certain circumstances, hospitals and physicians will be permitted to share gains arising from the providers' care redesign efforts. Participation will begin as early as April, 2013 (and no later than January, 2014) and will include most Medicare fee-for-service discharges for the participating hospitals.

In Model 2 (Retrospective Acute Care Hospital Stay plus Post-Acute Care) the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. The episode will end either 30, 60, or 90 days after hospital discharge. Participants can select up to 48 different clinical condition episodes.

For Model 3 Retrospective Post-Acute Care Only) the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, or home health agency. The post-acute care services included in the episode must begin within 30 days of discharge from the inpatient stay and will end either a minimum of 30, 60, or 90 days after the initiation of the episode. Participants can select up to 48 different clinical condition episodes.

Under Model 4 (Acute Care Hospital Stay Only) CMS will make a single, prospectively determined bundled payment to the hospital that would encompass all services furnished during the inpatient stay by the hospital, physicians, and other practitioners. Physicians and other practitioners will submit "no-pay" claims to Medicare and will be paid by the hospital out of the bundled payment. Related readmissions for 30 days after hospital discharge will be included in the bundled payment amount. Participants can select up to 48 different clinical condition episodes.[160]

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