Two of the most important and challenging health care issues for state policymakers are improving patient care and, at the same time, controlling escalating costs.\(^1\) According to the Centers for Medicare and Medicaid Services (CMS), health care spending grew 3.9 percent from 2010 to 2011. Yet Americans are not healthier—the incidence of chronic disease continues to grow.\(^2\)

These statistics lead policymakers to ask, “What are we paying for?” Unfortunately, the answer often is, “Not the health system we want.” How health care is paid for affects how it is delivered.\(^3\)

This brief explores how states can leverage their market power as a purchaser of health care services to create payment methods that may simultaneously contain costs and improve care.

### Payment Models
During the last 25 years, health care providers and payers have experimented with different payment models in an attempt to discover a methodology that aligns payment incentives with improvements in the value of health care—keeping people healthy at the lowest cost. It is important to note, however, that these methods are neither discrete nor mutually exclusive. Payers of health care services—such as Medicaid, Medicare and private health insurers—will often create a hybrid system using parts of multiple models that work for them, their patients and providers.

### The Status Quo: Fee-for-Service
Under the fee-for-service model, health care providers are paid for each service delivered to patients, such as an office visit, laboratory test or procedure.\(^4\) This model is fairly understandable, since it is used to pay for most commodities. In most sectors, however, the price of goods or services is determined by the market—what the con-
What Is Value (Does Higher Quality Always Mean Higher Cost)?

In health care, value is defined as the change in a patient’s health outcome per $1 spent. Research has shown that more services and higher spending do not always provide better results. For example, a diabetic who visits the emergency department several times a year is not in better health than a diabetic who controls his or her symptoms with diet and proper use of medication, even though the patient visiting the emergency department spends more on health care. The question is how to ensure that financial investments in health care are translated into improved health, that is, how to improve the value of the health system. It may be difficult to gauge value, however, since it cannot be measured by inputs (dollars spent, doctors visited) or processes (where and when care was received). Many payment methods described in this brief aim to define how to adequately measure value.

Emerging Trend: Pay for Coordination

Paying for care coordination is when a team of providers—such as physicians, nurses, nutritionists, pharmacists, and social workers—are reimbursed to work together to meet a patient’s health care needs. For example, the medical or health care home model and accountable care organizations (ACOs) reimburse provider “teams” for coordinating care.
As of 2013, policies in 43 states\(^9\) promote the medical home model for certain Medicaid or Children’s Health Insurance Program (CHIP) beneficiaries. States have created pilot projects, reformed payment structures, invested in health information technology, restructured Medicaid provider systems, and included the medical home model in service delivery.

Paying for care coordination has a number of benefits, including the potential to improve and enhance the provider-patient relationship and communication between patients and providers; to increase the level of patient and family involvement in care decisions; and to improve flexibility in how, where, and by whom care is provided. The model is intended to reduce unnecessary and duplicative care, to reduce emergency room visits for conditions that would be better handled by an urgent care facility or in a physician’s office, and to encourage a smooth transition between health settings. Recipients of pay-for-coordination payments also may be able to support care between visits in more cost-efficient ways such phone calls, email or group appointments.

Implementing this payment method requires providers to change how care is delivered, a process that can prove difficult and time-consuming. Paying for coordination requires providers to develop practice habits that support a team approach\(^10\) and may require many providers to learn new skills. Other limitations include the need to identify the scope of reimbursable services; the need to provide necessary health information technology (HIT) infrastructure; and some critics’ concern that this method might result in reduced patient loads and lead to reduced access.\(^11\)

### Accountable Care Organizations

Accountable care organizations (ACOs) consist of a range of health care service providers under a single umbrella organization. This may involve a variety of configurations, but all ACOs should have a strong base in primary care. Payers, such as Medicaid and Medicare, pay the ACO to be accountable for the health and for containing the cost of health care for a defined population of patients. ACOs are willing to assume this task because they are rewarded for cost savings achieved through better coordinated care.

### Payment Reform Methods: A Snapshot

**Fee-for-Service** – Health care providers are paid for each service—such as an office visit, test or procedure—delivered to a patient.

**Pay for Care Coordination** – Providers are paid for specified care coordination services. The most typical example is the medical or health care home model.

**Pay for Performance** – Providers receive payment or other financial incentives for achieving defined and measurable goals.

