Primary Care Program Advisory Committee

May 2, 2024

Agenda

Topic	Time
Opening Remarks and Welcome	5 Minutes
Goals for Today	5 Minutes
Part 1: Updates to Phase 2 Review	15 Minutes
Part 2: Refined Payment Model Structure	50 Minutes
Part 3: Technical Design Subcommittee Update	10 Minutes
Wrap Up & Next Steps	5 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.

Primary Care Program Design Process

Reminder

This committee has spent the last seven months on Phase 2, developing a primary care program structure. Today we are wrapping up Phase 2 and transitioning 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 – May 2024***	***Jun – 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

PCMH+ Timeline Update

DSS is planning to extend PCMH+ for CY 2025, while program design work is underway towards a new primary care program.

- As the program design process continues, we will revisit the PCMH+ timeline and develop a transition plan that acknowledges the anticipated timing of new program launch.
- The design and implementation timeline for the new program will be refined and finalized as part of Phase 3.

Goals for Today

1. **Revisit the Phase 2 Review crosscutting equity strategy & DSS supports materials** with updates incorporated based on the committee's feedback from last meeting

2. **Introduce a refined payment model structure** – review the committee's payment model feedback from last meeting and discuss a refined payment model structure to guide the Phase 3 technical design process

3. **Discuss next steps -** review Technical Design Subcommittee goals and meeting structure

Part 1: Updates to Phase 2 Review

Goal

Revisit the Phase 2 Review crosscutting equity strategy & DSS supports materials with updates incorporated based on the committee's feedback from last meeting

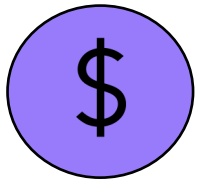
Incorporating Committee Feedback

At our last meeting, we heard important feedback that we have incorporated in the Phase 2 documentation.

(1) The committee recommends DSS **pursue Medicaid coverage of HRSN services**	→	**Incorporated** – see Equity Strategy Feedback
(2) Providers and patients **need to be educated on HRSN initiatives more broadly** in addition to why RELD data is collected	→	**Incorporated** - see Equity Strategy Feedback
(3) The committee requested that DSS work to explore how to **streamline access to services within the DSS portfolio** in parallel with this work	→	**Incorporated** – see DSS Supports

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 HRSN initiatives and 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.
- Acknowledging state and federal constraints, members emphasized the importance of supporting community provider capacity and recommended **DSS pursue Medicaid coverage of HRSN services**, in alignment with this work.

Red text indicates an update based on committee feedback from April 4th meeting

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
- **Explore how to streamline access to services** within the DSS portfolio in parallel with this work

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Part 2: Refined Payment Model Structure

Goal

Introduce a refined payment model structure – review the committee's payment model feedback from last meeting and discuss a refined payment model structure to guide the Phase 3 technical design process

Approach

- Review **committee feedback on the payment model structure** from the April meeting
- Review a **refined payment model structure** incorporating committee feedback
- Discuss and **collect committee feedback** to inform refinements and more detailed design of the payment model structure

Reminder

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

Reminder

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

Reminder
Reviewed Apr 4th

Payment Model Structure - Original

At the meeting on April 4th, the committee provided feedback on this 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

Committee Feedback: Payment Model Structure

At the April meeting, the committee shared valuable feedback on the **payment model structure** that has informed refinements.

- **Provider Tracks**
  - Members recommended using **capability-based tracks instead of size-based tracks** and suggested that providers have track options regardless of size, including a "risk free" option.
- **Base Payment & Flexible Funds Payment**
  - ***Base Payment.*** Some members raised concerns about the hybrid FFS/PBP base payment approach and voiced a **preference for maintaining a FFS foundation** to promote access and simplicity.
  - ***Flexible Funds Payment.*** There was **strong support for including flexible PBP/PMPM payments** to support activities like care coordination and behavioral health integration.
  - Some highlighted the importance of distinguishing base payment from add-on payments, recommending a guaranteed, adequate **base payment plus an add-on payment tied to specific expectations** and accountability standards.
- **Performance Based Payment**
  - Members highlighted the role of specialists, hospital systems, and community providers in impacting outcomes and raised **concerns about primary care providers' ability to impact total cost of care**.

