DEVELOPING INNOVATIVE PAYMENT APPROACHES: FINDING THE PATH TO HIGH PERFORMANCE

APPENDIX. CURRENT PUBLIC AND PRIVATE SECTOR PAYMENT INITIATIVES

Ongoing initiatives in both the public and private sectors are investigating alternative ways of aligning the incentives embedded in payment with the objectives of a high performing health system.

Current Medicare Initiatives

Medicare is the largest single payer for health services in the U.S., accounting for 19 percent of national health expenditures in 2007.[1] Medicare spending has grown steadily since the program's inception, putting increasing pressure on the federal budget.[2] Medicare faces unique challenges: the number of beneficiaries in 2050 is projected to be about double what it is today, with an increasing proportion of people with multiple chronic conditions in a program that was designed as an acute care benefit. However, the program's biggest challenge is rapid growth in spending per person throughout the health care system.[3] Medicare, therefore, is both an important part of the cost growth problem that health reform is intended to address and, at the same time, dependent on the success of health reform in curbing that problem across the health system. As the largest payer and the largest federal health program, it can serve as a platform for developing potential solutions to the high rate of cost growth, while also standing to benefit most from the broader application of those solutions.

In response to those circumstances, the Centers for Medicare and Medicaid Services (CMS) is conducting an array of initiatives to address the evolving needs of the Medicare program and its beneficiaries. Many of these initiatives have been developed under CMS's demonstration authority, which allows the agency to waive certain Medicare payment rules that determine what services are covered and how they are paid in order to test potential improvements; others have been specifically mandated by Congress, sometimes with additional authority specific to the initiative.[4]

Reporting Performance on Quality Measures

Reporting of performance measures can enhance quality and improve value. A 2006 study by the National Committee for Quality Assurance found that health plans that

collected and publicly reported performance data demonstrated broad-based improvements.[5] Public reporting can be an incentive for group practices, as well; groups that participate in public reporting tend to have higher performance.[6] CMS has developed and implemented several initiatives involving the reporting of quality measures for nursing homes, home health agencies, hospitals, and physicians. In the cases of hospitals, physicians, and home health agencies, payment is provided or withheld based on reporting of the required measures.

The **Nursing Home Quality Initiative** was launched nationally in 2002, with the availability of post-acute and chronic care quality measures on the Nursing Home Compare Web site. This initiative focuses on both regulation and enforcement, as well as collaboration with Medicare's Quality Improvement Organizations (QIOs), to improve the quality of care in nursing homes.

In 2003, the **Home Health Quality Initiative** began with a set of quality measures relating to improvements in patient functionality obtained from the Outcome and Assessment Information Set that is routinely collected from all Medicare home health agencies. These measures are available on the Home Health Compare Web site. A provision in the Deficit Reduction Act of 2005 (DRA) stipulated that each home health agency submit data on quality or its payment rate would be reduced by 2 percentage points beginning in 2007. A total of 12 measures are posted on the Home Health Compare Web site.

The **Hospital Quality Initiative** began in 2003, with voluntary reporting of a starter set of 10 hospital quality measures. The Medicare Modernization Act of 2003 (MMA) put in place a financial incentive to report these measures, withholding 0.4 percent of the annual update in Medicare payments for any noncompliant hospital beginning in 2005—at which point compliance with the "voluntary" reporting rose from a few hundred hospitals to almost all eligible hospitals.[7] The DRA expanded the set of reportable measures required for hospitals to receive their full update to 21 and increased the amount of the withhold to 2 percent of payments, beginning in 2008. In fiscal year 2010, CMS will collect a total of 44 quality measures, including data on outcomes and patient-reported experience. These measures are available on the Hospital Compare Web site.

The **ESRD Quality Initiative** began in 2004, with posting of quality measures for dialysis facilities on the Dialysis Facility Compare Web site. In addition, CMS implemented a strategy to improve care by setting a goal of arterial venous fistula (AVF) utilization by 65 percent of dialysis patients by 2009. (AVF is the preferred method of

vascular access for patients undergoing dialysis because it provides adequate blood flow, lasts longer than alternative methods, and has a lower complication rate.)

