Primary Care Program Advisory Committee

April 4, 2024

Agenda

Topic	Time
Meet & Greet	10 Minutes
Opening Remarks and Welcome	5 Minutes
Goals for Today	5 Minutes
Part 1: Phase 2 Review	30 Minutes
Part 2: Payment Model Structure & Key Design Elements	
Payment Model Structure: Review	25 Minutes
Break	10 Minutes
Key Design Elements: Review	25 Minutes
Discussion	60 Minutes
Wrap Up & Next Steps	10 Minutes

Primary Care Program Design Goals

Reminder

Primary Care Program Goal

Primary care program design is being conducted with the overarching goal to:

Improve the biopsychosocial health and well-being of HUSKY members, especially for the most historically disadvantaged members and in a way that reduces inequities and racial disparities.

While primary care is not the whole solution, it is a foundational piece of a high-functioning health care system that is oriented towards improving member health and well-being.

This Committee's Charge

This committee is charged with engaging critically to help DSS develop a primary care program that promotes health equity and improves the health and well-being of members.

We appreciate your engagement in this process.

Reminder

Primary Care Program Design Process

This committee has spent the last six months on Phase 2, developing a primary care program structure. Today, we will wrap up Phase 2 and discuss the transition to Phase 3 of this process.

Phase 1: **Background and Context**	Phase 2: **Program Design**	Phase 3: **Technical Design and Implementation**
Apr – Sep 2023	***Oct 2023 – Apr 2024***	***May – Dec 2024+***
✓ Establish advisory committee and FQHC subcommittee ✓ Review prior work with committees ✓ Respond to requests for additional starting point data and information ✓ Host listening sessions to understand priorities	✓ Discuss key primary care program design elements and incorporate feedback to develop a program structure, including: ✓ Care Delivery Requirements ✓ Performance Measurement ✓ Payment Model ✓ Equity Strategy	❑ Review key decision points in the development of program technical specifications and incorporate feedback ❑ Discuss key budget, authority, and program implementation model decisions

Goals for Today

1. **Take stock of where we are** - review the high-level program structure that the PCPAC has developed during Phase 2

2. **Introduce a committee informed payment model structure** – review a high-level structure that DSS has developed based on this committee's feedback, which will provide direction for the next phase of program design

3. **Collect directional feedback and discuss next steps** - collect feedback from the committee to inform Phase 3 of program design

Part 1: Phase 2 Review

Goal

Review the high-level program structure that the PCPAC has developed during Phase 2

Primary Care Program Design: Phase 2 Review

Care Delivery	*What are the key things that primary care should be doing differently or better to improve member health and well being?* **Oct 26th Meeting**	Chronic Condition, BH & Targeted Care Management → Accessibility of Care → HRSN Screening & Community Supports → Data Infrastructure & Data Sharing → Team Based Care
Performance Measurement	*What is the definition of success? How should this be measured?* **Nov 14th Meeting** **Dec 7th Meeting**	Each domain is associated with a definition of success – and select **measures** that will be used to drive progress towards success.
Payment Model	*How is primary care paid and incentivized for doing things that improve member health and well being?* **Jan 18th Meeting** **Feb 8th Meeting**	The primary care payment model includes **base and performance-based payments** that advance care delivery and performance measurement priorities.

Crosscutting Equity Strategy: *How do we address inequities and racial disparities?* **Mar 7th Meeting**

Jan 18th Meeting

Feb 8th Meeting

Committee Feedback: Payment Model

The committee reviewed a range of payment model options, and shared valuable feedback on payment model design – overall, and by model type.

Overall, the design of the payment model should consider how to:

- **Build in flexibility for broad based participation, using tiers/tracks or a glide path**, but do not require practices to graduate from one tier to the next; give providers options and the flexibility to choose which path is the right fit
- **Ensure FQHCs are able to participate**
- **Align with other payer models** (i.e., Medicare, State Employee Health Plan)
- Limit model complexity and administrative burden **to ensure provider participation and patient choice**
- Support providers with **data, tools, and technical assistance**

Preferences for a base payment model were mixed; some advocated that DSS use **a FFS model**, some spoke to the value of a **PBP/PMPM model**, many highlighted the benefits of **a hybrid model with FFS payment and PBP/PMPM.**

- **FFS** is well aligned with some of the care delivery priorities, and there are opportunities to expand the FFS payment structure by adding new codes.
- A **PBP/PMPM** is easier to bill, guarantees hiring, and enables partnerships with community providers
- **FFS payment with a PBP/PMPM** for additional capabilities is the best route to harmonizing with other payers
    - *For behavioral health services:* a FFS model is the best way to advance BH access and integration; any integration functions that are not FFS reimbursable should be included in an add-on PBP/PMPM.

