

# Categorizing Value-Based Payment Models According to the LAN Alternative Payment Model Framework: Examples of Payment Models by Category

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## Introduction

As the movement from volume to value payment progresses, more state purchasers are requiring their contracted health plans to implement alternative payment models (APMs)<sup>1</sup> with the goals of improving the quality of care and reducing costs for taxpayers. How states measure plan progress toward APMs varies among states that have instituted APM targets. An [accompanying issue brief](#) describes those ways. One increasingly common method is by using the [Health Care Payment Learning and Action Network \(LAN\) APM Framework](#). The LAN is a national effort funded by the Centers for Medicare & Medicaid Services (CMS) to accelerate APM adoption by states and in the commercial insurance market. As part of its work, the LAN has created a framework to classify APMs. APMs are complex and multi-faceted, making it difficult to categorize them into a simple framework. While the LAN offers purchasers a guidepost with which to categorize APMs, states still sometimes struggle with their interpretation of the LAN categories. The purpose of this brief is to provide real-world examples of APMs within the LAN categories and thereby provide states and other interested purchasers with a common understanding of what types of payment models fit within the framework categories.

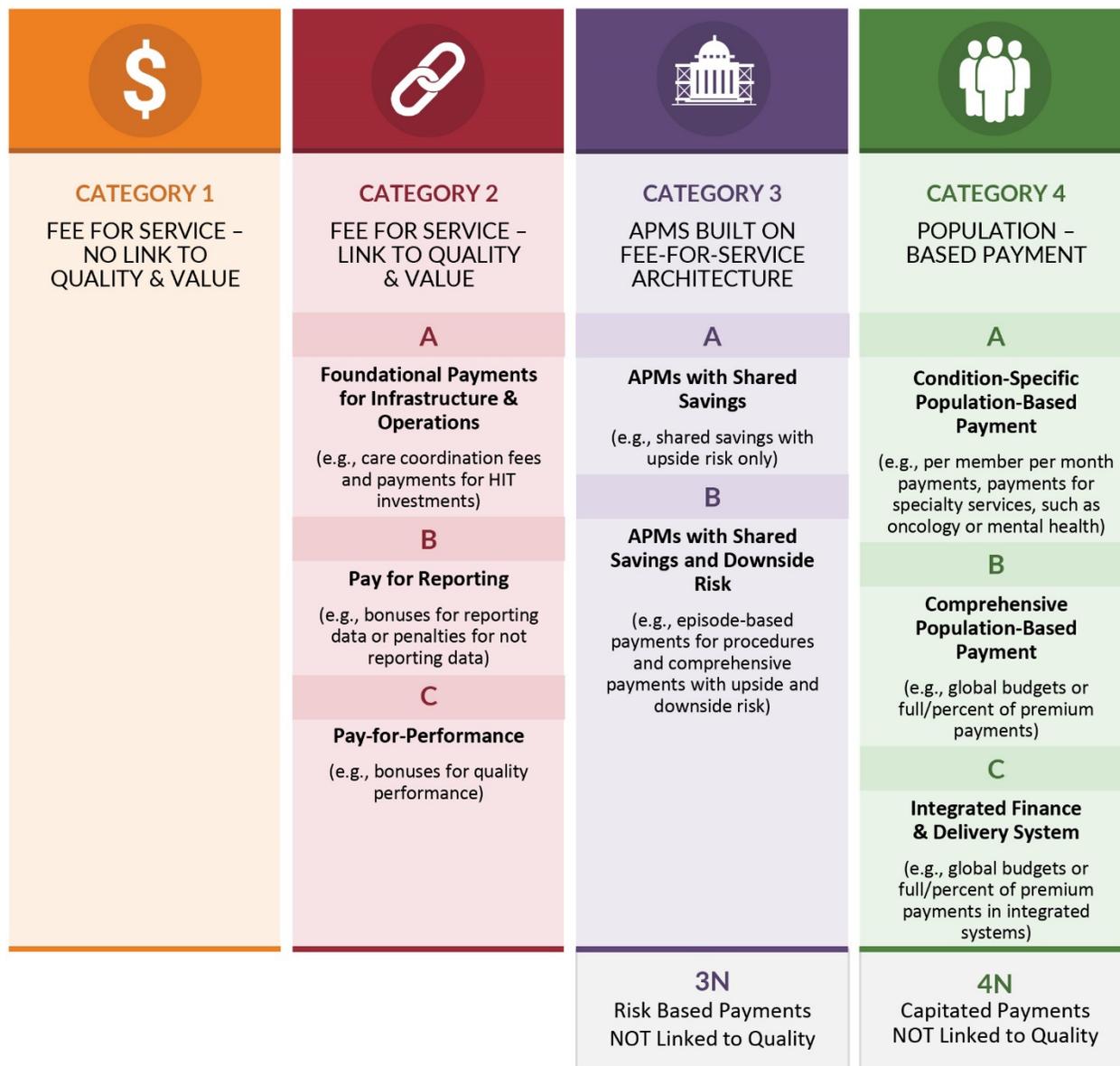
## The LAN Alternative Payment Model Framework