The Tax Relief and Health Care Act of 2006 established a **Physician Quality Reporting Initiative (PQRI)** that provided physicians with a 1.5 percent incentive payment beginning in July 2007 for reporting a set of 74 clinical quality measures on the claims they submitted to CMS, building on and strengthening a voluntary physician reporting program that CMS had instituted in 2006. In 2008, CMS expanded the PQRI measure set to 119 measures, and the Medicare Improvements for Patients and Providers Act of 2008 extended the PQRI and increased the incentive for reporting to 2 percent for 2009 and 2010 (but not thereafter); CMS further expanded the list of measures to 153, and providers can submit the required data on their claims or through a clinical registry.

Financial Incentives to Improve Provider Performance

Efforts to improve quality and efficiency have gone beyond public reporting, with Medicare conducting several demonstrations of incentive systems to encourage and reward those improvements.

CMS is testing models for rewarding hospitals that demonstrate high-quality performance. The **Hospital Quality Incentive Demonstration**, which started in October 2003 and was extended for a second three-year period, is a partnership between CMS and Premier, Inc., a nationwide purchasing alliance that includes some 1,500 nonprofit hospitals. About 250 hospitals in 38 states chose to participate in the demonstration when it began, with about 230 currently participating. Rewards (and potential penalties) under the demonstration are based on 34 process and outcome measures that describe the quality of care for inpatients in five clinical areas: heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacement.

Participating hospitals are rewarded with bonuses for high absolute or relative performance, as well as improvement. Results for the first four years indicate quality has improved significantly in all five clinical areas; a total of $36.5 million in performance bonuses has been awarded in the project's first four years.[8]

CMS is also testing financial incentives for physicians. The **Physician Group Practice Demonstration**, a five-year project that began in April 2005, provides incentives for large multispecialty group practices to improve the coordination of care for their Medicare fee-for-service beneficiaries. The demonstration's goals are to promote coordination of all Medicare services, encourage investment in administrative structure

and process to increase efficiency, and reward physicians for improving health outcomes.[9] The 10 sites participating in the demonstration represent more than 5,000 physicians and 200,000 fee-for-service Medicare beneficiaries.

Each of the participating practices shares in any Medicare savings resulting from improved coordination and efficiency, with the size of the bonus depending on the difference between total Medicare spending for the patients assigned to the practice and a target amount calculated from base-year spending for the patients assigned to the practice, inflated by growth in case-mix-adjusted per-capita spending for other beneficiaries in the practice's service area. Half of the bonus payments received by each practice are dependent on achievement of improvement on 32 quality measures.

Across sites there has been a focus on improving care management and coordination of care, expanding palliative and hospice care, modifying physician practice patterns and behavior, and enhancing information technology. Over the first three years, all the physician groups have achieved benchmark performance on at least 28 of the 32 measures.[10] In year three, five of the 10 participating groups received bonuses totaling $25.3 million as their share of the $32.3 million in Medicare savings produced by the sites.

CMS is also expanding its pay-for-performance demonstrations to smaller physician practices. The **Medicare Care Management Performance Demonstration**, which includes almost 500 solo and small to medium-sized practices in four states, began in July 2007.[11] The goal of this demonstration, which was mandated in the MMA, is to promote the adoption and use of health information technology to improve the quality of care for chronically ill beneficiaries. Physicians who meet or exceed clinical performance standards will receive bonus payments for managing the care of eligible Medicare beneficiaries and for provision of preventive services. Initial payments of $1.5 million were made to practices that reported baseline clinical quality measures. There will be an annual payment based on the practice's score on the clinical measures, as well as an additional annual bonus for reporting some or all of the measures through an electronic health record system that meets the standards of the Certification Commission for Healthcare Information Technology. Preliminary results from the first year indicate that CMS will award some $7.5 million in incentive payments to participating practices.

A **Medical Home Demonstration** is being developed by CMS to determine if the medical home model could result in better health care at lower cost. Under this model, Medicare beneficiaries with multiple chronic conditions designate certified physicians to

provide them with comprehensive and coordinated care. The physicians receive a per-patient care management fee, in addition to their usual fee-for-service payments. CMS anticipates that program savings, which will be partially shared with participants under specified conditions, will result from reduced resource use and fewer hospital readmissions. This project is currently scheduled to begin in 2010 in eight states.