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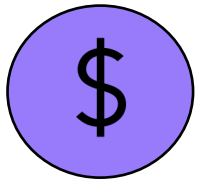
Performance-based payment model design should:

- Recognize that some **larger providers have ample experience** with VBP and are ready for risk arrangements, while **smaller providers often have less experience,** especially with risk, and will need more flexibility and support
- **Drive improvements in quality of care,** creating incentives for all providers to improve
- **Drive improvements in access**, recognizing a regular source of care to be foundational to quality and prevention
- **Incentivize a focus on prevention**, considering how to offset disincentives to investing in prevention that result from downward adjustments in cost benchmarks
- **Incorporate risk adjustment** and explore methods that recognize needs that are more prevalent in the Medicaid population
- **Set the stage for a financing and accountability model** that enables upstream prevention and invests in community capacity – for example, a regional model under which primary care practices and community partners share in any savings generated

Equity Strategy Review

The committee reviewed and provided feedback on a cross-cutting equity strategy that will be developed to address inequities and racial disparities.

Cross Cutting Equity Strategy		Equity Strategy Components
Care Delivery 	*What are the key things that primary care should be doing differently or better to improve member health and well being?*	• Integration of community health workers (CHWs) • HRSN screening and referral • Use of HRSN/SDOH data to implement interventions and prioritize needed community resources • Requirements for competencies in care of individuals with disabilities and/or ADA training for care team members • Adherence to National Standards for Culturally and Linguistically Appropriate Services (CLAS)
Performance Measurement 	*What is the definition of success? How should this be measured?*	• Collection of race, ethnicity, language and disability (RELD) data and performance measure segmentation to identify and track reduction of disparities in quality of care and member outcomes, at the program and provider level • Use of patient reported experience measures • Use of process measures related to screening for and addressing health-related social needs
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?*	• Performance-based payment tied to collection of RELD data and/or performance on population-segmented measures • Base payment that provides care delivery flexibility and funding to support care delivery and performance measurement priorities • Medical and social risk adjustment that accounts for patient needs • Multi-track program that enables broad-based provider participation

Committee Feedback: Equity Strategy

The committee shared valuable feedback on the **equity strategy** that will inform implementation.

- Members generally agreed that the health equity strategy **components represent a good starting point**, while highlighting areas that could be **enhanced or built upon.**
- Members noted that **practices should be held accountable to existing standards** (e.g., language access and disability accommodation standards) before adding new requirements.
- Members advised DSS to **leverage evidence-based practices and build on existing programs** to the greatest extent possible.
- Members emphasized the need to **appropriately support and fund community health workers,** both those embedded in medical settings and community organizations. Members highlighted the important role CHWs can play in advancing health literacy goals, educating members, connecting with hard-to-reach populations, and assisting with navigation and connection to services.
- Members noted the importance of **patient choice in HSRN providers**, and the participation of smaller agencies with representatives that share culture, language, neighborhood, race/ethnicity, etc.
- Several members stressed the importance of **educating providers and patients on why RELD data is collected** and how it will be used to further health equity – and noted that DSS could play a role in developing trainings and common messaging and materials.

DSS Supports

Throughout Phase 2, committee members have also highlighted tools and strategies that DSS could develop and implement to support practices in achieving primary care program goals.

DSS Support	
	*How can DSS provide <u>support</u> to practices to achieve primary care program goals?*

- Pursue strategies to **get more members attributed to a primary care doctor**, recognizing the importance of a regular source of care to quality and prevention
- Increase availability of **timely, actionable data**
- Provide **technical assistance to providers**, acknowledging different provider starting points, and providing the supports and flexibilities to help practices develop priority primary care capabilities
- Develop **trainings, materials and technical assistance related to health equity** data collection and interventions
- Participate in **broader statewide efforts underway** to invest in community supports

Part 2: Committee Informed Payment Model Structure

Goal

Review and discuss a high-level **committee informed payment model structure** that DSS has developed based on this committee's feedback, which will provide direction for the next phase of program design

Approach

- Review **design principles** developed based on this committee's feedback on payment models
- Review a **high-level payment model structure** and approach to key design elements
- Discuss and **collect committee feedback** to inform refinement of the payment model structure

Design Principles

Based on Phase 2 discussions, we have established a set of design principles that will guide the detailed design process in Phase 3.

