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Implementing Value-Based Insurance Products: A Collaborative Approach to Health Care Transformation

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SECTION ONE: Accelerating Progress Toward Value-Based Health Care in Commercial Markets

Background

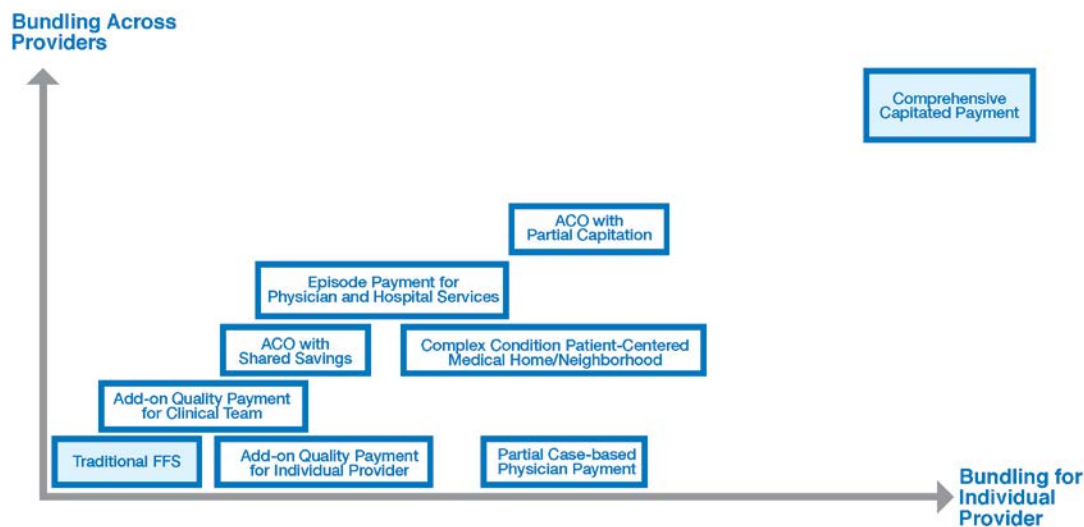
While American health care does more to improve and extend lives than ever before, overwhelming evidence has shown that outcomes could be substantially better and costs much lower. All over the country, innovative models of health care delivery are being piloted to address these considerations and there are even some pockets of broader adoption. However, the predominant system of payment for health care providers, even in these reformed delivery systems, remains based on fee-for-service (FFS) for specific activities. FFS provides little support for many innovative and personalized services that health care providers are trying to implement to improve health and health care. Many potentially valuable approaches are not reimbursed or are reimbursed poorly, including: team-based approaches to care, systems to coordinate care, virtual and wireless services, and home- and community-based programs that increase convenience for patients and avoid hospitalizations or even traditional office visits. In contrast, traditional FFS payment encourages more volume and intensity of traditional services.

To support innovative, less-costly care, health plans and providers have begun to develop, implement, and evaluate a range of financing reforms. These new models use reimbursement that seeks to reward value rather than volume in order to give providers greater support for delivering care that promotes higher quality and lower costs. The meaning of value is set by the parties in these payment agreements—which typically involve some assessment of quality, safety, and efficiency—with rewards or penalties based on reaching or surpassing predetermined targets.¹ The non-FFS, value-based payment models include episodic or bundled payments, per-member-per-month payments to support patient-centered medical homes (PCMHs) and other delivery transformation models, and shared-savings and shared-risk accountable care organizations (ACOs). These models seek to improve quality and reduce costs through different approaches. Episodic or bundled payments intend to address variation in quality and cost for a particular episode or procedure through retrospective or prospective reimbursement that includes a lump sum for the set (e.g., hip or knee replacement). Population-based payments and ACO programs create incentives to improve overall cost and quality targeted at the management and coordination of care for an attributed population.

Figure one (*next page*) illustrates the range of value-based payment model options in terms of the extent to which they move away from traditional FFS in the lower left hand corner, and toward more comprehensive, patient-level payments. The figure illustrates how much of the payment shifts from volume and intensity to case- or person-level payment for individual providers on the horizontal axis, and how much it shifts for the other health care providers (e.g., hospitals) on the vertical axis. Such case- and person-level payments are generally tied to the quality and experience of care, and would provide greater rewards than FFS payments for providers that succeed in steps to lower patient-level costs while maintaining or improving quality.

In the past few years, health plans and providers have been making notable progress in advancing value-based payments, with plans and providers piloting and expanding a broad range of financing reforms and associated care transformation strategies as they determine which approaches are most likely to be successful in improving care in particular contexts. For example, a recent report by the Blue Cross Blue Shield Association reveals with PCMHs in market or in development in 48 states and the District of Columbia, and ACOs in market or in development in 41 states and the District of Columbia.²

Figure 1: Payment Reforms That Move Away from Fee-for-Service³



In response to growing recognition that the financing of health care must change to support more efficient health care,⁴ the adoption of these value-based payment models appears to be accelerating. The Catalyst for Payment Reform estimates that 40% (a 29% increase from 2013⁵) of payments are tied to quality or financial performance or intended to reduce waste.⁶ Of these value-based payments, slightly more than half (53%) put providers at risk for costs going up (downside risk) whereas the remaining 47% are financial upside only.⁷

The transition to value-based payments contracts alongside efforts to reform care delivery has been difficult for all involved. It is challenging to develop and implement a model that meets the needs of all stakeholders—providers, payers, purchasers, and members—and that is sustainable in the long-term. This is especially true when the payment reform efforts are undertaken as add-ons to well-established activity-based contract negotiations that focus on price and access for traditionally covered medical services.

In moving to new payment arrangements, **physician groups** are looking for predictable reimbursement that will allow for necessary investments for transforming their health care practice (i.e. hiring care coordinators, investing in health information technology, etc.) without exposing them to substantial financial uncertainty about whether these investments will pay off.⁸ In addition, physicians want to practice autonomously and to not be burdened by administrative requirements.