CMS is also developing demonstrations that offer financial incentives to other types of providers. Under a **Nursing Home Value-Based Purchasing Demonstration**, financial rewards will be provided to nursing homes that meet certain standards for delivering high-quality care and also for quality improvement, facilitating the sharing of best practices.[12] Quality performance for each nursing home will be measured in four areas: staffing, appropriate hospitalizations, minimum data set outcomes, and survey deficiencies. Participating facilities will receive points for their performance, which will then be pooled to produce an overall score. Nursing homes in the top 20 percent for quality level and top 20 percent for quality improvement will be eligible for incentives.[13] The incentive payments will be made available through savings from avoidable hospitalizations and skilled nursing facility stays due to the improvements in quality of care. The three-year demonstration, scheduled to begin in July 2009, includes more than 180 nursing homes in three states.[14]

The **Home Health Pay-for-Performance Demonstration** is being implemented in seven states, including more than 30 percent of all Medicare-certified home health agencies (HHAs). It began in January 2008 and is scheduled to run for two years. The aim is to determine whether incentives to HHAs improve the quality of care of Medicare beneficiaries.[15] Bonus payments will be given to HHAs that provide the highest quality of care and the greatest improvements in quality of care, based on seven performance measures.[16] The payments will come out of a pool created from accrued savings from decreasing the use of costly Medicare services. Seventy-five percent of the pool will be shared among the top 20 percent of HHAs with the highest quality of care. The remaining 25 percent will be shared among the top 20 percent of HHAs with the biggest improvements in quality of care.[17]

Medicare also has implemented or is planning several initiatives that encourage collaboration between hospitals and physicians. The DRA mandated a **Medicare Hospital Gainsharing Demonstration** to test different types of arrangements between hospitals and physicians to improve quality and efficiency of care. This three-year demonstration, which began in 2008, allows hospitals to provide physicians with gainsharing payments that represent solely a share of the savings incurred as a result of

collaborative efforts to improve overall quality and efficiency. These arrangements are otherwise restricted by the civil monetary penalty law, which prohibits hospitals from rewarding physicians for reducing services to patients, even if such reductions are limited to duplicative services or otherwise represent improvements in quality.[18]

The **Medicare Acute Care Episode Demonstration,** a three-year project that was implemented in five sites in four states beginning in May 2009, is a test of more bundled payment approaches to encourage improved efficiency and quality of care. Specifically, Medicare will make a global payment that covers both hospital and physician services pertaining to inpatient stays involving specified cardiovascular or orthopedic procedures for Medicare fee-for-service beneficiaries. The Medicare payment for covered procedures at each site is based on competitive bids submitted by the sites as part of the application for selection to participate in the demonstration; each site must have established quality improvement mechanisms in place. Sites have the option to reward individual clinicians, teams of clinicians, or other hospital staff who succeed with measurable quality and efficiency improvements, and they may also provide in-kind services to beneficiaries and their families. In addition, CMS will share up to 50 percent of the program savings with beneficiaries in the form of payments to offset their Medicare cost-sharing obligations, up to their annual Part B premium amount.[19]

The **Medicare Health Care Quality Demonstration Program** is a project with a very broad scope that involves broader demonstration authority for CMS. The program was mandated by Section 646 of the MMA. It is a five-year project under which CMS will test major changes in system design aimed at improving quality of care while increasing efficiency. Unlike most other demonstrations, which are relatively limited in scope and intended to test specific types of changes in Medicare rules, Section 646 gives CMS broad flexibility to consider a range of payment systems designed to support significant changes in the organization of health care delivery. Organizations eligible to participate in the demonstrations are integrated delivery systems and regional consortia of providers. The first two sites approved under this authority are the Indiana Health Information Exchange (IHIE) and the North Carolina Community Care Networks (NC–CCN). The IHIE program will be regional, multipayer, and pay-for-performance. It is expected to provide evidence on the effectiveness of pay-for-performance, health IT, and multipayer initiatives to improve quality and efficiency of care. NC–CCN will combine physician-directed care management and information technology to support care coordination and evidence-based practice with a regional physician pay-for-performance program. It will test changes in organization, delivery, and financing of care to improve quality and efficiency.[20]

Payment Initiatives in Medicaid Programs

Medicaid, which is dependent on state budgets that often are limited and required to be in balance, is particularly concerned with developing approaches to keep costs down while maximizing its ability to provide needed services to the eligible population.

Currently, Medicaid programs in more than half the states are operating one or more pay-for-performance programs—half of which have been in place for five years or more—and that proportion is expected to increase to nearly 85 percent over the next five years. Many Medicaid directors have stated their focus on pay-for-performance is not to reduce costs, but to improve quality.[21] However, pay-for-performance payment models also are viewed as good mechanisms for controlling costs, because they pay physicians based on value, rather than the quantity of the services they provide.