**Episode or Bundled Payments** – Payments are made for a group of services related to a treatment or condition that may involve multiple providers in multiple settings.

**Capitated Payments** – A single, risk-adjusted payment is made for the full range of health care services needed by a specified group of people for a fixed period of time.

**Global Payments** – A group or network of health care providers receives a fixed rate per enrollee for a defined scope of services over a specific period of time—typically a month or a year. Services provided outside this scope are reimbursed per service provided. Providers, who could be located in various settings, are responsible for the total cost and quality of their patients’ care and receive financial incentives to improve the quality of care and reduce costs.
Initial Attempt to Link Payment to Outcomes: Pay for Performance (P4P)

According to the University of Minnesota, pay for performance can be defined as “a payment or financial incentive (e.g., a bonus) associated with achieving defined and measurable goals related to care processes and outcomes, patient experience, resource use, and other factors.” According to the Center for Health Care Strategies, the “pay” in P4P can refer to monetary or non-monetary incentive payments for reaching pre-specified goals. The “performance” in P4P can be outcome-based (e.g., for achieving certain clinical goals) or process-based (e.g., physician compliance with certain quality improvement processes or protocols, or participation in a designated quality improvement activity).

The main goals and possible benefits of pay-for-performance systems are to improve health care results by ensuring that patients receive timely, cost-effective care—especially preventive and chronic care—and to reduce costs.

Limitations to P4P center on not reflecting the complexity of caring for patients with multiple conditions. Programs with rigid measures and standards could create incentives for physicians to avoid high-risk patients and encourage them to stop seeing noncompliant ones. In addition, the time-consuming administrative work necessary to collect and report performance data could otherwise be devoted to direct patient care.

Focus on Care Improvement: Episode or Bundled Payments

Episode or bundled payments are single payments for a group of services related to a treatment or condition that may involve multiple providers in multiple settings. Examples include a payer who provides a pre-determined payment for all aspects of a hip replacement, or all treatment related to a diabetes diagnosis within a determined time frame.

Episode or bundled payment models may improve coordination among multiple caregivers, simplify billing (one bill instead of many), and clarify accountability for a defined episode. This model also supports flexibility in how and where some care is delivered and creates incentives to efficiently manage an episode (reduce treatment/manage costs).

The challenges associated with this model include difficulty in defining the boundaries of an episode (what care falls within and outside of the episode); limiting the number of providers and geographic locations for care if the model is not widely adopted; lack of incentives to reduce unnecessary episodes; and the potential for providers to avoid high-risk patients or cases that may exceed the average episode payment.

Capitated Payments

The capitated payment model—often thought of as managed care—involves providing a single payment to providers for the full range of health care services needed by a specified group of people for a fixed period of time.

The benefits associated with this model include a greater potential for innovation in delivery design; incentives to deliver care efficiently; improved incentives for providers who serve a particular population to collaborate with each other; and a greater emphasis on maximizing health.

Limitations of this model include the potential to overemphasize population health at the expense of individual patients’ health; possible incentive to avoid high-risk or noncompliant patients; the possible limit in patient choice of provider and/or
geographic preferences for care if adoption of the model is not widespread; and the potential for care to be withheld (“gatekeeping”).

Global Payments
A global payment—a fixed prepayment made to a group of providers or a health care system—covers most or all of a patient’s care during a specified time period. Global payment is similar to capitation and episode-of-care. The main difference from capitated models is that global payments often use more sophisticated risk-adjustment methodologies (this issue is discussed later in this brief). Similar to episode-of-care payments, global payments usually are paid monthly per patient over a year. However, in both cases, payment is bundled instead of made separately for each service. The major difference is that global payments are made on behalf of a group of patients and cover all care for all conditions covered by the health plan.

Among the challenges involved in implementing global payments on a broader scale are the relative sophistication of data and information systems, the analysis required of providers, and issues with defining the types of care covered by a global payment. In addition, the patient population must be stable, and most providers are not set up to accept global fees. As with other payment models, risk adjustment is an important factor in ensuring payments are high enough to manage the level of risk assumed by providers.

Difficulties in Payment Reform Implementation
To understand the complications associated with payment reform, particularly in relation to safety-net providers, it is important to understand two theoretically simple concepts: risk adjustment and aligning incentives with desired outcomes.