Hospitals are looking for models that sustain or increase their net reimbursement and give them an increasing role in ambulatory and population-based health care. All providers also want better data to optimally manage their population and reduce the uncertainty of payment reform.⁹ There are additional challenges for providers to implement and pace delivery reforms successfully during the process of payment evolution from FFS to value-based insurance products (VBIP). In many cases, payment reforms have been implemented gradually to avoid large disruptions and enable adjustments based on experience along the way. While this may reduce providers' exposure to new and uncertain financial risks, if payment and delivery changes are out of sync, the limited changes mean meaningful reforms to eliminate waste and inefficiency under FFS may reduce provider revenue. For this reason, some providers and plans feel it will be less painful to shift a critical mass of payments into value-based

payment systems quickly by using a substantial change in payment to create a much clearer business case for providers to change delivery methods. In this view, it is very difficult for providers to stand with “one foot in two canoes” for very long.

Payers want a product and associated provider contracts that provide more stability and predictability about the costs of care¹⁰ while promoting high quality care, can be administered easily, and achieve cost reductions and predictability without significant member discontent or disruption. **Purchasers**, or self-funded employer groups, want to provide their employees a product that not only has affordable premiums but also delivers high quality, efficient care, in order to maintain a healthy and productive workforce.¹¹ Payers must demonstrate to their purchaser clients that these value-based payment models are solutions that will not only result in further improvements in quality but will also drive savings in excess of any newly created costs, like a PMPM fee. After years of cost increases, containing costs and premium increase is often an overriding concern.

Lastly and most importantly, payment reforms will not succeed unless they are acceptable to consumers. **Consumers**, who choose insurance plans, want an insurance product with an affordable premium that provides access to care that they can be confident is of high quality when needed, that limits their out-of-pocket costs and the unpredictability of such costs if they become ill, and that minimizes the hassle of getting care and getting it reimbursed. Traditionally, consumers have focused on premiums, and on whether their drugs, physicians, hospitals, and other providers are covered at favorable rates. New provider payment models and the associated steps to improve care delivery have implications for patients as they have the potential to give consumers higher value, but only if consumers are aware of and confident about the quality and cost benefits to them of choosing plans that feature such providers. Further, consumers’ experience with the plans must confirm that confidence.

While most would conceptually agree that the health care system should provide accessible, high quality care at a low cost, and that there are many opportunities to make changes that could be “wins” for all stakeholders, competing priorities among different stakeholders coupled with the traditional win-lose approach to insurance contract negotiations based on prices and access to services may make it very difficult to move toward this ideal. When the only well-established basis for contract negotiations is ICD- and CPT-based payment rates, and there is no trust or a clear, straightforward way to implement an alternative payment system that would be more conducive to win-win steps, it is easy to understand why plans, providers, employers and their brokers cannot easily move to contracts that enable transformative improvements in health care value. Further, given the traditional models of plan design, it is understandable why consumers might be skeptical of insurance reforms that claim to produce higher value while encouraging consumers to change the providers and services they receive.

Despite these challenges, the rising pressures of quality gaps and high costs are compelling progress toward transformative health insurance products. To accelerate progress, a clearer path is needed for the systematic, feasible adoption of value-based payments by providers and payers in insurance contract negotiations, and simultaneously by purchasers and payers in contracts for adopting such payment systems into employer coverage.

Methods

To enable more rapid progress in value-based payment, the Center for Health Policy at Brookings convened a roundtable of stakeholder groups – payers, providers, and purchasers—to understand current initiatives and challenges. Prior to this meeting, Brookings conducted a literature review (both peer-reviewed and gray literature) and interviewed a selection of roundtable participants (including 10 plans and 3 providers) to learn of current programs, barriers, potential

for scalability, and future directions in value-based payment. In addition to the roundtable, Brookings also conducted analyses on value-based payment models in a range of clinical areas¹² and has incorporated relevant findings from those studies here. Moreover, after the roundtable, Brookings conducted 16 subsequent interviews with different stakeholders (five providers, seven plans, three purchasers, one consumer group, and one brokerage firm) and further targeted literature review based on issues raised by our participants.

Overview of Value-Based Insurance Products

The result of our process is a model framework for VBIPs that integrate reformed payment models facing providers matched with consumer-facing benefit reforms, all focused on value. These products capitalize on new network developments and delivery system transformation strategies as well as engaging consumers in understanding and benefitting from the enhanced support for value measurement and creation. While each of the individual, incremental payment reforms that have been implemented around the country are contributing to progress, the VBIP provides a new foundation or “reset” in contract negotiations around value and a framework and pathway for increasingly effective value-based reforms. It also accounts for the diversity of starting points and opportunities for payment reform. At the same time, it recognizes that “productizing” such provider payment reforms requires complementary changes in benefits and information for consumers about the value of the new model of payment and benefit design. Focusing on VBIP provides a widely applicable roadmap to move from activity-based contracts toward increasingly value-based contracts. The key elements of a VBIP model are described in Figure Two.

Figure 2: Key Features of Value-Based Insurance Products¹³

| | |
|---|---|
| 1 | Per case or per beneficiary component of payment for most providers that is tied to value of care and that increases over time – new foundation of insurance contract |
| 2 | Freeze or reduction in FFS-based payments for most physicians, hospitals, and other providers, in conjunction with shift to value-based payment |
| 3 | Per case or per beneficiary payments reflect performance metrics related to quality of care, outcomes and overall costs—not activity |
| 4 | Transparent, timely and actionable sharing of claims and other data to enable providers to support performance improvement |
| 5 | Beneficiary premiums and copays that include a complementary shift from volume to value, with lower and more predictable payments for using providers that deliver measurably higher value care |

One key feature is a foundation in value-based payment, not activity-based payment. That is, the focus of contract negotiations shifts from FFS rates relative to Medicare, to the magnitude and composition of payments to providers based on performance at the case or person-level. Such components may initially be small if the plans and providers have uncertainty about their effects, but with greater experience with value-based payment and better supporting data systems and evidence, more substantial reforms are feasible. FFS payments may not be fully replaced; they would still be used to limit provider risk in practice areas where case- and person-based payments create too much unpredictability for providers. Another key element is well-understood performance measures, ideally measures that can enable care improvements implemented by providers to “pay off” across multiple payers. Contract negotiations would include a path to improving these measures over time; as VBIP contracts become better

established, the key or core performance measures could become as standard as ICD and CPT codes are today. Related to performance measurement, VBIP contracts require a new emphasis on data sharing, particularly for claims and enrollment data, to enable transparency in the performance measures and timely access by providers to actionable information they need to achieve care improvements. Such data sharing is an important tool for promoting confidence in the ability of all parties to achieve their goals under the new payment models, and to build trust and momentum for the new approach to payment. Finally, VBIP implementation requires a focus on consumers – ensuring that the payment changes supporting higher-value care from providers are matched by opportunities for savings when consumers shift to these providers, as well as compelling information and support that consumers can give consumers confidence in changing their own care choices.