1. **Build in flexibility for broad based participation, using tiers/tracks or a glide path** that recognizes different starting points and gives providers options and the flexibility to choose which path is the right fit
2. **Align with other payer models** to the greatest extent possible, while recognizing the distinct characteristics and needs of the Medicaid population
3. **Limit model complexity and administrative burden** to ensure provider participation and patient choice
4. **Recognize the respective strengths of FFS and PBP/PMPM** and assess which payment model is the best fit for addressing opportunities on a service specific basis
5. **Provide predictability and flexibility to enable** practices to advance care transformation goals
6. **Incorporate risk adjustment** and explore methods that recognize needs that are more prevalent in the Medicaid population
7. Establish a quality measurement program that will **drive performance and enable ongoing monitoring of quality, equity, and access**, recognizing both performance and improvement at the practice level

State and Federal Constraints

As we move forward with technical design, we will also be working within the context of state and federal constraints and will need to:

1. **Recognize state budget constraints** in the design of the model, acknowledging the dependency of certain design elements on state appropriations and developing options that could be pursued with or without additional funding
2. **Recognize federal authority constraints** in the design of the model, and work with our federal partners at CMS to design a model that is consistent with federal requirements

Intro to High-Level Payment Model Structure

	Small Provider Track	Large Provider Track
FQHC Participation	**FQHCs are eligible to participate in either track, depending on their size.** Each track will be customized to enable FQHC participation, acknowledging that federal PPS requirements will impact the design and implementation of the FQHC payment model.	
Payment Model Components	✓ Primary Care Hybrid Population Based Payment (PBP/PMPM) and FFS ✓ Flexible Funds (PBP/PMPM) ✓ Quality Performance P4P	✓ Primary Care Hybrid Population Based Payment (PBP/PMPM) and FFS ✓ Flexible Funds (PBP/PMPM) ✓ Quality Gated Shared Savings/Risk

Detailed program design will consider additional tiers and glide paths within these tracks.

Reminder: Key Terms *(see Appendix for details)*

- **Population Based Payment (PBP):** Fixed, prospective payment made to cover the cost of care for a defined population over a specified time period.
- **Fee for Service (FFS):** A specific amount is paid when a particular service is delivered.
- **Flexible Funds ("Nonvisit Functions"):** A per member per month payment (PMPM), layered on top of another form of payment (e.g. FFS). Providers typically receive this payment to help them manage their patients' care and to support their coordination with other providers.
- **Pay for Performance (P4P):** Financial incentives based on the ability or inability of the provider to meet certain performance standards.
- **Shared Savings:** A provider shares generated savings with the payer when actual spending for a defined population is less than a target amount.
- **Shared Risk:** Requires providers to share in payers' financial risk by accepting some accountability for costs that exceed their targets.

Payment Model Structure

	Small Provider Track	Large Provider Track
Base Payment	**Primary Care Hybrid Population Based Payment** (PBP/PMPM) **and FFS** *Transition a share of primary care service revenue to a population-based payment that provides more predictability and flexibility to support care delivery redesign*	
Incremental Payments	**Flexible Funds** (PBP/PMPM) *Provide upfront to primary care practices additional funding for otherwise unfunded activities*	
	Quality Performance P4P	**Quality Gated Shared Savings/Risk**
	Hold providers accountable for quality of care, member outcomes and/or a defined array of member costs beyond primary care, with parameters tailored by provider track	

Committee Informed Rationale

- **Build in flexibility** for broad based participation, using tiers/tracks
- **Recognize the respective strengths of FFS and PBP/PMPM** with a hybrid model that transitions some revenue to PBP, while retaining a FFS foundation and ensuring no increase in admin burden
- **Align with the add-on PBP/PMPM** structure commonly used in other payer models to provide upfront funding and greater flexibility
- **Create incentives for all providers to improve quality of care** – while recognizing the limitations smaller providers have around shared savings/risk and tailoring the performance-based payment model accordingly

Key Design Elements

Based on committee feedback, we have outlined an initial approach to key program design elements. Each of these elements will be defined in detail during Phase 3.