Committee Feedback: Payment Model Structure

The committee also made recommendations about aligning with other efforts.

- **Populations**
  - Members pushed for more attention to **dual eligible populations** – within or beyond the scope of this work.
- **Alignment with Other Efforts**
  - Members highlighted the importance of adequate base rates and recommended that program design consider the **potential impact of rate increases** (e.g., in the context of shared savings benchmark development).
  - Members revisited the interest in more **comprehensive strategies** (e.g., regional accountability and/or AHEAD model participation) and highlighted the importance of developing this program with attention to alignment.

FQHC Subcommittee Feedback

At the April 16th meeting of the FQHC Subcommittee, FQHC representatives shared additional feedback on the **payment model structure** that has informed refinements.

- **Hybrid FFS/PBP Base Payment**
  - FQHC representatives expressed **interest in a PBP/PMPM base payment**, highlighting that a PMPM base payment would:
    - give additional predictability and budgeting flexibility to build the infrastructure needed to support the program
    - be especially helpful for members with chronic conditions, who have a lot of touch points
    - support functions such as having calls with families with young children to answer questions and prevent them from making an unnecessary trip to the hospital
- **Performance Based Payment**
  - FQHC representatives expressed concern with having shared risk begin with the launch of the program, stating that it would make sense for shared risk to be delayed until the program is well understood

Payment Model Structure Refinements

Based on feedback, we have refined the payment model structure to:

1. Use **capability-based tracks** that give providers the flexibility to select their track, with a "risk free" option available to all providers, regardless of size

2. Give providers the **option to transition to a hybrid FFS/PBP base payment**, while retaining options for providers who want to continue receiving FFS base payments

3. Respond to discussion around **further defining the model** by outlining key components in more detail

Payment Model Structure – Updated

Provisional, pending technical design review

	Track 1	Track 2	Track 3
Base Payment	**Fee For Service (FFS) Base Payment**	**Fee For Service (FFS) Base Payment**	**Primary Care Hybrid Population Based Payment** (PBP/PMPM) **and FFS**
Incremental Payments	**Flexible Funds Payment** (PBP/PMPM)	**Flexible Funds Payment** (PBP/PMPM)	**Flexible Funds Payment** (PBP/PMPM)
	Quality Performance P4P	**Quality Gated Shared Savings/Risk**	**Quality Gated Shared Savings/Risk**

Key Features

- **Three capability-based tracks** with an option for all providers to select the track they participate in
- Different base payment models across tracks that **give providers the option to remain in FFS or transition to a hybrid PBP/FFS model**
- **A flexible funds PMPM add-on payment that** provides upfront funding for otherwise unfunded activities – payment increases by track, aligned with increasing care transformation expectations and accountability
- **A performance-based payment model that holds 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

Program Alignment

Tracks 1-3 build on DSS' existing primary care programs and align with other payer models to limit complexity and administrative burden.

	Goal	Track 1	Track 2	Track 3
CT DSS Program Alignment	*Build off DSS' existing primary care programs, making refinements to the current models to advance program goals.*	**PCMH similar** *+ Flexible Funds Payment*	**PCMH+ similar** *+ Flexible Funds Payment* *+ Phased Approach to Shared Risk*	**PCMH+ similar** *+ Hybrid PBP/FFS Base Payment* *+ Flexible Funds Payment* *+ Phased Approach to Shared Risk*
CT Multi-Payer Alignment	*Align with other payer models to the greatest extent possible, limiting complexity and administrative burden.*	**SEHP aligned,** on Flexible Funds Payment and Quality Performance P4P components	**SEHP** and **MSSP aligned**	**SEHP** and **MSSP aligned,** with additional base payment transformation