The LAN APM Framework was created by public and private stakeholders as a way of establishing a standardized and nationally accepted method to measure progress toward achieving greater penetration of APMs. It serves as a common lexicon in conversations about APMs. In addition, the Framework has been used in state goal and requirement setting for APM adoption. For example, Arizona has set a target that 70 percent of its acute care managed care organization (MCO) spending should be at or above LAN Category 2C by 2021, while [Washington's Health Care Authority has set a goal](#) that 90 percent of state-financed health care payments to providers will be in LAN Categories 2C-4B<sup>2</sup> by 2021. (A summary description of each category is provided in the Appendix.)

The LAN has created four broad categories of payment models, and within those categories, several subcategories that further differentiate payment arrangements. One of the challenges of categorizing APMs in the LAN Framework is that APMs often have aspects of multiple LAN categories, e.g., an accountable care organization (ACO) contract could have elements of foundational payments for infrastructure development (Category 2A) and shared savings (Category 3A) arrangements. The LAN Framework instructions call for categorizing by the “dominant APM” instead of separating the payment models into its sub-components. The dominant APM is defined as the most advanced payment model employed in the payment model design, regardless of the amount of incentive dollars attached to it. For the LAN, “more advanced” APMs are those in columns to the right in [Figure 1](#), and within each column further toward the bottom. However, depending on how the payment model is designed, it is possible that a payment model in a higher category has fewer incentive dollars or less risk than in a lower category.

This issue brief describes each payment category and the types of APMs that fall within those categories. It also provides more detailed descriptions of actual payment model methodologies for interested readers.

Figure 1. The LAN APM Framework



**Category 1: Fee-for-Service—No Link to Quality and Value**

The purpose of this category is to recognize that a significant, but decreasing, proportion of payments from health plans to providers use a traditional fee-for-service payment with no financial link to quality or value. These arrangements pay providers to deliver a service without providing any incentive to improve quality or reduce costs. Payments in this category include a common hospital payment model—the Diagnosis Related Group (DRG), payers who pay providers based on percentage of charges, and the traditional fee schedule method.

**Category 2: Fee-for-Service—Link to Quality and Value**

Payment models within Category 2 utilize traditional fee-for-service payment, but provide enhancements or reductions to the payment as a way to create incentives and disincentives for superior performance on quality, patient satisfaction, efficiency, or for having certain provider qualities or completing certain activities that could lead to improved care. The

LAN Framework describes these models as an “on-ramp” to more advanced APMs, but it should be noted that these models are sometimes coupled with more advanced APM concepts (e.g., shared savings or shared risk). There are three subcategories comprising Category 2.

### *2A: Foundational Payments for Infrastructure and Operations*

Payment models within Category 2A provide incentives for physicians and/or other clinicians to invest in resources that are thought to improve the value of patient care, such as care managers and electronic medical records, or for other infrastructure that aids in practices becoming patient-centered medical homes (PCMH). In Category 2A, payers recognize the significant provider investment required to improve the quality of care through additional payments that support the continuous use of the value-added work or resources. The concept of providing additional financial support to providers for infrastructure and operations has been a common concept among PCMH programs, and is often coupled with other models within Category 2. One example of this model is [South Carolina's PCMH Incentive Program](#).

### *2B: Pay for Reporting*

Most value-based payment models require providers to report quality data to payers. In the nascent days of value-based payment models, and still in some cases today, payers commonly incentivized providers to report data for the first time or improve upon existing data reporting. Some payers still do, particularly for newly developed or introduced measures, and with providers new to APMs. In addition, some payers will reduce annual rate increases to providers that do not report quality measures. By focusing on reporting, some payers are able to gain more complete data on the quality performance of contracted providers. Like Category 2A, this category is often coupled with other payment models. [Medicare's Hospital Inpatient Quality Reporting Program](#) is one example of Category 2B.