	Key Design Elements
Crosscutting Features	• Populations included • Member attribution method • Risk adjustment methodology
Primary Care Hybrid Population Based Payment (PBP/PMPM) **and FFS**	• Services included in the PMPM • % Revenue transitioned to PBP/PMPM • Timing - prospective/retrospective • Billing process
Flexible Funds (PBP/PMPM)	• Value of the PMPM • Timing - prospective/retrospective
Quality Performance P4P ("Pay for Performance")	• Quality measure slate • Performance standards and scoring • Value of the P4P and application
Quality Gated Shared Savings/Risk	• Services included in the shared savings/risk model • Quality measure slate • Performance standards, scoring, and application • Cost benchmark and target setting methodology • Shared savings/risk parameters

Key Design Elements

	Key Design Elements	Initial Approach	Principle
Crosscutting Features	**Populations included**	• Include all PCP attributed members, except dual Medicare-Medicaid eligible members – recognizing that these members have a distinct cost structure that requires a customized design • Limit complexity and administrative burden by establishing a core program model that can be tailored to include population specific features over time	**#3:** Limit Complexity
	Member attribution method	• Limit complexity and administrative burden using an attribution method that builds off the current PCP attribution method	**#3:** Limit Complexity
	Risk adjustment methodology	• Implement a risk adjustment methodology that considers both clinical and social risk factors, consistent with committee feedback and the approach DSS has taken in the development of the maternity bundle payment program	**#6:** Incorporate Risk Adj.

Key Design Elements

	Key Design Elements	Initial Approach	Principle
Primary Care Hybrid Population Based Payment (PBP/PMPM) **and FFS**	**Services included in the PBP/PMPM**	• Define the array of services included in the PBP/PMPM based on an assessment that considers whether FFS or PBP/PMPM is the best fit model on a service specific basis • Incorporate service specific committee feedback recommending that BH services be reimbursed on a FFS basis to promote access	**#4**: Recognize Model Strengths
	% Revenue transitioned to PBP/PMPM	• Implement a minimum % PBP/PMPM threshold for each track with practice flexibility to choose a % revenue above the minimum threshold	**#1**: Flexibility **#5**: Predictability
	Billing process	• Retain FFS billing such that PBP/PMPM reimbursement changes are implemented with minimal disruption to existing billing processes	**#3**: Limit Complexity
	Timing - prospective/ retrospective	• Implement the PBP/PMPM payment as a prospective payment to provide predictability and flexibility to advance care transformation goals	**#1**: Flexibility **#5**: Predictability

Key Design Elements

	Key Design Elements	Initial Approach	Principle
Flexible Funds (PBP/PMPM)	**Value of the PMPM**	• Provide practices additional funding for otherwise unfunded activities • *<u>Constraint:</u> Recognize that the value of the PMPM will be dependent on state appropriations and develop options that could be pursued with or without additional funding*	**#1**: Flexibility **#5**: Predictability
	Timing - prospective/ retrospective	• Implement the Flexible Funds PBP payment as a prospective payment to provide predictability and flexibility to enable practices to advance care transformation goals	**#1**: Flexibility **#5**: Predictability

Key Design Elements

	Key Design Elements	Initial Approach	Principle
Quality Performance P4P ("Pay for Performance")	Applicable to **Small Provider Track**		
	Quality measure slate	• Select a manageable set of quality measures that will drive performance and enable ongoing monitoring of quality, equity, and access, with a focus on multi-payer alignment through the OHS Quality Council Aligned Measure Set	**#2**: Payer Alignment **#3**: Limit Complexity **#7**: Drive Performance & Monitor
	Performance standards and scoring	• Establish performance standards and a scoring methodology that drives performance and enables ongoing monitoring of quality, equity, and access, recognizing both performance and improvement at the practice level	**#7**: Drive Performance & Monitor
	Value of the P4P and application	• Create incentives to drive performance and enable ongoing monitoring of quality, equity, and access • *<u>Constraint:</u> Recognize that the value of an additive P4P payment will be dependent on state appropriations and develop options that could be pursued with or without additional funding – considering for example, a quality adjustment applied to base payment*	**#7**: Drive Performance & Monitor