Risk Adjustment
Risk adjustment is used to determine how much health care a group of patients will need compared to a baseline rate. The provider payment then is set to reflect patient health needs. For example, safety-net providers who accept all patients regardless of ability to pay or health status attract patients with worse ailments than their peers who do not treat a similar patient population. If payments are not accurately risk-adjusted and safety-net providers receive payment amounts similar to their peers, it is likely that payments will be inadequate.

Risk adjustment does not only concern cost, however. In many payment models outlined in this brief, reimbursement rates are influenced by the quality of services—the higher the quality (as measured by the payer), the higher the pay. Risk
adjustment makes it possible to compare performance fairly. Comparing the same quality goals and benchmarks for different providers, regardless of the pre-existing health status of their patients, would unfairly penalize those who treat higher risk patients.\(^\text{18}\) For example, an 86-year-old female with diabetes who undergoes bypass surgery has a higher risk for complications and poor outcomes than a healthy 40-year-old male who undergoes the same procedure.

**Aligning Incentives with Desired Outcomes: What Are the Desired Outcomes?**

Paying health care providers to meet quality and cost containment goals has widespread appeal but, to create effective incentives, policymakers and payers first must agree on desired results, then determine how to measure whether these are reached.

The Institute of Medicine defines safety, effectiveness, patient centeredness, timeliness, efficiency and equity as key components of a successful health care delivery system.\(^\text{19}\) How a payer measures whether a provider has successfully reached these outcomes is more complex. Table 1 illustrates desired Institute of Medicine definitions.

Determining what constitutes an improved outcome is simple on a case-by-case basis. For the diabetic patient, it might mean two less visits to the emergency department in a year. However, since it would be impossible to create a payment methodology for individuals, patients often are grouped based on their health status and needs. Payers can use outcome-based (e.g., whether certain clinical goals were achieved) or process-based (e.g., whether the physician complied with certain quality improvement processes or protocols, or participated in a designated quality improve-

<table>
<thead>
<tr>
<th>Key Component</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Safety</td>
<td>Protecting patients from injuries and harm from the care intended to help them.</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Using the latest scientific data to provide all those who could benefit from treatment with the correct care, and keeping those who will not benefit from treatment from receiving it.</td>
</tr>
<tr>
<td>Patient Centeredness</td>
<td>Giving care based on a patient’s values, needs, and preferences, and letting patient values guide medical decisions.</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Reducing potentially harmful waits and delays for those who wait and those who administer care.</td>
</tr>
<tr>
<td>Equity</td>
<td>Providing care irrespective of gender, ethnicity, geographic location, socioeconomic status, etc., unless it is medically necessary to differentiate.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>Avoiding waste. This includes equipment, supplies, ideas, and energy.</td>
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</table>

*Source: Institute of Medicine.*
ment activity) measurements. These measures sometimes are too limited to truly gauge whether patients’ health was improved using the most cost-effective care.

**Aligning Incentives with Desired Outcomes: What Are the Incentives?**

The most straightforward incentive is to provide pre-determined direct monetary payments to providers for reaching outcome- or process-related goals. Direct payments do not always encourage provider innovation because no enticement exists to improve the standards upon which the pre-determined payment or benefit is based. Another incentive model is the shared-savings method.

Shared-savings programs allow providers to keep a portion of the money that is “saved” due to more efficient and effective care, so long as they meet quality standards. In some cases, providers also can be assessed a fee for cost overrides or failure to meet quality measures—this is referred to as shared-risk. According to the Dartmouth Institute for Health Policy and Clinical Practice and the Engelberg Center for Health Care Reform at the Brookings Institution, shared-savings payment models, implemented as part of an accountable care organization (ACO), will benefit patients, payers and providers.²¹

Some possible shortcomings exist with the shared-savings technique, however. Costs must decrease in order for a provider to receive any increase in payment, despite the fact that providers cannot control all costs, such as inflation. The model may require providers to make an up-front investment in their practice—such as hiring case managers and improving health information technology capabilities. Some critics suggest that these care-changing investments may be made years before the practice can share in the savings and realize a return on its investment. Others are concerned the model itself may not be sustainable. Once costs are reduced, there is less to be “saved,” since shared savings payments may disappear while the costs of reaching quality benchmarks will remain.