### *2C: Pay for Performance*

Historically one of the most popular value-based payment models, pay-for-performance incentives have been used in health care for decades. This category covers both incentives and disincentives for providers that achieve (or fail to achieve) payer-defined quality improvement or performance excellence targets. Incentives could be in the form of a bonus payment to the provider, a percentage increase in rates for the following year, or reductions. Incentive payments could be made prospectively or retrospectively. Examples of this model include [Gateway Health Plan's Gateway to Practitioner Excellence](#) and [Tennessee's Quality Improvement in Long Term Services and Supports \(QuILTSS\) Program](#).

## **Category 3: APMs Built on Fee-for-Service Architecture**

Payment models within Category 3 are still built on the fee-for-service “chassis” as the means to administer payment, but are considered to be more advanced than Category 2 payment models because they utilize potentially more powerful incentives for well-coordinated care for a) a comprehensive set of services in a single episode of care, or b) for a patient's total cost of care. Providers participating in Category 3 payment models are eligible to share in savings they generate with the payer, but may also be at financial risk should costs exceed a budget.

### *3A: APMs with Shared Savings*

In this category, providers share with the payer any savings the provider generates. The amount of savings for which they are eligible varies by a number of different factors across different payment models. For example, some shared-savings payment models required a certain percentage of savings to be achieved before additional savings are shared.

In addition, it is often the case that the stronger the performance on quality measures, the greater the proportion of savings shared with the provider. This category also includes “incentive-at-risk” payment models where incentive payments are based on utilization measures that are a close proxy for total cost of care (e.g., inpatient hospital and emergency department utilization). Examples of payment arrangements in Category 3A include a primary care payment model with shared savings on the total cost of care, [Ohio's Comprehensive Primary Care Program](#) and a primary care “incentive-at-risk” payment model, [Medicare's Comprehensive Primary Care Plus Track 1](#).

### *3B: APMs with Shared Savings and Downside Risk*

This category is different from 3A in that providers are eligible to share in savings, but are also at risk for financial penalties based on their performance against cost budgets, and potentially also for performance on quality measures. The amount of exposure to financial loss a provider has varies by payment model. In some models, such as the [Blue Cross Blue Shield of Massachusetts Alternative Quality Contract](#), provider risk can modulate based on quality performance, in that high quality can reduce the amount of losses that a provider must share if they exceed the budget. This concept recognizes the importance of high-quality performance. Similarly, in [Community Health Choice's Maternity Episode](#) model, quality not only modulates risk positively, it can also increase risk if performance is poor. In certain models, like the [Minnesota Integrated Health Partnership](#), providers must exceed the budget by a set percentage before being required to repay the payer. This allows payers and providers to be more confident that the losses generated by the providers are “real” and not a result of random variation.

## **Category 4: Population-Based Payment**

Payment models in Category 4 break free from the fee-for-service chassis and are prospectively paid models—meaning the payer pays providers up front, in a lump sum once (as with an episode) or on a periodic basis. Category 4 encompasses models that focus on all care provided for certain conditions (e.g., cancer) or all care provided by a certain provider type (e.g., primary care or mental health). Quality plays a role in these payment models by adjusting future prospective payments (up or down), or in the form of incentive payments or penalties. These models also begin to recognize the unique and complex payment structures of health care systems that involve multiple provider types, and in some cases payers. While Category 4 payment models exist in Medicaid, they are far less common than other payment models, with California being an exception.

### *4A: Condition-Specific Population-Based Payment*

This category covers prospectively paid value-based payment arrangements that cover a specific condition or all the care delivered by a particular type of clinician. This category can include intensive medical home models that care for patients with a specific condition, like cancer (if it covers care for the entire condition, not just chemotherapy) or cover all the primary care or specialty care delivered. Examples include the [Capital District Physicians' Health Plan Enhanced Primary Care](#) model and [Medicare's Comprehensive Primary Care Plus \(CPC+\) Track 2](#) program. It does not include traditional capitation models where quality had no role in adjusting the capitation level or being included as an incentive. Those models (which still exist) are included in Category 4N and are not considered to be APMs.