Key Design Elements

	Key Design Elements	Initial Approach	Principle
Quality Gated Shared Savings/ Risk	Applicable to **Large Provider Track**		
	Services included in the shared savings/risk model	• Define the array of services included in the shared savings/risk model based on a service specific assessment that considers a provider's ability to impact cost and utilization • Hold providers accountable for a defined array of member costs beyond primary care to incentivize and reward a focus on prevention and management	**#4**: Recognize Model Strengths **#5**: Predictability
	Quality measure slate	• Select quality measures that will drive performance and enable ongoing monitoring of quality, equity, and access, with a focus on multi-payer alignment through the OHS Quality Council Aligned Measure Set	**#2**: Payer Alignment **#3**: Limit Complexity **#7**: Drive Performance & Monitor
	Performance standards, scoring, and application	• Establish performance standards and a scoring methodology that drive improvements in quality of care, reduce disparities, and recognize both performance and improvement at the practice level	**#7**: Drive Performance & Monitor
	Cost benchmark and target setting methodology	• Consider design elements to protect against downward adjustments in cost benchmarks that can result from improvements in performance over time	**#7**: Drive Performance & Monitor
	Shared savings/risk parameters	• Recognize different provider starting points using tiers/tracks or a glide path with shared savings/risk parameters that vary based on experience and give providers the options and the flexibility to choose which path is the right fit	**#1**: Flexibility

For Discussion – Payment Model Structure

Acknowledging this high-level structure will be articulated in greater detail in Phase 3 – is there anything you recommend refining about the overall structure or approach?

Next Steps: Phase 3

DSS will be transitioning to Phase 3: Technical Design and Implementation in May.

- ✓ Establish advisory committee and FQHC subcommittee
- ✓ Review prior work with committees
- ✓ Respond to requests for additional starting point data and information
- ✓ Host listening sessions to understand priorities

- ✓ Discuss key primary care program design elements and incorporate feedback to develop a program structure, including:
  - ✓ Care Delivery Requirements
  - ✓ Performance Measurement
  - ✓ Payment Model
  - ✓ Equity Strategy

- ❑ Review key decision points in the development of program technical specifications and incorporate feedback
- ❑ Discuss key budget, authority, and program implementation model decisions

Phase 3 Stakeholder Engagement Next Steps

During Phase 3, stakeholder engagement will shift from more open-ended co-design to a **detailed design phase focused on articulating the technical details** of the program.

- To enable this process, DSS will establish a **Technical Design Subcommittee to meet monthly** and focus efforts on expediting initial technical design decisions to meet federal and state authority and budget timelines.
- The Technical Design Subcommittee will **bring updates to the full Primary Care Program Advisory Committee on a quarterly basis.**
- Additional details regarding participation in the Technical Design Subcommittee are forthcoming.

Appendix

- **Phase 2 Review**

Primary Care Program Design: Phase 2 Review

Care Delivery	*What are the key things that primary care should be doing differently or better to improve member health and well being?* **Oct 26th Meeting**	Chronic Condition, BH & Targeted Care Management → Accessibility of Care → HRSN Screening & Community Supports → Data Infrastructure & Data Sharing → Team Based Care
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Crosscutting Equity Strategy: *How do we address inequities and racial disparities?* **Mar 7th Meeting**

Oct 26th Meeting

Nov 14th Meeting

Dec 7th Meeting

Care Delivery Priorities

The committee identified care delivery priorities and aligned on definitions of success for each.

Care Delivery Priorities	Chronic Condition, Behavioral Health & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Definition of Success	Practices engage and support patients in healthy living and in **management of chronic conditions and behavioral health.** Care delivery follows evidence-based guidelines for prevention, health promotion and chronic illness care, supported by electronic health record (EHR) clinical decision support.	**Care is easily accessible and prompt,** using multiple care modalities, including in-person, electronic and virtual visits, and including time outside of traditional work hours. Care is **accessible to persons with disabilities** and is **culturally and linguistically competent.**	The practice team **screens patients** for social risk factors, is knowledgeable about community resources, and **facilitates a referral to address the member's need.**	The practice team **utilizes patient information** in conjunction **with data** from an EHR when utilized by the practice, HIE, pharmacies and payers to identify patient care needs, monitor change over time, and inform **targeted quality and equity improvement activity,** including design and implementation of quality improvement plans.	Care delivery **is team-based,** with the practice team consisting of a **range of clinicians and non-clinicians,** working with the patient, all with defined responsibilities that are clear to the patient and support the patient and the practice to the full extent of training and credentials.