**Federal Support for Payment Reform: The Innovation Center**

The Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures … while preserving or enhancing the quality of care” for those who receive Medicare, Medicaid or Children’s Health Insurance Program benefits.

The Center provided $10 billion in funds to test payment models (highlighted on page 9) in FY 2011 through FY 2019. The law allows for opportunity to test models and then “scale up” to ensure distribution of successful methods. The Innovation Center is currently focused on the following priorities:

- Testing new payment and service delivery models,
- Evaluating results and advancing best practices, and
- Engaging a broad range of stakeholders to develop additional models for testing.

**Evaluating Results and Advancing Best Practices**

The Innovation Center evaluates each new payment and service delivery model tested. The law specifies that measures in each evaluation must include an analysis of the quality of care furnished under the model (including measurement of patient-level outcomes and patient-centeredness criteria) as well as changes in spending.
State Innovation Models Initiative

The Innovation Center created the State Innovation Models Initiative for states that are prepared for or committed to planning, designing, testing and supporting evaluation of new payment and service delivery models in the context of larger health system transformation. The Innovation Center supports testing innovative payment and service delivery models that potentially could lower costs for Medicare, Medicaid and the Children’s Health Insurance Program, while maintaining or improving quality of care for program beneficiaries. The goal is to create multi-payer models with a broad mission to raise community health status and reduce long-term health risks for beneficiaries of these programs.

Twenty-five states have received State Innovation Models (SIM) awards from the U.S. Department of Health and Human Services (HHS), as of March 2013. These states will work on health care system innovations and reforms to improve the quality and decrease the cost of health care. The nearly $300 million in funding was appropriated under the Affordable Care Act.

Six states—Arkansas, Maine, Massachusetts, Minnesota, Oregon and Vermont—received “model testing awards” to implement plans to transform health care delivery. According to HHS, “These states will use the funds to test multi-payer payment and service delivery models on a broader scale within their state.” The remaining 19 states will use the funds to develop their plans. The broad-based projects will focus on people enrolled in Medicare, Medicaid and CHIP.

Model Testing Awards

Over the next two-and-half years, more than $250 million in model testing awards will support six states that are ready to implement their state health care innovation plans. A state health care innovation plan is a proposal that describes a state’s strategy to use all methods available to transform its health care delivery system through multi-payer payment reform and other state-led initiatives.

Model Pre-Testing Awards

The three states that received pre-testing assistance will use the funding to continue work on a comprehensive state health care innovation plan. States that receive pre-testing awards under the State Innovation Models Initiative will have six months to submit a state health care innovation plan to CMS.

Model Design Awards

Sixteen states received model design funding to produce a state health care innovation plan. States will use these plans to apply for an anticipated second round of model testing awards. States that receive model design awards under the State Innovation Models Initiative also will have six months to submit their plans to CMS.
Every test of a new service delivery or payment model developed by the Innovation Center also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be widely and effectively used to support improvement for both CMS and the overall health care system. Evaluation results are continually shared with participating providers to promote more rapid learning. The U.S. Department of Health and Human Services supports many initiatives that allow for payment reform.

**Payment Reform in Medicare**

Value-based health care payments have been developing for years in the Medicare program, which accounts for 16 percent of the federal budget and is expected to increase to 20 percent by 2016. In 2003, the Medicare Modernization Act charged the Institute of Medicine to “identify and prioritize options to align performance to payment in Medicare” and supported a “pay-for-performance” strategy. The 2005 Deficit Reduction Act and the 2008 Medicare Improvements for Patients and Providers both contained provisions that required the Department of Health and Human Services to implement value-based payments for various Medicare providers. The 2010 Affordable Care Act (ACA) provides new incentives and penalties for payment reform in Medicare so the program will offer incentives to hospitals that provide high-quality care.

The goal of a value-based system is to offer providers incentives to more efficiently coordinate high-quality care. To do this, payment reform aims to spread accountability for patient health across a patient’s physicians, specialists, nurse practitioners and other providers so the team works together for “patient-centered” results. In a move away from fee-for-service payment, value-based payments in Medicare save money by relying on efficiency and effectiveness rather than on quantity of services used by patients. With health information technology, a patient’s data can be exchanged among facilities so that any provider can be up to date on the patient’s office visits, diagnoses, medications, operations and results.