Some states are pursuing multipayer initiatives. Structural and financial alignment between Medicare and Medicaid is another fundamental payment reform that is being considered: CMS recently announced a demonstration project to align Medicare with Medicaid and private insurers in state-based initiatives that will integrate patient-centered medical homes and public health services to promote efficient delivery and high-quality care.[22] In addition, several state initiatives are involve the medical home model.

Pennsylvania was one of the first states to implement a Medicaid provider payment initiative under an enhanced primary care case management (PCCM) program called **ACCESS Plus.** The goals of the program are to establish medical homes and provide disease management for those with asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, and coronary artery disease. Physicians who help enroll their patients, manage their care, and deliver clinical interventions receive bonus payments.[23]

Oklahoma's SoonerCare Choice, under the Oklahoma Medicaid department, began using a PCCM model that aims to improve access and care coordination through a fee-for-service structure, with an additional payment to compensate for care management responsibilities. The model originally reimbursed providers through a fixed monthly capitated payment for case management and some primary care services.[24] The new model realigns payment incentives to support the patient-centered medical home. SoonerCare does this through a monthly care coordination payment, a visit-based fee-for-service component, and a performance-based component. During the first year, transitional payments of $9 million will be distributed to practices. Excellence payments are also established to reward practices that work toward higher quality and efficiency.

As of October 2009, only 18 percent of practices were still receiving transition payments; 50 percent had fully transitioned to the new model and 93 percent were receiving an incentive payment, with 708 providers receiving $1.5 million to date.[25]

Community Care of North Carolina (CCNC) adopted a medical home model almost 18 years ago, with physicians compensated through care coordination fees. The original concept has evolved to focus on targeted case management, with 16 networks of physicians, pharmacists, health departments, hospitals and social services, which serve roughly 750,000 Medicaid enrollees. CCNC pays providers and networks a per-patient per-month (PMPM) payment, with networks receiving a $2.50 PMPM fee to target care management toward the highest-risk patients. Primary care physicians are paid 95 percent of the Medicare fee schedule plus a $2.50 PMPM fee for providing 24/7 coverage, following practice guidelines, and helping educate patients on managing their own care. North Carolina, as of 2006, has saved almost half a billion dollars in Medicaid costs since 1999, decreased hospital and emergency room visits, and lowered the average episode cost for children enrolled.[26] The Medicare Health Care Quality Demonstration described above will provide an important opportunity to include Medicare in this approach.

Rhode Island Medicaid has developed a new initiative called the **Rhode Island Chronic Care Sustainability Initiative (CSI)**, which is a multipayer PCMH. CSI is part of an initiative to bring together purchasers (Medicaid, state employers, commercial, self-insured) and health plans to target chronic conditions.[27] CSI will be implemented at five sites, consisting of collaborations between medical groups, physician specialty societies, and health plans and purchasers, covering 35,000 people, with each plan receiving $3 PMPM (roughly $166,000 to $387,000 per practice) to cover the costs of the PCMH.[28] The pilot is designed to align quality improvement and financial incentives, improve the care of patients with chronic conditions, and enhance primary care.

As of January 2009, all the CSI pilot sites had hired nurse care managers and were receiving the $3 PMPM payment; by April all the sites had submitted applications to the National Committee for Quality Assurance for formal PCMH recognition. Part of this progress is attributable to the central role of Medicaid, which is the state's largest purchaser with the highest number of patients with chronic conditions. This puts Medicaid in a position to encourage multiple stakeholders to work toward quality improvement.[29]

Colorado is also using the PCMH model to increase quality of care and reduce costs for children in Medicaid and the Children's Health Insurance Program . As of March 2009,

there were 97 community-based practices in the program with 310 physicians serving 150,000 children. Children in the program have received more well-child visits than those outside the program (72% versus 27%) and costs are less: $785 for PCMH children compared with $1,000 for those not in the program, with fewer emergency room visits and hospitalizations.[30]

Alabama operates a PCCM program called **Patient 1st**, which requires patients to designate a primary medical provider and employs two reimbursement schemes: one pays providers an itemized case management fee that is associated with a PMPM, depending upon the service rendered; and the other is a shared savings program under which the state shares 50 percent of any savings with the primary care physician. Physicians are measured on performance, generic medication use, and emergency room and office visits. Using Medicaid claims data, the measures are calculated and shared savings are allocated on a point system that scores physicians relative to their peers on performance and efficiency.[31] In 2009, the fee structure changed, making part of reimbursement dependent on the use of electronic information to gather patient information.[32]