SEHP: State Employee Health Plan
MSSP: Medicare Shared Savings Program

Payment Model Details

Track 3

Primary Care Hybrid Population Based Payment (PBP/PMPM) and FFS

There are **two key options** for transitioning a share of primary care service revenue to a population-based payment (PBP) that provides more predictability and flexibility to support care delivery redesign:

Option 1: Select services for inclusion in the PBP, retaining FFS payment for the set of services not included in the PBP

Primary Care Service Array

PBP Services	FFS Services
100% PBP	100% FFS

Examples
- *MCP Track 3*
- *MassHealth ACO Program*

Option 2: Shift only a defined share of revenue to a PBP, retaining partial FFS payment for services in the PBP

Primary Care Service Array

PBP Services	FFS Services
50% PBP	100% FFS
50% FFS	

Examples
- *MCP Track 2 (50%)*
- *CPC+ (% Varies)*
- *CO APM 2 (% Varies)*

Phase 3 Next Step:
- *Weigh options and consider experience from other state and federal programs to determine path forward*
- *Define service array included in the primary care PBP, based on an assessment that considers whether FFS or PBP/PMPM is the best fit model on a service specific basis*

Payment Model Details

Tracks 2 & 3

Quality Gated Shared Savings/Risk

DSS anticipates taking a **phased approach to implementing the quality gated shared savings/risk** arrangement – detailed parameters will be developed during Phase 3

Illustrative Phasing – *pending budget discussions*

Upside Potential Only
(Shared Savings)

Phased Approach to Downside Potential
(Shared Savings/Risk)

In line with other programs, DSS will:

- Consider using asymmetrical upside/downside potential as part of a stepwise transition
- Consider different parameters for Tracks 2 and 3 over time

Phase 3 Next Steps:

- *Define service array based on an assessment that considers a provider's ability to impact cost and utilization*
- *Articulate detailed shared savings/risk parameters*
- *Develop and implement an underservice monitoring strategy and quality gate*

For Discussion – Refined 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?

Part 3: Technical Design Subcommittee Update

Goal

Discuss next steps - review Technical Design Subcommittee goals and meeting structure

Technical Design Subcommittee Goals & Expectations

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.

Goals:

- ❑ Collect feedback on decisions that will need to be made in the development of program technical specifications
- ❑ Discuss key budget, authority, and program implementation model decisions

Meeting Structure:

The Technical Design Subcommittee will meet monthly and bring updates back to the full PCPAC quarterly.

Draft Meeting Schedule	
June 6th	Technical Design Subcommittee
July 4th *(rescheduling)*	Technical Design Subcommittee
Aug 1st	*Full PCPAC*
Sept 5th	Technical Design Subcommittee
Oct 3rd	Technical Design Subcommittee
Nov 7th	*Full PCPAC*
Dec 5th	Technical Design Subcommittee

Example TDS Topics:

- **Service Array** – hybrid PBP, flexible funds, shared savings
- **Performance Based Payment Parameters** – quality P4P structure, shared savings/risk parameters
- **Quality Measure Slate –** quality P4P and shared savings/risk model measures
- **Quality Performance Standards** – performance standards and scoring
- **Payment Structure Details** – hybrid PBP and flexible funds payment structure/timing

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
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** **Apr 4th 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**

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			++		

++: substantial impact; +: moderate impact

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.

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.

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.

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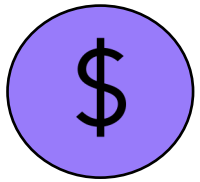
Payment Model 	*How is primary care paid and incentivized for doing things that improve member health and well being?*	• Performance-based payment tied to collection of RELD data and/or performance on population-segmented measures • Base payment that provides care delivery flexibility and funding to 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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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 • **Explore how to streamline access to services** within the DSS portfolio in parallel with this work

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