### *4B: Comprehensive Population-Based Payment*

This category addresses the prospective payment arrangements currently utilized in limited fashion with ACOs. They are payments made to providers to cover most or all of a population's health care needs, oftentimes including pharmaceutical and behavioral health expenses. These types of arrangements provide incentives to providers to not only manage the cost and quality of care they deliver, but also examine their referral patterns, ensuring they are referring

patients to high-quality and efficient providers. Examples include [WellCare's Pediatric ACO](#) and [UnitedHealthcare's Global Capitation](#).

#### *4C: Integrated Finance and Delivery System*

Finally, Category 4C seeks to recognize the unique and complicated payment arrangements that exist between integrated finance and delivery systems where insurance plans and health care providers are part of one organization. These models align the incentives of providers and payers, instead of the traditional push-and-pull of contrasting incentives. While there are still relatively few organizations that fit this arrangement, they may become increasingly common as provider and insurer consolidation takes place. This brief profiles the arrangement of [Kaiser Permanente](#), an example of a Category 4C.

## Conclusion

Value-based payment goals and performance requirements are being defined by states across the country. Utilizing the national LAN Framework for payment reform categorization, this issue brief provides real-world examples of the complex arrangements that fall within each of the categories. By doing so it concretizes an abstract framework that is designed to provide a common lexicon for purchasers, payers and providers, but that may sometimes be difficult to interpret.

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#### ABOUT BAILIT HEALTH

This brief was prepared by Megan Burns and Michael Bailit. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see [www.bailit-health.com](http://www.bailit-health.com).

## APPENDIX

### Category 2A: South Carolina's Patient Centered Medical Home Incentive Program

- › **Payment Model:** Incentive for National Committee for Quality Assurance (NCQA) PCMH recognition level attainment
- › **Payment Mechanism:** Per member per month (PMPM) bonus paid quarterly
- › **Provider Type:** Primary care providers
- › **Patient Population:** Medicaid adults and children
- › **Methodology:** South Carolina disperses PMPM payments to primary care providers that have achieved NCQA patient-centered medical home recognition. As of October 2017, payment amounts varied by level achieved from \$1.00 to \$2.00 PMPM. Practices that were applying for NCQA certification were also eligible for a smaller incentive (\$0.50 PMPM) during their application period.

More information is available in the state's [MCO Policy and Procedure Guide](#) (page 57).

### Category 2B: Medicare's Hospital Inpatient Quality Reporting Program

- › **Payment Model:** Penalty for not reporting hospital quality measures
- › **Payment Mechanism:** Adjustment in annual payment rate update
- › **Provider Type:** Hospitals
- › **Patient Population:** Medicare inpatients
- › **Methodology:** Medicare requires all hospitals to submit specified data in a certain way. It requires providers to register with their electronic quality reporting system and submit these data, including the hospital's hospital-acquired infection rate, and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey data, to cite two examples. If a hospital fails to meet the program requirements, it will receive a 25 percent reduction in its annual Medicare payment rate adjustment.

More information on this payment model's methodology is available [here](#).

### Category 2C: Gateway Health Plan's Gateway to Practitioner Excellence Program

- › **Payment Model:** Pay-for-performance and foundational payments for infrastructure
- › **Payment Mechanism:** Fee-for-service with performance bonuses paid quarterly and annually for completing clinical interventions. In addition, infrastructure payments are made on a PMPM basis for PCMH certification-level achievement.
- › **Provider Type:** Primary care practices (i.e., family practice, internal medicine, pediatrics)
- › **Patient Population:** Medicaid and Medicare Advantage, adults and pediatrics
- › **Methodology:** Practices are paid incentives for closing gaps in key Healthcare Effectiveness Data and Information Set (HEDIS) performance measures. Incentives are paid annually or quarterly depending on the measure, and payment ranges from \$10 to \$200 per member per year (or per quarter). For example, each practice receives annual bonuses for completing certain clinical interventions like:
  - » Six well-child visits in the first 15 months of life-\$10

- » Three to six year-old annual visits-\$10
- » Colorectal screening-\$10
- » Face-to-face transition care manager visits within seven days post-hospital discharge-\$190
- » First trimester prenatal visit plus needs assessment form completion-\$200
- » Completing eight prenatal visits-\$100
- » Completing one postpartum visit-\$75

Practices are paid additional sums of money on a quarterly basis for other clinical events:

- » Controlling blood pressure for patients with hypertension-\$10
- » Controlling blood sugar (i.e., HbA1c)-\$20

More information on this payment model's methodology is available [here](#).

