Health Care Payment Models

Accountable Care Organizations	Integrated systems where providers are responsible for the total cost and quality of care for a defined population
Patient-Centered Medical Home	Primary care centered practices that coordinate patient care, payment generally FFS with add-ons for coordination, bonuses for quality (30 states)
All-Payer Systems	All payers, public and private, pay the same rates for the same service at a given hospital or to doctors in a given geographic area (ex. Maryland, Germany, the Netherlands)
Pay-for-performance	Payment incentives for high performance on certain quality metrics (ex. Michigan, Medicare e.g. Hospital Quality Incentive Demonstration)
Shared savings	Primary care practices share rewards from patients using fewer health care resources (ex. Alabama, Medicare e.g. Physician Group Practice Demonstration)
Global Payments	Global payments for all services needed, baseline reimbursement and incentives for improved quality (ex. Massachusetts)
Bundled Payments	Fixed rate for an episode of care, severity adjusted (ex. Pennsylvania)
Tiered provider networks	Cost and quality tiering of hospitals or providers
Non-payment for adverse events	No payments for certain hospital acquired complications or certain readmissions (ex. Maryland, Medicare)
Public reporting on cost and quality	Reporting on outcomes, processes, encourages consumers to select high-quality, low-cost providers and hospitals

Patient Protection and Affordable Care Act

Center for Medicare and Medicaid Innovation (sec. 3021)

Opportunities: Models to be tested

i. Payment and practice reform in primary care, including patient-centered medical homes

ii. Direct contracts with groups of providers to promote innovative care delivery models, such as risk-based comprehensive payment or salary-based payment

iii. Comprehensive care plans and geriatric assessments for individuals with multiple chronic conditions and an inability to perform two activities of daily living or cognitive impairment

iv. Care coordination that transitions from FFS reimbursement towards salary-based payment

v. Care coordination for chronically ill individuals as high risk of hospitalization using health information technology-enabled provider networks

vi. Vary payment to physicians who order advanced diagnostic imaging services

vii. Use medication therapy management services

viii. Establish community-based health teams to support small-practice medical homes

ix. Assist individuals in making informed health care choices using patient decision support tools

x. Allow states to test and evaluated fully integrated care for dual eligibles

xi. Allow states to test and evaluate systems of all-payer payment reform

xii. Align evidence-based guidelines of cancer care with payment incentives

xiii. Improve post-acute care through inpatient rehabilitation, home health, or skilled nursing during an inpatient stay and 30 days immediately following discharge

xiv. Fund home health providers who offer chronic care management services

xv. Develop a collaborative of high-quality, low-cost health care institutions to develop and disseminate best practices

xvi. Facilitate inpatient care using electronic monitoring by specialists

xvii. Promote improved access to outpatient services through models that do not require a physical referral

xviii. Establish Healthcare Innovation Zones that deliver integrated and comprehensive health care services with incorporation of innovative methods for the clinical training of future health care professionals