Implementing a VBIP contract is not easy. Consequently, this paper focuses on the obstacles to implementing a VBIP and a framework to approach and overcome the obstacles. As we have noted, this framework reflects extensive interviews, discussions, and data review with payers, providers, and purchasers who have been leading the implementation of new payment systems.

In Section Two, we describe the major obstacles faced by each stakeholder group in the adoption and implementation of value-based payment models. In Section Three, we highlight specific steps that these stakeholders can take together to overcome the challenges. In Section Four, we describe the implementation of VBIPs to achieve the paradigm shift away from activity-based payment to value-based payment.

SECTION TWO: Overview of Key Obstacles to Creating a Value-Based Insurance Marketplace

Our literature review, roundtable, and subsequent interviews identified a set of common themes regarding challenges or barriers to VBIPs that offer significant benefits to all stakeholders. Based on these common themes, **Figure 3** describes the key challenges to overcome in shifting from paying for activity to paying for value.

- 1. Many plans and providers are entering into some form of an alternative payment model with an emphasis on value, but these programs and their degree of adoption are highly dependent on market dynamics, stakeholder relationships, institutional features, and other factors.***

The term “value-based payment” holds multiple meanings for payers, providers, and other stakeholders. The reforms include augmenting RVU-based payments with a case or PMPM-based component tied to expectations of quality improvement and/or quality and cost performance measures (i.e. a medical home, accountable care organization, etc.) as well as those that move to episodic and bundled payments, and partial capitation or global population-based payments. Stakeholders noted varying progress across the spectrum of models depending on a number of factors: geography and market share, leadership priorities, presence of accommodating local partners, and the status of relationships with providers and other stakeholders. Especially when the parties have historical relationships that have focused on win-lose negotiations over payment rates alone, there may be little foundation for trust for working collaboratively on an alternative contract model. Moreover, there is mixed interest in accelerating the pace of value-based models; some plans anticipate more extensive efforts in the near future, whereas others are content with their current progress or have discontinued certain programs based on experiential learning. Progress is further complicated by individual physician compensation

models that pay directly or indirectly using RVU-based measures of productivity, even within provider organizations that are shifting to value-based payments in their insurance contracts.

Figure 3: Key Elements to Facilitate the Paradigm Shift from Activity-Based Payment to Value-Based Payment



2. Progress on transparent, bilateral information and data sharing is a requirement for meaningful progress towards value-based payments.

The provision of data is an important foundational requirement for all payment models, but especially in the transition away from FFS. Most providers identified the lack of timely data and information sharing as a significant barrier to further progress with value-based payments, with some providers also expressing concerns that even when they receive data from payers (public and private) there is a significant amount of data analytics required to turn the data into actionable information, which in turn requires infrastructure investments. This process has been made more challenging as electronic health records (EHRs) and legacy claims systems may not be capable of producing the required data to power robust population management analytics and management systems. However, purchasers and payers all expressed the desire and commitment to implement steps to ease these burdens. Almost universally, stakeholders felt the provision of transparent data provides the foundation for needed constructive relationships among parties that, in turn, facilitate the successful implementation of reforms in care. In some cases, payers and providers have worked bilaterally to share data effectively. In other cases, regional initiatives have helped overcome barriers to data sharing. For instance, Minnesota Community Measurement leads a multi-payer initiative to successfully collect and exchange comparable data across health systems for quality improvement and public reporting.¹⁴ In addition, CMS has begun to produce monthly reports, though some providers expressed concerns about interpreting the CMS data and the difficulty of conducting analyses that combine CMS data with data from other payers. Significant further challenges include privacy concerns, how best to integrate meaningful data into clinical workflows, and the integration between claims and clinical data.

3. *Consistent quality metrics across payers and providers will accelerate progress towards value-based payments.*

The development of quality metrics for use in payment models is certainly not a new concept, and quality measurement continues to advance. However, the growth of payment methods based on quality metrics, as well as the increase in heterogeneity of quality metrics and the data and methods used to compute them, has contributed to disparate requirements for quality measurement, additional administrative complexity, and a lack of alignment and thus impact of payment reforms. A recent study conducted by the America's Health Insurance Plans (AHIP) found 546 distinct measures across the measure sets of 23 health plans.¹⁵ Another study found that only 20% of measures used in 48 state and regional sets were used by more than one program.¹⁶ Thus, providers who participate in both commercial and public programs must meet different reporting requirements that include measures that are topically similar, yet differ in their measure specification, creating significant administrative burdens and furthers barriers to multi-payer arrangements.¹⁷ For purchasers, the proliferation of measures contributes to confusion surrounding value-based payment models, as the lack of measure consensus does not send a clear signal about the product's value. Efforts from stakeholders to use a common standardized set of metrics involve a great deal of effort and upfront work from all stakeholders, but models that have achieved greater alignment have promoted broader uptake of value-based payment. Alignment between public and private payers has received considerable attention, with examples including the Comprehensive Primary Care Initiative.¹⁸ A further challenge is the lack of validated, reliable, meaningful measures of quality in some key areas, such as for high cost and complex patients, like those with advanced cancers or multiple complicating conditions.

4. *New models for contracting and negotiations are needed to shift to value-based payments.*

Purchasers, payers and providers have all expressed the need for a different framework for contracting to accomplish value-based payment models. Traditional payer-provider relationships have focused on negotiating FFS prices, negotiating quality bonuses or penalties in conjunction with FFS, and other contractual add-ons to a FFS "chassis." Without well-established standards like those provided by CPT and ICD9 codes, negotiations to set up alternative payment mechanisms may seem much more daunting and uncertain.