### Category 2C: Tennessee's Quality Improvement in Long-Term Services and Supports Initiative Pay for Performance

- › **Payment Model:** Pay-for-performance
- › **Payment Mechanism:** Fee-for-service with retrospectively paid quality payments
- › **Provider Type:** Nursing facilities
- › **Patient Population:** Individuals who receive long-term services and supports (LTSS) from Tennessee's TennCare (Medicaid) program
- › **Methodology:** Nursing facilities are eligible to receive quality incentive payments if they meet minimum standards of performance. Once the minimum standards are met, nursing facilities are eligible to receive incentive payments based on their performance on quality and process measures that cover patient satisfaction, quality of life, staffing, and clinical performance. Each measure has a point value, and the total number of points received divided by the maximum potential points determines the percentage of the quality incentive payment the nursing facilities are eligible to receive.

More information on this payment model's methodology is available [here](#).

### Category 3A: Ohio Comprehensive Primary Care Program

- › **Payment Model:** Shared-savings program with pay-for-performance payments
- › **Payment Mechanism:** Fee-for-service, with quarterly risk-adjusted prospectively paid PMPM payments for meeting "activity requirements" and quality and efficiency thresholds, a shared savings based on total cost of care, and an additional bonus for the most efficient practices.
- › **Provider Type:** Primary care providers
- › **Patient Population:** Medicaid and commercially insured pediatrics and adults
- › **Methodology:** Primary care practices participating in the Ohio Comprehensive Primary Care (CPC) program receive an average \$3 to \$5 PMPM for meeting three types of requirements:
  1. Eight activity requirements including, for example, having same-day appointments, 24/7 access to care, and stratifying patients based on risk and using that information to inform care;

2. Twenty clinical quality metrics including, for example, well-child visits, antidepressant medication management and controlling high blood pressure; and
3. Five efficiency metrics including, for example, generic dispensing rate and emergency room visits per 1,000 members.

In addition, practices are eligible to share in savings based on the total cost of care. Practices that have a total cost of care below a predefined threshold, or which participate in Medicare's CPC+ Track 2 receive 65 percent of their shared savings. All other practices receive 50 percent of their shared savings, if the savings are greater than a one percent reduction on their total cost of care over the prior year.

Finally, an additional bonus payment of \$5 per attributed member is made to the top 10 percent of practices with the lowest average risk-adjusted total cost of care.

More information on this payment model's methodology is available [here](#).

### Category 3A: Medicare's Comprehensive Primary Care Plus Track 1

- › **Payment Model:** Incentive-at-risk payment
- › **Payment Mechanism:** Fee-for-service with prospectively paid care management payments and prospectively paid performance incentive bonuses that are at risk
- › **Provider Type:** Primary care providers
- › **Patient Population:** Multi-payer model that includes Medicare, Medicaid and commercially insured individuals
- › **Methodology:** CPC+ has two separate but similar pay-for-performance models with primary care providers. Track 1 is categorized under 3A and Track 2 is categorized and [explained in more detail in 4A](#). In Track 1, primary care providers receive a prospectively paid care management payment on a PMPM basis to support comprehensive care management and care coordination. Practices also receive a prospectively paid PMPM incentive payment. Fifty percent of that incentive payment is tied to quality and patient experience, and 50 percent is tied to inpatient hospital and emergency department utilization. In order to prevent the practice from having to repay the incentive payments, practices must meet certain performance benchmark thresholds for both quality and patient experience, and utilization. If they do not, they are eligible to receive *a portion* of the payment based on a methodology that rewards attainment at lower thresholds.

More information on this payment model's methodology is available [here](#).