Note: Definitions of success align closely with OHS' Core Function Expectations of Primary Care Practice Teams, with amendments proposed by the Primary Care Program Advisory Committee.

Nov 14th Meeting

Dec 7th Meeting

Outcome Measures

The committee reviewed and provided feedback on a starting point array of cross-cutting outcome measures that will allow us to measure if we are accomplishing our care delivery priorities.

Care Delivery Priorities	Chronic Condition, Behavioral Health & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Outcome Measures					
Plan All-cause Readmission	++	++	+		++
Avoidable ED	++	++	+		++
Avoidable Hospitalization	++	++	+		++
PCMH CAHPS Survey		++			++
PCPCM Survey	++	++			++
Comprehensive Diabetes Care	++	+			+
Controlling High Blood Pressure	++	+			+
Chronic Condition Cost of Care	++	+			+

++: substantial impact; +: moderate impact

Nov 14th Meeting

Dec 7th Meeting

HUSKY HEALTH CONNECTICUT

Process Measures

The committee reviewed and provided feedback on a starting point array of process measures that can be used to drive progress on care delivery priorities, when outcomes measures are insufficient.

Care Delivery Priorities	Chronic Condition, Behavioral Health & Targeted Care Management	Accessibility of Care	HRSN Screening & Community Supports	Data Infrastructure & Data Sharing	Team Based Care
Process Measures					
Child and Adolescent Well-care Visits		++			+
Asthma Medication Ratio	++	+			+
Eye Exam for Patients with Diabetes	++	+			+
Kidney Health Evaluation for Patients with Diabetes	++	+			+
Behavioral Health Screening and Management	++	+			+
Cancer Screenings		++			+
Participation in an Alerting Exchange System				++	
Social Determinants of Health Screening			++		

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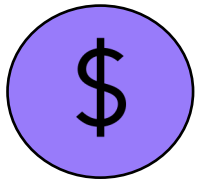
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?*	• Performance-based payment tied to collection of RELD data and/or performance on population-segmented measures • Base payment that provides care delivery flexibility and funding to support care delivery and performance measurement priorities • Medical and social risk adjustment that accounts for patient needs • Multi-track program that enables broad-based provider participation

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- Pursue strategies to **get more members attributed to a primary care doctor**, recognizing the importance of a regular source of care to quality and prevention
- Increase availability of **timely, actionable data**
- Provide **technical assistance to providers**, acknowledging different provider starting points, and providing the supports and flexibilities to help practices develop priority primary care capabilities
- Develop **trainings, materials and technical assistance related to health equity** data collection and interventions
- Participate in **broader statewide efforts underway** to invest in community supports

Appendix

- **Payment Model Types:** Definitions

Payment Model Types: Definitions

(1) Base Payments	**Fee for Service (FFS)**	A payment approach in which **a specific amount is paid when a particular service is delivered**; generally, the payment amount differs depending on which discrete service is delivered. Payments are made only for services that are codified and determined by the payer to be approved for payment.
	Hybrid FFS/PBP	A form of population based payment in which **some services, but not all, are to be delivered in return for a population based payment**, while other services are paid through FFS.
	Population Based Payment (PBP)	Fixed, prospective payment made to cover the cost of care for a defined population over a specified time period. **A specific dollar amount per member per month** (or per year) is paid to providers, and in return they provide whatever quantity of services is needed to meet defined patient population's health needs.
(2) Incremental Payments	**Nonvisit Functions**	In its simplest form, this model is a per member per month payment, layered on top of another form of payment like fee-for-service. Providers typically receive this payment to help them **manage their patients' care and to support their coordination with other providers** in the patient-centered medical home.
	Pay for Performance	A payment model that includes financial incentives based on the ability or inability of the provider or provider organization to **meet certain performance standards**. A P4P system can provide rewards (upside), penalties (downside), or both upside and downside.
	Shared Savings/Risk	A form of payment in which a provider or a provider organization **shares generated savings with the payer when actual spending for a defined population is less than a target amount**. Under shared savings—also referred to as one-sided or upside-only—the recipient is not at risk for overspending. Two-sided or upside/downside models—referred to as shared savings and shared risk or just shared risk—require providers to share in payers' financial risk by accepting some accountability for costs that exceed their targets.

Source: A Typology of Payment Methods, Urban Institute, April 2016, https://www.urban.org/sites/default/files/publication/80316/2000779-A-Typology-of-Payment-Methods.pdf