In addition to the technical and logistical challenges around implementing a value-based payment contract, the skill sets necessary to negotiate these contracts are different. In traditional pay for activity contracting, each party is out to achieve their own needs (higher reimbursement or lower payments) at the expense of the other organization. In value-based contracting, the goal is mutual success, which is the only path to long-term sustainability for all parties. This kind of negotiation requires a different mindset and different skills.

Health plans also face challenges in how to "sell" value-based arrangements to purchasers and their employees. Purchaser pressure is a great driver of health plan behavior – purchasers are health plan's main customers. But traditional purchaser negotiations may not be well suited to the adoption of value-based arrangements. When a health plan shifts to person-based payments for fully insured business, there are not well-established processes to charge back an equivalent PMPM payment to self-insured (Administrative Services Only or ASO) employers. Typically each employer must be approached and reach agreement to participate individually – an administratively burdensome approach, especially for a contract that is likely to be unfamiliar to the employer and their broker. Likewise, reconciliation for upside (providers get paid extra if costs are lower than target) or downside (providers have to reimburse health plans if costs are higher than target) risk is difficult to pay back to ASO employers, especially when they may have a population that cannot be characterized with much statistical precision for any

particular provider group. Health plans can reduce the challenge of this shift by retaining traditional FFS and layer a value-based reimbursement on top (or use value multipliers on FFS payments). Nevertheless, to the extent the foundational system remains based in FFS, progress in achieving a new contracting framework will remain slow.

Further, given years of extreme concerns about the cost of care, purchasers and their brokers have been skeptical of reforms that might seem to require them to pay more to get better value, or to pay more for fewer services. Many purchasers believe that they have already been paying enough for what should be high-quality care, and that they should not be paying more for what they should be getting already. The uncertainty and skepticism has led many of them to opt to sit at the sidelines while their contracted Third Party Administrators pilot programs in the fully insured populations. In turn, this reinforces the retention of the FFS chassis for provider payment.

SECTION THREE: Steps to Address Barriers and Facilitate Paradigm Shift

Despite the challenges to implementing value-based payment models, key common features of feasible value-based payment are beginning to emerge. All of these models involve implementing a component of payment for most or all providers that is tied explicitly to value – including accountability for cost – rather than volume and intensity of services. These might be case-based payments, patient-based per-member per-month payments or practice-level payments. These payments can then grow over time, replacing FFS as the foundation for provider payment.

Shared savings programs can initiate this alternative payment track at the level of patient populations. For instance, Florida Blue initiated a cancer specific accountable care arrangement with 330 oncology practitioners¹⁹ in 2012 and Health Care Service Corporation has launched a program similar to the Medicare Shared Savings Program (MSSP) that relies heavily on HEDIS quality measures. In shared savings, organizations are rewarded when they demonstrate lower growth in health care costs while meeting performance standards on quality metrics; if these goals are achieved, organizations can share in the savings with the payer. However, shared savings alone may not provide enough support for investments in major practice reforms. Further, designing a payment reform based only on comparing a provider group with its previous performance will harm early adopters and favor those practices or hospitals that start out with the highest baseline expense. Consequently, as experience accumulates, many shared-savings programs have developed into **partial-capitation programs**, in which some of the FFS payments are shifted into the case- or person-based payments tied to quality, and in which the benchmarks are based not only on the provider group's own performance but also that of peer organizations.

Other payment models enable a shift from FFS to value-based payment at the level of particular types of patients and cases. **Episodic or bundled payment** programs such as the Arkansas Payment Improvement Initiative, a public-private partnership that includes Arkansas Medicaid and Arkansas Blue Cross Blue Shield, intends to reward coordinated, team-based care for specific conditions or procedures. While there is FFS reimbursement throughout the episode of care (i.e. hip and knee replacements, congestive heart failure, perinatal care), incentive payments are calculated based on the average cost of the episode at the year's end; if the average cost exceeds the acceptable level of cost, the provider will pay a portion of the excess cost and if the provider is under the "commendable" cost, he or she is eligible to share in savings with the payer.²⁰ Additional payers have explored reference pricing in areas of colorectal cancer screening, a form of cost control effective for a discrete episode/procedure.²¹ In all these cases, once established, the value-based payment component can increase over time.

We distinguish these models from pay-for-performance models, in which providers receive additional payments based on following evidence-based processes of care, or based on developing certain capabilities, as in a traditional medical home model without accountability for overall costs. Most current models are hybrids, continuing beneficial aspects of fee-for-service payments in some settings. FFS payments can help assure that needed services are provided, especially in situations where a provider has relatively little control over the overall cost of service (e.g., anesthesia fees), services are provided to relatively small numbers of patients (so that outcome measures are unreliable), or relevant performance measures and other means to assure quality are unavailable. For example, Blue Cross Blue Shield Michigan's "Physician Group Incentive Program"²² provides additional payments to participating primary care providers that can amount to 40% increase in reimbursement based on a set of criteria: performance on a range of quality and utilization measures as part of a large enough real or virtual "physician organization" to allow reliable measurement, adoption of a set of patient-centered medical home capabilities (i.e. patient registries), and achieving lower overall population spending growth in the organization.²³ Specialists can also earn significant additional payments for adopting registries and other care-coordination practices with the primary care providers, and similarly taking on accountability for quality of care and costs for the overall population. This plan implements the bonuses as multipliers on fee-for-service payments; often, however, the quality- and efficiency-based payments represent a new payment track that can be expanded over time.

These examples provide a brief review of payment models that illustrate the shift away from FFS, activity-based payment, to value-based payment. Based on examples like these, we have reviewed experiences with overcoming the key barriers to moving away from traditional FFS payment. While the path is not easy, these "best practices" show that there is a path forward, and provide guideposts for accelerating progress toward value-based payment. This section describes specific steps for overcoming the barriers and addressing the key elements for payment reform in commercial markets.