### Category 3B: Texas Community Health Choice's Maternity Episode

- › **Payment Model:** Episode-based payment
- › **Payment Mechanism:** Retrospectively reconciled episode of care with shared risk
- › **Provider Type:** Large, multi-specialty physician groups
- › **Patient Population:** Pregnant women enrolled with Community Health Choice and enrolled in the Texas STAR Medicaid eligibility category (low-income women and children)
- › **Methodology:** Community Health Choice has an episode-of-care payment model program that covers all related care for the mother and baby. For the mother, prenatal care, delivery and postpartum care (up to 60 days post-delivery) are included in the episode. For the baby, the initial delivery and all services and costs up to 30 days post-discharge are included. The plan established patient-specific budgets by blending historical average costs for C-sections and vaginal delivery rates and risk adjusting based on mutually agreed upon historic risk factors of

the patient. The episodes are administered on a fee-for-service basis with a retrospective reconciliation to budget at the conclusion of the performance period. Providers are eligible to keep a portion of any savings earned and are accountable for a portion of any losses incurred. Quality measures are tracked and are used to adjust the percentage of savings for which a provider is eligible, and to adjust the percentage of losses that may be incurred.

More information on this payment model's methodology is available [here](#).

### Category 3B: Minnesota's Integrated Health Partnership

- › **Payment Model:** Shared risk on total cost of care
- › **Payment Mechanism:** Fee-for-service, plus a prospectively paid PMPM for care management, with shared risk on a risk-adjusted total cost of care target
- › **Provider Type:** Integrated delivery systems that provide the full scope of Medicaid services with at least 2,000 attributed patients
- › **Patient Population:** Minnesota Medicaid eligibility categories of pregnant women, children under 21, adults without children, individuals who are blind or disabled but not dually eligible
- › **Methodology:** There are two tracks to Minnesota's Integrated Health Partnership (IHP). Track 1 is a shared savings model that would be categorized in 3A. The following description is of Track 2, which is a shared risk model meant to support Medicaid ACOs. All services are paid for on a fee-for-service basis. In addition, Minnesota's IHP provides a PMPM "population-based payment" fee on a quarterly basis for the purposes of care coordination. It is adjusted based on the medical risk and social complexity of each attributed individual. After three years, entities participating in this model are only be able to earn this payment based on their performance on key quality measures.

Entities participating in this model are also held financially responsible for the total cost of care in the following manner:

- » Each entity has a risk-adjusted total cost of care target set based on the experience of a prior year.
- » The target is the total cost of all expected services received by a patient and covered by Medicaid for one year.
- » The target is risk-adjusted, and an expected trend rate is applied to account for increases in costs to care for the population.

At the conclusion of a performance year, the participating entity's performance on the total cost of care will be measured by comparing the target to the actual costs for that year. Entities that have costs at least two percent below the target are eligible to share in any realized savings. The proportion of savings an entity is eligible for is generally set at 50 percent, but can vary as a result of contract negotiations and/or provider type. Fifty percent of the eligible savings amount is directly tied to savings. In other words, if an entity is successful in lowering costs, they are only guaranteed 50 percent of their negotiated savings rate. The remaining 50 percent must be earned based on quality performance.

Entities that have costs two or more percent higher than the target are required to pay a portion of the losses back to the state. Quality performance does not adjust the amount of losses an entity must repay the state.

A claims cap is applied to this payment model on a per member basis and is used to protect providers from excessive exposure to high cost cases.

More information on this payment model's methodology is available [here](#).

## Category 3B: Blue Cross Blue Shield of Massachusetts Alternative Quality Contract

- › **Payment Model:** Shared risk on total cost of care
- › **Payment Mechanism:** Fee-for-service plus shared risk on a risk-adjusted total cost of care target and quality performance incentives
- › **Provider Type:** Accountable care organizations
- › **Patient Population:** Commercially insured members enrolled in Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) products
- › **Methodology:** The alternative quality contract (AQC) holds providers accountable for a total cost of care target on a shared-risk basis. The target is developed using historical claims, and then is risk adjusted. A trend is negotiated between Blue Cross Blue Shield of Massachusetts and the providers, and is then applied to multi-year contracts.

Quality performance is used in two ways under the AQC. First, it adjusts the amount of savings the providers can keep or the amount of deficit they must repay. Providers that perform better than the target are eligible to share in an increasingly large percentage of the savings dependent upon their quality performance. Providers that perform worse than the target are at risk for a portion of the savings. Their losses can be mitigated by high-quality performance. Second, providers are eligible for a PMPM quality incentive bonus that is tied to their quality performance.

More information on this payment model's methodology is available [here](#).