Massachusetts' Medicaid program, **MassHealth,** has been authorized to implement a pilot program for global payments to one or more hospitals or hospital systems in its fiscal year 2010 budget, as part of a state-wide plan to move away from fee-for-service payment. The Massachusetts Medicaid Policy Institute (MMPI) released a report in November outlining how MassHealth could carry out this initiative. MMPI suggests that the pilot program include a defined set of providers with a large number of Medicaid patients and who are currently participating in a global fee initiative with a commercial payer, as well as a Medicaid managed care organization with the ability to test the approach in a fully capitated delivery system. For providers outside the pilot program, MMPI recommended that MassHealth begin a gradual implementation of payment reforms, using payment adjustments for preventable readmissions, expanding bundled payment approaches, and incorporating pay-for-performance incentives.[33]

Payment Reform Initiatives in the Private Sector

Although each of the individual insurers in the private sector is far smaller than Medicare, private insurance makes up 35 percent of national health spending (compared with 19 percent for Medicare) and, similar to Medicare, the private sector is concerned about spending growth.[34] Under current projections, the average premium for employer-sponsored family health coverage, $12,298 in 2008, would increase to $23,482 by 2020—a 94 percent increase.[35] This has caused growing concern among private insurers and the employers who purchase that insurance.[36] In response to those concerns,

numerous initiatives aimed at increasing value obtained for the health care dollar have been undertaken in the private sector. Several of them are described here.

The Institute for Clinical Systems Improvement (ICSI) is a collaboration of health plans in Minnesota and Wisconsin, founded in 1993 by HealthPartners Medical Group, Mayo Clinic, and Park Nicollet Health Services. It seeks to provide patients with quality, affordable health care through evidence-based health care guidelines.[37] ICSI includes the baskets of care program, which was written into Minnesota law as part of their 2008 health reform bill and will be implemented in January 2010. The baskets of care is a voluntary program, which encourages use by rewarding providers for delivering high quality, low cost health services across an episode of care.[38]

Patient Choice Healthcare, Inc. was formed in 2000 under the auspices of the Buyers Healthcare Action Group of Minnesota, to create a consumer friendly health care marketplace by increasing transparency through reporting on measures of cost and quality and promotion of value-based purchasing. Consumers use the comparative data to find providers with the best cost and quality information, providers work to increase their quality and efficiency, and employers see cost savings as employees choose providers with better quality at lower costs.[39] Patient Choice includes the Patient Choice Care System program, which creates "Care Systems"—tiered networks of health care providers based on cost and quality—that allows employers to offer their employees a choice of available systems. It also includes the Patient Choice Insights program, which rewards employees when they choose more efficient, high quality providers.[40]

Geisinger Health System is an integrated, physician-led health care system operating in Pennsylvania. In 2006, Geisinger began its **ProvenCare** model, which is an effort to provide streamlined, efficient, quality care through bundled payments via adoption of a fixed pre-care rate covering preadmission, inpatient, and follow-up care and a patient compact to encourage patient engagement through education.[41] The system requires providers, beginning before surgery is performed, to complete a list of 40 best practices (since expanded to over 200). Insurance companies, in turn, pay a flat fee for the procedure, and any readmissions within 90 days are free. As of 2009, the readmission rate has been lowered by 44 percent and hospital net revenues have increased by 7.8 percent.[42] ProvenCare was initially developed to focus on providing bundled payments for coronary artery bypass surgery, but has since expanded to include hip replacement, cataract surgery, angioplasty, perinatal care, bariatrics, and treatment for low back pain and kidney disease.[43]

In 2005, Blue Cross Blue Shield of Michigan, in collaboration with the Michigan State Medical Society, initiated the **Physician Group Incentive Program (PGIP)**, which is designed to reward high-quality, cost-effective care; proactive management of populations of patients; and collaboration across physician organizations. The PGIP offers an incentive pool (initially 0.5 percent of payments, now up to 3.1 percent) for high performance on quality metrics based on the Chronic Care Model developed by the MacColl Institute for Healthcare Innovation at the Group Health Research Institute (also known as the Wagner model).[44] Performance incentives are made only to physician organizations evaluated in the aggregate, rather than on an individual basis. The focus is on primary care and chronic care management, with primary care physicians comprising the majority of PGIP participants—as of July 2009, a total of 7,618 physicians in 36 groups were participating in the PGIP, with 1.8 million covered lives; 73 percent of those physicians were primary care providers.[45]