Figure Four (*next page*) summarizes key steps to enable the shift to value-based contracts.²⁴ The foundation for the new type of contract negotiations is *data* related to the results and costs of care; such data, which can start with claims information and be augmented by clinical data from providers and other sources, are essential to identify opportunities for greater value. These data provide the basis for the contracting parties to identify opportunities for changes in *delivery* of care that will feasibly lead to measurable improvements in outcomes and reductions in costs. In turn, the evidence on delivery changes – and the up-front implementation costs and savings from implementing the changes – enables all parties to come together behind a new *payment* contract that is based at least in part on measures of value rather than activity. Together, these elements enable the implementation of a *value-based insurance product* that will replace the traditional FFS contract.

Along with these technical steps for implementing a value-based contract, the interviews and stakeholder discussions identified some key "process" steps to enable the contract to be achieved. They include:

- Implementing a new framework for contract negotiations to reflect the changes in the contract goals;
- Building trust to facilitate win-win negotiations around value;
- Implementing ongoing bilateral data sharing around increasing value;
- Implementing core performance measures to facilitate the insurance contracts; and
- Developing systems to facilitate a "virtuous cycle" for the identification and adoption of value-increasing reforms in care delivery.

Figure 4: Overcoming Key Obstacles to Value-Based Insurance Products²⁵

| | | |
|--------------------|---|--|
| Data & Information | Building Trust | <ul style="list-style-type: none"> > Invest in long-term relationship among parties > Identify mutual goals to improve care and lower costs > Clear understanding and transparency of delivery and financing reform details or arrangements > Avoid unilateral decision making > Develop best practices and straw models for agreements for standardization and promotion of certainty > Win/win mentality |
| | Bilateral Information Sharing | <ul style="list-style-type: none"> > Send raw data and/or data reports at regular intervals (i.e. monthly or quarterly) > Develop "Best Practice Report Initiative" to be the minimum standard for all agreements > Ongoing discussions of data needs and use of reports to make the data "actionable" |
| | Standard Core Measures & Supporting Information | <ul style="list-style-type: none"> > Develop consistent set of multi-payer performance measures > Develop consistent, timely methods of supporting data sharing across parties > Strengthen support systems to enable use of data, measures for quality improvement |
| Delivery | Identify & Implement Effective Delivery Reforms | <ul style="list-style-type: none"> > Promote population health management > Extend hours and improve patient access > Team approach to patient management > "Whole person" care approach |
| Payment | Implement Re-designed Payment Systems that Move Away from FFS | <ul style="list-style-type: none"> > FFS "enhancements" as bridge to current activity-based payment > Increase ASO employer engagement > Enhance use of new payment models (bundling, member-based payments, etc.) > Upside and downside risk-sharing |
| Product | Implement New Value Frame Work for Contract Negotiations | <ul style="list-style-type: none"> > Develop additional skills to identify mutual wins for payers, providers, purchasers > Incorporate needed skill sets to understand value-based payment models in negotiating teams |

Implementing a New Framework for Contract Negotiations

To include and promote value-based models in contracts (both payer-provider and payer-purchaser), there must be a corresponding transformation in the current strategy for negotiations. That is, there are additional skills required to identify mutual wins related to health care quality and costs for all parties. While payer, provider, and purchaser considerations differ depending on market characteristics, there is a common goal that should be at the center of the new value-based contracting approach; a “win-win” vs. a “I win-you lose”. All parties are looking for partners who will build for success as measured by improved or at least no worse quality, decreased costs or at least lower rate of rise in costs, satisfied members/patients/employees who will stick with the plan or provider and minimal administrative expenses required to ensure that all the aforementioned happens. One health plan stated their three main considerations in entering into a value-based arrangement: leadership from the provider executive team, local market conditions (i.e. strength of the brand and patient admissions), and operational considerations (i.e. total cost of care and performance on cost, quality, and convenience parameters).²⁶

At the same time, providers need to gain confidence that reaching quality and cost targets are feasible; thus, they must understand their data, be able to identify outliers and other opportunities to reduce waste and improve care, and implement strategies to target these opportunities. In addition, health care providers should involve colleagues with expertise in modeling and implementing changes in care (not just expertise in prices and costs of services) in the contract discussions.²⁷ Employers and their brokers must also understand the critical demand for value-based products they can introduce through their purchasing power; they should not regard the status quo approach to negotiating and providing benefits as unchangeable. A growing set of tools is available to help employers and their brokers reframe negotiations to focus on value.²⁸

Building Trust for a Productive Relationship among Payers, Providers, and Purchasers

Historically, the relationships between payers and providers have often been adversarial, with perceived winners and losers in contracting arrangements. However, value-based payment compels meaningful partnerships and cooperation between the parties to meet their mutual goals of improved health care quality and lower health care costs. To facilitate this collaboration, there must be a clear understanding of the delivery and financing reform details or arrangements between payer and providers. For instance, discussions should occur in a transparent fashion about areas where costs could be lowered and outcomes improved through feasible care reforms. Clear documentation and expectations for the new payment arrangements should occur with prospective decisions. Once these terms are established, the development of more specific and quantitative models can occur, and the elements of the negotiation process can be standardized and made more predictable around identifying gains in value and sharing in them. The same issues apply to fostering a value-focused relationship between payers and purchasers, who are often not engaged in the payer-provider efforts to reform care. In some cases, providers are working directly with employers to demonstrate commitment to quality improvement and cost and quality and to overcome skepticism about health care cost reduction.²⁹

Bilateral Information Sharing to Identify Feasible Opportunities for VBPs

Sharing meaningful information and data between payers, providers, and purchasers is not only critical for managing patient populations and improving health care quality. Transparency also encourages trust and collaboration. Factors for successful data sharing between payers and providers include minimum standards for content, timeliness, and regularity of reports (i.e. monthly or quarterly), and common processes to reduce their administrative burden. The development of a “Best Practice Report Initiative” could identify key elements for reporting, and could provide some standards for value-based payment agreements. This initiative would ease the move from raw data to mutually accepted understanding of

actionable opportunities, and accelerate the effective implementation of value-based payment models. While purchasers generally do not need such frequent and detailed data feeds, the same analytic products can provide a basis for greater transparency with purchasers and their brokers about opportunities for quality improvement and cost reduction through payment reform.