## Category 4A: New York Capital District Physicians' Health Plan Enhanced Primary Care

- › **Payment Model:** Prospectively paid capitated payments with incentive-at-risk payments
- › **Payment Mechanism:** Prospectively paid capitation with fee-for-service on non-capitated services and bonuses
- › **Provider Type:** Primary care physicians with at least 150 attributed Capital District Physicians' Health Plan (CDPHP) members who committed to delivery system transformation
- › **Patient Population:** Commercial HMO and non-HMO members, New York State Medicaid and Medicare
- › **Methodology:** The goal of the enhanced primary care (EPC) payment model is to improve the cost and quality of primary care and to improve the desirability for physicians to remain in independent primary care practice. CDPHP designed a payment model that addressed both the incentives to improve quality and lower costs, as well as provide additional compensation to primary care physicians. It also required its practices to participate in significant delivery system transformation efforts.

EPC is prospectively paid risk-adjusted capitated payment delivered on a PMPM basis. The capitated payment covers the majority of primary care services delivered. Certain services are still paid fee-for-service, like vaccines. In addition to the base PMPM payment, primary care providers received a 20 percent increase in their base payment as a raise to help achieve the goal of making the delivery system change required to participate in the payment model sustainable.

Primary care practices are also eligible for an additional bonus (worth about 20%) for performance relative to quality and cost outcomes like HEDIS claims-based process measures; patient satisfaction; efficiency; utilization of inpatient services, emergency department and specialists. This bonus is paid nine months after the end of the performance period.

More information on this payment model is available [here](#).

## Category 4A: Medicare’s Comprehensive Primary Care Plus Track 2

- › **Payment Model:** Prospectively paid capitated payments with reduced fee-for-service and incentive-at-risk payments
- › **Payment Mechanism:** Prospectively paid capitated payments
- › **Provider Type:** Primary care providers
- › **Patient Population:** This is a multi-payer program where Medicaid and commercial payers are participating with Medicare. Exact patient population composition varies by participating region.
- › **Methodology:** CPC+ has two separate but similar pay-for-performance models with primary care providers. Track 1 is categorized and [explained in more detail under 3A](#) and Track 2 is categorized in 4A. In Track 2, primary care practices receive three prospectively paid payments. As in Track 1, primary care practices receive a care management payment that is designed to support care management and care coordination, and a prospectively paid incentive payment. Fifty percent of that incentive payment is tied to quality and patient experience, and 50 percent is tied to inpatient hospital and emergency department utilization. In order to prevent the practice from having to repay the incentive payments, practices must meet certain performance benchmark thresholds for both quality and patient experience, and utilization. If they do not, they are eligible to receive a portion of the payment based on a methodology that rewards attainment for lower thresholds.

Unlike in Track 1, Track 2 participants will be in a hybrid payment model of prospective payment and fee-for-service payment. Practices will receive a prospectively paid payment on a quarterly basis that is meant to cover the majority of services delivered in a primary care office. This “comprehensive primary care payment” (CPCP) is calculated using the historical fee-for-service payments of the practice and increasing them to account for inflation, and adding 10 percent to account for the expected increase in the “breadth and depth” of services delivered by primary care providers in this payment model. CPCP is also adjusted for the expected physician fee schedule update. A practice is able to choose what percentage of its CPCP is administered via prospective payment versus fee-for-service, with some general parameters. Over time, practices participating in this model will either have 40 percent of their CPCP payment delivered prospectively and 60 percent paid by fee-for-service, or have 65 percent of their CPCP payment delivered prospectively and 35 percent paid by fee-for-service.

More information on this payment model’s methodology is available [here](#).

## Category 4B: WellCare’s Pediatric Accountable Care Organization with Kansas City Children’s Mercy Primary Care Network

- › **Payment Model:** Capitation that covers the majority of health care expenses for pediatric members attributed to Children’s Mercy Primary Care Network (CMPCN) centers
- › **Payment Mechanism:** Prospectively paid PMPM payment that generally covers medical and behavioral costs, less a 5 percent withhold that is returned based on HEDIS results and other performance metrics that are primarily utilization focused
- › **Provider Type:** Currently one pediatric health system in Kansas City with 36 health care centers
- › **Patient Population:** Pediatrics
- › **Methodology:** WellCare’s pediatric ACO model is a prospectively paid capitation model that covers the majority

of care a child receives. The ACO receives a risk-adjusted capitated payment to cover primary care services of an attributed member, less a 5 percent withhold that is returned based on quality performance. To earn the withhold, providers must successfully achieve specified HEDIS and performance targets such as reduction in readmissions and non-emergent emergency department utilization. In addition, a separate budget is established to cover the costs of services performed outside of the CMPCN centers for which the ACO is responsible. If costs for the total cost of care exceed the capitated payment or budget, CMPCN is responsible for those costs and adjustments are made to the following year's capitation level and out-of-network care budget.