The Boeing Company sponsored an initiative in Seattle, called the **Intensive Outpatient Care Program (IOCP)**, designed explicitly for patients with severe chronic disease.[46] The project was managed by Regence BlueShield of Washington, Healthways, ValueOptions, and leaders of three physician groups (Everett Clinic, Valley Medical Center IPA, and Virginia Mason Medical Center clinics). Employees and pre-Medicare retirees were invited to enroll in the IOCP if they received primary care through one of the participating physician groups and had a severe chronic illness likely to benefit from intensified primary care. Patients in the initiative had improved functional status scores, outcomes scores, depression scores, and experience of care scores. In addition, employees' absenteeism declined relative to the baseline.

In January 2009, Blue Cross Blue Shield of Massachusetts began paying their medical groups under the **Alternative Quality Contract (AQC)** to improve quality of care and efficiency of the health care system. The AQC is a five-year contract that sets a baseline reimbursement to providers at a global capitated rate, designed so inflation-adjusted spending will not rise unless quality improves, coupled with incentives to improve quality based on performance measures. The AQC also is intended to reduce the fragmentation of care by creating accountability for financial and quality outcomes across providers and settings. Patients are assigned to physician groups based on their primary care physician, with the physician group representing the basic unit of responsibility, similar to a medical home. As of July 2009, seven delivery organizations have signed up for the AQC, including 1,037 primary care physicians and 265,000 HMO members and similar number of PPO members.

Bridges to Excellence (BTE) is an initiative that was funded initially by several large employers to increase the quality of care by recognizing and rewarding comprehensive management of patients and delivery of safe, timely, effective, efficient, equitable, and patient-centered care. It began in 2003 by offering bonus payments to physicians in four geographic areas (Boston, Massachusetts; Schenectady, New York; Louisville, Kentucky; and Cincinnati, Ohio) who treated patients employed by participating employers or enrolled in member plans for high performance (according to measures explicitly defined by the National Committee for Quality Assurance) along three dimensions: Physician Office Link (clinical information systems, patient education, chronic care management); Diabetes Care Link (management of diabetic patients); and Cardiac Care Link (management of cardiac care patients). By March 2009, BTE programs were operating in 17 states, including almost 14,000 physicians, and bonus payments are made for high performance along 12 dimensions.[47]

PROMETHEUS Payment was developed in 2006 to offer a different approach to payment to include all providers treating a patient for specific conditions. The payment system creates payments to providers using an evidence-informed case rate (ECR)—a global payment for an entire episode of care for a particular group including payers, providers, and patients. The ECRs are severity adjusted based on patient and provider characteristics and demographic factors, with a stop-loss to create a boundary for any expected variation in an ECR and to insulate the provider from any costs above the stop-loss.[48] The Prometheus payment model recognizes the perceived difficulties with creating organized delivery systems, so it yields to the formation of collaborations and does not depend on the existence of an organized delivery system.[49]

The **Accountable Care Organization (ACO)**, as designed by researchers from the Brookings Institution and Dartmouth Medical School, is an organizational model intended to achieve quality improvement and reduced cost growth.[50] The ACO model is characterized by three key features: local accountability for effectively managing the full continuum of care; shared savings based on historical trends and adjusted for differing patient populations; and performance measurement, including outcome and patient experience data.[51] Though these features are consistent across ACOs, they may differ due to their mix of patients, configuration of providers, and other factors related to the environments in which they operate. The ACO model also is compatible with a wide array of payment approaches.

There are many other initiatives being undertaken by private insurers, groups of employers, or other private sector organizations. For the most part, these initiatives are

being separately conducted, by separate organizations. With a few exceptions, there is little or no interaction among them and even less interaction between them and any of the Medicare initiatives described above.

APPENDIX NOTES

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[39] http://www.patientchoicehealthcare.com/aboutus/index.html

[40] http://www.patientchoicehealthcare.com/aboutus/index.html#results

[41] http://www.innovations.ahrq.gov/content.aspx?id=2373

[42] http://www.geisinger.org/provencare/AARP_Bulletin_4_1_09.pdf

[43] http://www.geisinger.org/provencare/faq.html

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