Standard Core Measures and Supporting Data

All stakeholders agree that standard core measures along with the supporting data infrastructure are helpful to accelerate the adoption of value-based payment models. Not only do standard measures and supporting data minimize the administrative burden of implementing these programs, but it also provides a clearer signal for what is valued in the health care system. In particular, providers often express frustration in meeting requirements for multiple payers that involve non-standardized quality measures and reporting methods. In conjunction with standard measures, standardization of key elements in data sharing (as mentioned earlier in this section) will also support effective use of the measures. Consensus around core measures would facilitate contract negotiations, as all parties would share a common understanding and expectation. One interviewee noted that providers needed to be able to make data actionable, and having clear, shared quality and cost goals as well as standardized shared information would speed progress towards action.

Implement Virtuous Cycle for Effective Delivery Reforms with Redesigned Payment Systems that Move Away from FFS

Plans and providers can draw on the growing set of experiences with value-based payment models as they implement their own delivery and payment reforms. With growing evidence available, we found clear examples of early adopter successes. The particular financing models and amounts vary, but in general, these delivery reforms shift payments from FFS to provide more resources for population health improvement, facilitated access to less costly approaches and settings of care, and a team approach to patient care. The reforms show how to take initial steps from current activity-based payment to value-based payment using such steps as shared savings, PMPM payments, or partial-episode payments, and how to build to more extensive shifts away from FFS payment where the initial performance experience indicates that bigger payment shifts would support more extensive delivery reforms to increase value. We describe this iterative process, and in particular the costs and additional benefits for early adopters of these new contracts, in the next section.

SECTION FOUR: The Development of a Value-Based Insurance Product

Along with identifying the barriers to shifting from an activity-based payment contract to a value-based payment contract, stakeholders noted both specific steps and the need for clear unifying themes to create momentum for overcoming the specific barriers. While not a universal solution, a clear unifying theme that can bring together the needed steps to overcome the barriers is the development and introduction of a value-based insurance product (VBIP). This product could be introduced by health plans on a fully insured basis, by health plans that administer plans for self-insured employers, or by new entities (e.g., provider organizations or provider-plan collaboration). The VBIP would bring together the needed changes in relationships, care, and financing to implement value-based reforms systematically and successfully. The product would provide a clear and transparent framework for all parties—payers, purchasers, providers, and members—to build toward case and person-based payments and away from activity-based payments. In addition, it would help meet the shared needs of all stakeholders: high quality, lower costs, understandable, and predictable. The incentives would address removing waste, maximizing health and sharing in the results, whether good or bad.

Figure Five illustrates how a strategic agreement implement a VBIP can bring together all the elements needed for a sustainable shift from volume- to value-based payment; that is, implementing the shift in a way that increases net revenues for plans, reduces costs for purchasers, improves quality and margins for providers, and results in higher-value care for patients. Although the costs described above for implementing a VBIP are likely to be larger for early adopters (because they will be working from less well-established standards and processes for data sharing, delivery changes, value measurement, and payment reform), the benefits of this shift are likely to be larger as well. In particular, because the implementation of VBIPs will be iterative, early adopters will have an advantage in terms of the experience and performance under value-based contracts; this market leadership can create a virtuous cycle for supporting further improvements in care and value over time.

Main Features of a Value-Based Insurance Product

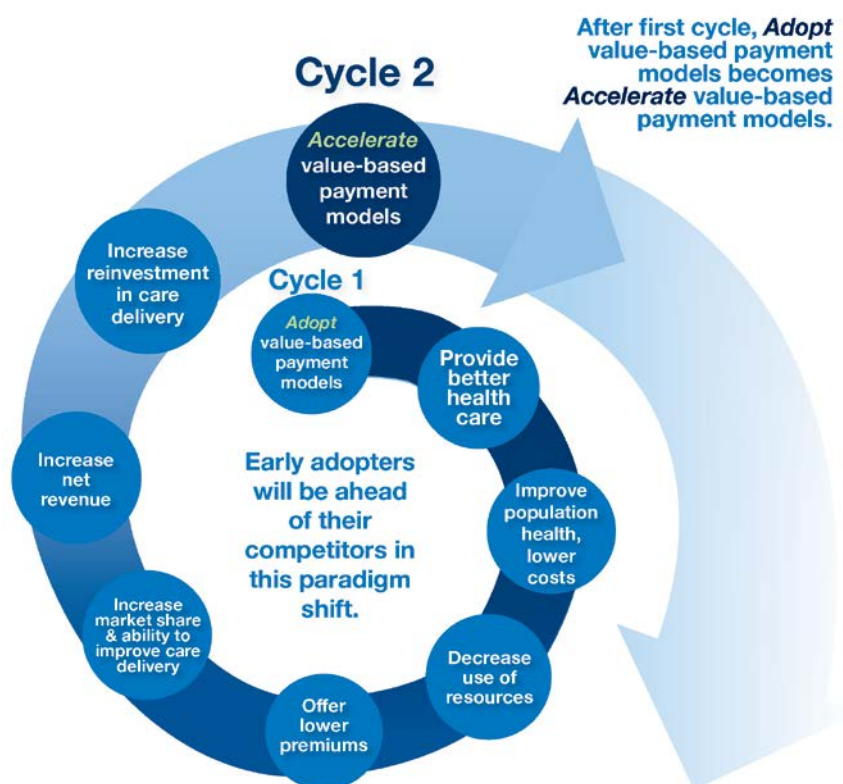
The VBIP would include a PMPM person-based payment for primary care, bundled reimbursement for episodes for common procedures (e.g., hips and knees, maternity care, colonoscopy) and complications requiring hospital admission, and shared savings or (eventually) an overall partial-capitation component for most providers if quality and cost goals are met. Over time, these non-FFS components of reimbursement would increase.