## Category 4B: UnitedHealthcare Global Capitation

- › **Payment Model:** Capitation that covers the majority of health care expenses for an individual
- › **Payment Mechanism:** Prospectively paid PMPM payment that generally covers professional and institutional medical, behavioral and pharmaceutical costs. Services vary slightly between fully insured and self-insured populations, and by lines of business.
- › **Provider Type:** Primary care practices, multispecialty group practices, integrated health care providers
- › **Patient Population:** Commercial adults and pediatrics, Medicare Advantage, Medicaid adults and pediatrics
- › **Methodology:** A practice, group or ACO receives a risk-adjusted PMPM that covers the majority of services for an attributed member. The practice, group or ACO is responsible for the cost of services provided to attributed patients who are cared for by providers outside of the global capitation arrangement. UnitedHealthcare pays claims for services delivered by providers outside of the global capitation arrangement and the mechanism for reconciling with the global capitation providers varies by contract. This provides incentives to providers under the global capitation arrangement to refer to specialists and hospitals who excel in quality and efficiency. A stop-loss mechanism is used to prevent practices from being exposed to high cost outliers.

In terms of quality, the risk-adjusted PMPM is adjusted in future years to reward providers that score high on certain efficiency and quality metrics. If they perform poorly, they risk having their PMPM adjusted downward in future years.

Practices, groups and ACOs that participate in this model are also delegated certain health plan functions like utilization management and credentialing.

## Category 4C: Kaiser Permanente<sup>3</sup>

- › **Payment Model:** Integrated finance and delivery system
- › **Payment Mechanism:** Medical groups are paid capitation, physicians are paid salary plus financial incentives based on performance
- › **Provider Type:** Kaiser Permanente consists of a non-profit health insurance company (the Kaiser Foundation Health Plan), hospital systems (Kaiser Foundation hospitals) and for-profit medical groups (exclusive to a region) that provide care for Kaiser Permanente members. The for-profit medical groups (Permanente Medical Groups) have an exclusive contractual relationship with the Kaiser Health Plan, and the Kaiser Foundation hospitals have a different contractual relationship with the health plan, which includes hospital operating and capital budgets. This allows all financial incentives to be aligned since the medical group and health plan share risk related to budget variance for each entity.
- › **Patient Population:** Adults, seniors and pediatrics in HMO model
- › **Methodology:** The medical groups receive a negotiated prospectively paid PMPM for all care a member would be

expected to receive within, and external to, the medical groups. The physicians within those medical groups are salaried with financial incentives available for quality, patient satisfaction, evaluations by peers and chiefs (managers) and financial performance of the medical group. The health plan and medical groups are in a contractual risk-sharing arrangement where each entity shares in the financial performance of the other entity and together, they share in financial risk at a program level. Since the hospital budget is set by the health plan, the efficiency of the hospital operation has a direct impact on the health plan's financial performance; this impacts the total financial performance that the health plan shares with the medical group. This unique contractual relationship facilitates financial alignment among all three entities. This financial alignment provides no incentive for withholding necessary covered medical care (positive variances to budget that might have to be shared between the entities, and cannot be retained solely by either entity). If delay or denial of care led to greater ultimate expenses, these negative budget variances are also shared between the entities. Traditional utilization based incentives for hospital and ambulatory services are non-existent because of the capitation payments to the medical group and shared risk for the hospital's expense budgets. This provides the medical groups and hospitals the financial incentives to deliver care in the most efficient manner and setting. Finally, the medical group makes all decisions with respect to care, and the health plan does not require prior authorization from the Permanente Medical Groups for covered medical services.

For more information on this payment model's methodology please refer to this [FAQ](#) and this [case study](#).

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## Endnotes

1. Alternative payment models are often also referred to as value-based payment models.
2. The Washington Health Care Authority established their targets prior to the LAN Framework being updated with a new category, Category 4C.
3. Developed with input from Jeff Selevan, senior advisor, Southern California Permanente Medical Group, Kaiser Permanente.