**State Examples**

**Arkansas – Bundled Payments**

To control costs and promote quality health care, the Arkansas Medicaid program is partnering with the state’s two largest insurers, Arkansas Blue Cross and Blue Shield and Arkansas QualChoice, to change how they pay providers. Because the Health Care Payment Improvement Initiative involves the largest health care payers in the state, it likely wields enough influence to change how health care is delivered. Arkansas’ Medicaid plan amendment was approved by the Centers for Medicare and Medicaid Services.

Providers still submit claims for services and receive payment as they did under the fee-for-service model, but now will enter information about the patient’s condition into a statewide database. In time, the Medicaid program and private insurers will use the data to pay providers by episode of care. If the data reveals providers delivered efficient, quality care, they will receive a “commendable” rating and share in a portion of the payer’s savings. A rating of “acceptable” means no payment changes and, if the expected standard of care is not given, providers will owe the payer a portion of the excess costs.

The episodes of care eligible under the new system are upper respiratory infections, total hip and knee replacements, congestive heart failure, attention deficit/hyperactivity disorder (ADHD) and prenatal care. The state Medicaid program expects to save $4.4 million in FY 2013 and $9.3 million in FY 2014.
Minnesota – Medical Homes, Care Managers and More

Minnesota passed comprehensive health care legislation in 2008, designed to overhaul its health care delivery system. The legislation included the creation of a standardized set of quality-of-care measures, moving all claims and payments for payers and providers to a centralized electronic database, public ranking of providers by costs and quality, the creation of health care homes, and a standardized system of incentive payments used by public and private payers. Although the state has yet to fully implement these reforms, it has been approaching these goals through subsequent legislation, including work incorporating the 2010 ACA into its health plan.  

In addition, Minnesota has received a variety of three-year innovation grants to pursue health care innovation on many fronts. It was awarded a $1.7 million grant from CMS to pursue “Courage Center,” a community-based medical home structure for non-elderly people with disabilities in the state. It also was given money to improve care delivery and lower readmission rates, primarily through the use of care managers to transition certain patients to self-management—those diagnosed with depression, diabetes, and cardiovascular disease. Care managers are designed to check-in on patients, change prescriptions as needed, and monitor those receiving treatment though a centralized computer database.

New Jersey – Accountable Care Organization

The New Jersey Legislature created the Medicaid Accountable Care Organization (ACO) Demonstration Project in 2011. The three-year project allows the state’s Medicaid program to pursue projects that coordinate care among providers and patients, in lieu of the managed care model, with the goal of reducing costs. The 2011 plan was designed to test the ACO model. To help guide design of New Jersey’s ACO demonstration projects, the Center for Health Care Strategies (CHCS) released a toolkit to aid organizations with development. Under New Jersey’s plan, ACOs that participate in the demonstration project must be nonprofits that serve at least 5,000 patients, and they must contract with all hospitals, 75 percent of primary care providers and four or more mental health providers in their region. The CHCS report focused on three main steps of development: Building the ACO Framework, ACO Nuts and Bolts, and Constructing the ACO. These are included in templates CHCS has released to the public: a readiness assessment, a business plan and a work plan.

Two urban ACO models in Camden and Trenton already were working in the state before the legislation passed. In Camden, from 2002 through 2011, just one percent of the city’s patients generated 30 percent of emergency room expenses, and 20 percent of patients were responsible for 90 percent of emergency room costs. The ACO models pioneered the use of care teams to monitor “superutilizers” who pose a large financial drain on health networks. The Camden Coalition of Health Providers is working to integrate care among its various health providers, and to eliminate unnecessary screening and preventable ER visits to reduce this disproportionate burden.

New York – Pay for Performance

New York has experimented with pay for performance programs since 2002, when it launched “The Quality Initiative,” a four-year program that used statewide benchmarks and consumer satisfaction survey data on a variety of measures. Statewide measures included breast cancer screenings, postpartum visits, diabetes and high blood pressure control, use of appropriate medication for people with asthma, and follow-up after hospitalization for mental illness. For a high score, providers could be awarded up to 3 percent of the
premium as an incentive. By the time the program was completed in 2006, the state had paid bonuses of $71.5 million and had seen an increase in enrollment for plans designated as high-quality.