- Members would select a primary care provider as part of the enrollment process, and would receive premium or copayment savings for enrolling in the VBIP; in some cases, this choice might be superseded by actual patterns of primary care use.
- Primary care PMPM payment: primary care payments would be partially case-based or population-fee based.
- Specialist payments would be partially case- or episode-based (e.g., hip or knee replacement, uncomplicated maternity care, colorectal cancer screening); specialists who provide chronic care in collaboration with primary care providers would also have a shared payment for these services.
- Hospital payments would similarly be partially case or episode-based including post-hospital care.
- Post-acute care would also be case-or episode-based.
- Most providers would receive shared savings and a bonus (or potentially a penalty) on their PMPM payments if quality and cost benchmarks were met.
- Members could reduce their costs through lower premiums and copayments for participating in the VBIP, and they would receive tools and resources based on better performance data to help them understand and shop for “value.”

The ideal model may eventually be a complete transition to case- or person-based reimbursement with better performance measurement. But the experience and comfort with these reforms are in early stages in much of the United States, and there are good reasons to keep elements of activity-based payments, such as risks of high utilization and cost in unusual cases that are beyond the control of providers. For this reason, most providers and plans that have been using FFS reimbursement are likely to want to begin with partial or limited value-based reimbursement elements, combined with traditional FFS payments. The FFS rates might be frozen or reduced, so that providers receive needed reimbursement but a nontrivial and growing share of that reimbursement comes from the value-based framework. Implemented properly, this would be the win-win for providers and payers: the providers would get up-front payments that could be invested in supporting the needed services and service reforms, and thus would be willing to take on more accountability for better outcomes and lower overall costs, leading to the net savings while improving care that payers want. Based on experience with financial performance and quality outcomes, plans and providers can then develop a glide path for a transition to increasingly value-based payments over a period of time, with adjustments along the way.

This approach creates a framework for purchasers, payers, providers, and ultimately consumers or members to reframe contract discussions away from focusing primarily on discounts to achieve savings, including negotiations in which value adjustments are add-ons or afterthoughts. Implementing the VBIP elements would require a shared focus on performance metrics and data and other implementation requirements. The VBIP framework is especially important for accelerating early adoption of value-based contracting among payers and providers that are collectively most dissatisfied with current payment arrangements. For example, physician-led organizations may be more willing than hospital-based organizations to be early adopters of contracts that shift more payments away from fee-for-service, both because their total costs are lower (e.g., because of lower prices) and because they have

Figure 5: Business Case for Adopting Value-Based Insurance Products



more to gain financially from reductions in costly hospital care. However, these organizations are likely to need more support in terms of up-front payments and technical assistance with care coordination through such in-kind help as data analytics, electronic records, and care management support. They are also less likely to be able to support very different approaches to payment reform across payers. Thus, more clear development and dissemination in VBIPs could both accelerate the adoption of value-based contracts and strengthen competition with large organizations in health care markets.

Proposed Options for VBIP Design

We propose two options for value-based insurance product design: 1) a “Value Network” (VN) product and 2) a “Value Provider Option” (VPO). A range of products that vary in premiums and breadth and generosity of coverage could be developed within each of these basic configurations. The first option, “Value Network,” would be a plan associated with one or more exclusive (i.e. limited) provider value networks that would ultimately aim to be under capitation. It would thus involve significant provider risk

sharing, perhaps initially upside-only but moving to significant downside risk and partial capitation. It is important to distinguish this option from many current narrow network plans that have traditional FFS payments, with providers selected primarily based on their costs under FFS and their ability to meet minimum standards on current, limited quality measures, and without the patient engagement steps we have described here. The VN could include integrated delivery networks, one or more IPAs, or virtual provider organizations. The key distinguishing feature of a VN is a substantial commitment to higher value as reflected in their payment contracts, implementation of improvements in care delivery, and use and improvement on meaningful performance measures. This could become a relatively lower cost (but demonstrably higher-value) product on a health insurance exchange, and could also be an option for employers who are able to work closely with their employees to build confidence about the quality and cost of the product. Especially if enrollees are confident about the quality of care delivered in the VN, its lower premiums and lower expected out-of-pocket costs would be attractive; further, enrollees may appreciate the increased predictability and transparency of out-of-pocket costs associated with case-based procedures and episodes.

The second option, “VPO,” would be an open access product that with two or three coverage tiers associated with varying cost sharing for members. The lowest cost tier would be the “value tier.” It would include only those providers who are contracted through a complete or hybrid value-based arrangement, and members would have significantly lower copays and other financial incentives for using value-tier providers. Tier two could be a “value light” tier, consisting of providers who are implementing some steps toward value-based payment but have not yet achieved demonstrably high-value performance. The third tier would consist of providers who are not participating in the VPO network, with the higher patient out-of-pocket payments that are typical for out-of-network providers. (A two-tier version of the VPO, consisting only of “value tier” and non-VPO providers, is another potential VPO design; this is similar to the Blue Cross Blue Shield Michigan insurance reform model described previously.) The providers in the value tier would implement payment reforms with performance measurement and other support systems like those described in the VN product. Because the VPO providers would have significant PMPM payments to support medical homes, case management, and care coordination, use of the VN providers would come not only with lower out-of-pocket costs but also with increased access and more personalized service. This would include some of the services provided by concierge practices today, particularly those services that lead to fewer complications and better patient experience with care. These might include 24/7 access to the value-tier providers, email consultation, wireless monitoring, and other steps that discourage use of more costly emergency services or in-person care. The “VPO” would thus allow patient choice and foster member empowerment through a combination of carrots and sticks. This will minimize network leakage and preferentially drive members to value-based providers, increasing not just their reimbursement but also their competitiveness in the marketplace relative to their non-value-based colleagues.

Because of its more open design and less extensive payment reforms, the VPO product is likely to be significantly more expensive than a VN product, much as PPOs typically have higher costs than closed-network plans today. For many members with concerns about relying entirely on a VN, the VPO product could provide a middle-ground option on the way to building broader participation in VNs. Similarly, while the “value light” middle provider tier adds to the complexity of the product, it also can help create a pathway to facilitate movement of reluctant providers into a VN over time.