After continuing to experiment with various payer models, the most recent initiative is a new pay-for-performance pilot in the 14 hospitals of the New York City Health and Hospital Corp., announced in January 2013. The nation’s largest public hospital system will allot $59 million in incentives to physicians based on patient satisfaction scores, duration of time before discharge, and post-visit recovery. Meanwhile, state policymakers are reworking New York’s State Healthcare Innovation Plan from the Center for Medicaid and Medicare Innovation in hopes of receiving an innovation model grant to assemble community-based care mechanisms and accountable care organizations and to use health information technology.

**Ohio – Pay for Performance**

The Ohio Department of Job and Family Services (ODJFS) selected qualified applications from managed care organizations (MCOs), making them eligible to serve Ohioans enrolled in Medicaid under pay-for-performance standards. This is one of several recent changes to Ohio Medicaid, which serves more than 2.1 million low-income residents. In January 2012, ODJFS committed to pay-for-performance and quality standards and issued a request for proposals from MCOs that were interested in enrolling to serve Medicaid patients. In June 2012, the ODJFS Legal Department released the 10 MCOs that tentatively qualify, and in January 2013, MCOs began accepting patients. The qualified MCOs now must meet national performance standards to receive incentive payments. Other changes within “Ohio Medicaid Modernization” include consolidating health plan regional populations for efficiency, integrating care for dually eligible beneficiaries, and enrolling children with disabilities in managed care.

**Oregon – Accountable Care Organization**

Oregon is one of six states to receive a “model testing award” through the U.S. Department of Health and Human Services’ State Innovation Models Initiative. The state’s award of up to $45 million over 42 months to implement and test the Oregon Coordinated Care Model (CCM) will leverage the state’s purchasing power and help ensure that quality, low-cost health insurance options are available and sustainable. The CCM will realign health care payments and incentives, moving toward a system that rewards quality of care over quantity; integrates physical, behavioral and oral health; partners with local public health systems to address health disparities; and aligns incentives across health care and long-term care systems.

The coordinated care model will be tested in Medicaid through the state’s network of coordinated care organizations (CCOs)—community-based organizations that assume financial risk for health care costs. Although CCOs are responsible for their own payment and delivery reforms, they also are responsible for the health of the people they serve and have incentives to reduce the cost and improve the quality of the care they provide. Over time, CCO payment will shift from a fully capitated arrangement to one that increasingly depends on health care outcomes. To help facilitate this transition, Oregon plans to establish a Transformation Center to share best practices and to help expand the model to Medicare and private health insurance plans, such as those qualified in the state Health Insurance Exchange.
Washington – Multi-Payer Demonstration
In 2012, Washington, along with two other states, received Center for Medicaid and Medicare Innovation pre-testing grants to continue designing their health care innovation plans. With its $1 million, Washington policymakers are enhancing the plan so that it will be available to more residents and reflect a clear vision for the proposed multi-payer system.33 By bringing together the critical mass of payers and providers and agreeing upon transparent, evidence-based quality indicators, the multi-payer system would have quality and payment standards for all payers. All ACOs would be subject to clear, evidence-based utilization metrics and transparent evaluation in order to efficiently provide the highest quality care. Also included in the state’s proposal is a plan to improve maternal/child care, coordinate chronic conditions and create virtual accountable care organizations.34 Washington will finalize the plan by Sept. 30, 2013.

Conclusion
Research has shown that more services and higher spending do not always provide better results.35 To ensure that financial investments in health care are translated into improved health, states are exploring how they can leverage their market power to create payment methods that may simultaneously contain costs and improve care—two of the most important and challenging health care issues for state policymakers. Health care providers and payers are experimenting with different payment models, including hybrid systems using parts of multiple models that work for them, their patients and providers.
Notes


6. Ibid.


11. Minnesota Medicine, “Five Payment Models: The Pros, the Cons, the Potential.”


13. Minnesota Medicine, “Five Payment Models: The Pros, the Cons, the Potential.”


15. Minnesota Medicine, “Five Payment Models: The Pros, the Cons, the Potential.”

16. Ibid.


18. Ibid.


28. Ibid.


This brief was written by Melissa Hansen.

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