Path to Broader Implementation and Scale

The benefits of the VBIP in accelerating value-based payment will not be realized if it is a fringe product with small membership and market share. This is a product for plans, providers, and employers who are ready for value-based care to become “mainstream.” To accelerate VBIPs becoming mainstream, health

plans, interested providers, and policymakers should support the development of best practices and, where possible, standard models for each of the key elements of a VBIP:

1. **Clear examples of successful person-based payment** either on top of, or instead of, FFS payments, including examples of how such payments can progress successfully from a relatively small share of total provider payment to a more substantial component.
2. **Standard pre-specified metrics** (quality and cost) and pre-specified (but iterative) benchmarks of success based on the metrics.
3. **Best practices for member engagement** and incentives in conjunction with the provider value-based contracts. These could include combinations of carrots and sticks:
 - Model benefit designs for lower member cost sharing for members who stay within VN tier;
 - Best practices from behavioral economics and other approaches to promote member engagement in programs that promote wellness, effective use of services, and otherwise enhance the success of the VN;
 - Best practices for implementation and for beneficiary engagement around the benefits of secure information sharing with a member's provider team – without this engagement and understanding, beneficiaries may withhold consent for meaningful sharing of information, getting in the way of coordinated care;
 - Best practices for shared decision-making: Members can be active participants in their care and make decisions that lead to better quality and lower costs; however, they and their providers need resources and tools to implement shared decision effectively.

If done well, including with meaningful employee education by purchasers, more beneficiaries will choose to enroll in VBIP and use value-network providers, leading to improvements in quality of care, data completeness and care coordination, and further opportunities to mitigate cost trends.

- **Standard bilateral data sharing** is required between healthcare providers and health plans with education and training on how to translate data into “information” – making it meaningful and actionable. Plans have claims information, and providers increasingly have clinical and patient-reported information, that is critical for implementation but that is not exchanged in standard, low-cost ways today.
- **Best practices for engagement of brokers and consultants**, as brokers and consultants will continue to play a large role in health care purchasing both in group and individual business. For this product to attain scope and span, brokers and consultants must engage and support value-based payment and actively work to increase enrollment and adoption. Enhanced resources for brokers and consultants would help, as would clearer evidence from successful models of broker-plan interaction.

Incremental Strategy

As our review has shown, health plans can and are incorporating the elements of a VBIP incrementally into their current products. The success of the incremental approach has varied by geography and the level of engagement and support by plans and providers. We interviewed many plans that have developed at least some robust relationships and scalable value-based reimbursement strategies that impact a large share of their membership. Despite interviewees generally expecting the shift to value-based care to continue, many providers continue to practice in ways that are driven by the underlying activity-based contracts. To make progress and prepare for more rapid change when a tipping point is reached in their market, some plans and providers may prefer an incremental approach rather than a

market-leading approach. VBIP components that can be incorporated incrementally into existing products include:

Activity-based fee-augmentation: for example, increasing primary care reimbursement specifying that the increase is intended to support medical home transformation and programmatic support;

Case-maintenance/ administrative fee in addition to, or instead of, FFS;

Episode-based payments; still administratively challenging but best for clearly circumscribed procedures, such as orthopedic surgeries, colonoscopies, etc.;

Risk-sharing; including:

- **Upside only:** provider shares in any cost reductions but is not financially responsible for cost increases
- **Downside:** provider responsible for cost increases as well.
- Including a “quality adjustment” including larger rewards for improved or better quality-providers need to demonstrate better or no worse quality to share in the savings;
- **Capitation:** Though few providers in most markets are not prepared to take on overall accountability, large groups and systems in some markets are doing so, and in some cases are contracting directly with purchasers.

Each of these features has been successful to varying degrees for involved plans and providers. Nonetheless, a growing number of plans and providers are getting closer to the systematic implementation of VBIPs.

SECTION FIVE: Summary Recommendations and Conclusion

While there are significant obstacles to the implementation and growth of value-based payment models, the evidence and experiences that we have reviewed show that a paradigm shift is underway to value-based payments and benefit designs. To accelerate this transformation, we have described ways to address the obstacles, and to bring these steps together in the concept of a value-based insurance product. Implementing a VBIP can provide a comprehensive framework for providers, plans, and purchasers to make the transition from volume to value.

Leading examples around the country suggest that this transformation is feasible, but it is difficult. It requires new kinds of engagement and work by all of the stakeholders involved in delivering care – with new activities and roles for providers, purchasers, and plan members in the new products. Not all of these groups are ready to commit to such a transformation now. However, those that are early adopters—those who start earlier on building the new relationships, and develop better access to data and more experience knowing what to do with it – will have a significant head start on learning about and implementing the best approaches to VBIP.

We have described a set of system-level and policy steps that could accelerate progress toward broader implementation and scale of VBIPs, which would increase the benefits and reduce the costs of early VBIP adoption, as well as enable more plans and providers to begin to make the shift to VBIP. These steps lead to the following recommendations:

Increase understanding of the new VBIP and educate all stakeholders (i.e. health plans, providers, purchasers, and members)

Build consensus for common metrics, or common methods for calculating any particular metrics from available administrative and clinical data, to support case- and person-based payment. This would also facilitate multi-payer initiatives. For expansion of VBIP, providers will need to participate in programs in both public and commercial plans; increased alignment across programs would reduce burden and strengthen provider participation in more value-based payment models. As we have noted, providers and payers must develop more standard ways to share data, and measures based on data from providers, to improve care and avoid additional administrative work.

Create a forum for neutral parties to facilitate mediation and contracting arrangements between payers and providers to establish and strengthen trust and identify areas of mutual wins. This will be especially important to get to the “next level” of contracting, between payers and providers who have historically not had good relationships.

Develop “best practice” glide paths/implementation maps, and a model menu of VBIPs, that can be used to facilitate value-based arrangements between payers and providers as well as easier implementation by employers.

Improve the evaluation capacity around VBIP activities to build confidence about value-based payment models that will enable identification of best practices for increased implementation of these models that support the paradigm shift. Evaluations would be supported by greater use of consistent, validated performance measures.

While these steps would accelerate progress, VBIP can be a successful market-leading strategy today. Although many obstacles have challenged this transition, the innovative approaches being implemented now are overcoming each of the barriers to value-based payment models. These innovations in payments, performance measurements, networks, and benefits can be implemented together now in the comprehensive value-based insurance product strategy that we have described here – a strategy that can create a virtuous cycle now for both health care improvements and financial benefits for providers, payers, purchasers, and most of all consumers or patients.

Endnotes

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