Session 115IF, Provider Risk-Sharing Arrangements in Medicaid

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[SOA Antitrust Disclaimer](#)
[SOA Presentation Disclaimer](#)
Provider Risk Sharing Characteristics

Most provider experience has been associated with fee for service reimbursement

• Providers are generally risk averse
• Typically work with patient records & clinical data
• Increased familiarity with quality metrics & outcome reporting but not risk parameters
• More comfortable with upside risk sharing
• Trade in higher risk reward for lower risk/gain sharing opportunities
• Larger hospitals usually major players in risk partnerships
Risk Sharing Arrangement Spectrum

Types of Risk Contracts

• Risk contracts span the spectrum from simple to complex risk sharing arrangements
• Partial FFS, Shared Savings Programs, Health Homes, Accountable Care Organizations (ACOs) to fully capitated contracts
• Can be limited risk sharing by risk group or disease specific health homes
• Risk sharing can also be limited to a specific set of services to multiple COS e.g. behavioral health or PCP cap PMPM vs. total cost of care (TCOC)
### Risk Sharing Spectrum

#### Continuum of Integrated Care Models (ICM) and Features

<table>
<thead>
<tr>
<th>CARE MODELS</th>
<th>MEASUREMENT</th>
<th>PAYMENT</th>
<th>SUCCESS INDICATORS</th>
<th>METRICS/VALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS Only</td>
<td>Data capturing &amp; sharing</td>
<td>Made to individual PCP</td>
<td>Fixed $ amount</td>
<td>Process measures indicate improved care in future, yield data collection for policy development and baseline</td>
</tr>
<tr>
<td>PCOM Only</td>
<td>Improved clinical processes</td>
<td>Made to individual providers or entity</td>
<td>$10-service Quality/Savings</td>
<td>Clinical processes and new benchmarks informed by data collection; benchmarks adjusted for continuous improvement</td>
</tr>
<tr>
<td>PCOM Plus P4P</td>
<td>Improved outcomes (costs down, better patient experience)</td>
<td>Made to entity</td>
<td>$5-service Quality/Savings</td>
<td>Improved care outcomes, not volume, patient experience</td>
</tr>
<tr>
<td>PCOMH</td>
<td></td>
<td>$5 - service Quality/Savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Network of PCOMH</td>
<td></td>
<td>$10-service Quality/Savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACOs</td>
<td></td>
<td>$15-service Quality/Savings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive ACOs</td>
<td></td>
<td>Population-Focused</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other ICMs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full ICMs</td>
<td></td>
<td></td>
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</tbody>
</table>

Current Trends in Risk Sharing

Provider risk sharing trends in the market place

• Trends toward alternatives to FFS both under Medicare & Commercial
• Risk contracts generally more prevalent within Commercial contracts
• Next Gen/MSSP ACOs & Value Based Payment (VBP) initiatives under Medicare
• Increased focus on risk contracts, outcomes & quality in addition to cost of care
• Spilling over into Medicaid - innovative provider contracts & increased risk sharing
Medicaid Risk Sharing

What is unique about Medicaid?

• Managed care rate setting - States use minimum loss ratios & rebates collected if experience falls below a minimum MLR

• General pressure to find alternatives due to funding concerns and increased focus on innovation

• Initial funding through ACA sponsored programs like Delivery System Reform Incentive Payment (DSRIP)

• Value Based Payments, Accountable Care Organizations common under Medicaid and here to stay

• All health care services covered - recent trends include value based contracting under pharmacy
## Provider Risk Sharing Option Considerations

<table>
<thead>
<tr>
<th></th>
<th>Operating Control</th>
<th>Investment Needed</th>
<th>Downside Risk</th>
<th>Upside Potential</th>
<th>Disruption to Status Quo</th>
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<tbody>
<tr>
<td><strong>FFS Option</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td><strong>Provider Risk Sharing</strong></td>
<td>☐</td>
<td>☐</td>
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<tr>
<td><strong>Arrangements</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>Partial Risk</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td><strong>Fully Capitated Plan</strong></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Aids to Provider Risk Sharing Arrangements

Some aids to provider risk sharing arrangements include:

• Vertically integrated providers/organized provider groups find it easier to accept risk e.g. IPAs integrated with large hospitals
• Convenient access to larger geographic areas
• Prior risk sharing experience of providers
• Progressive states like Minnesota, Oregon etc. support innovation
• Increased risk sharing over time & with experience
• Funding & access to capital needs
• Infrastructure needs – operational, reporting & performance monitoring
Providers Charting a Path Forward See the Opportunity, as Well as Some Areas of Concern

**OPPORTUNITIES**

**FINANCIAL**
- Capture Underwriting Margin
- Reduce Delivery System Loss
- Benefit From “Asset Value”

**STRATEGIC**
- Hedge Against Rate Cuts
- Diversification Into Insurance Business
- Create Economies of Scale

**COMMUNITY**
- Pursue the Mission
- Allow for Investment in Pilot Activities
- Foster Deep Community Partnerships

**CONCERNS**
- Legislative / Regulatory Support
- Significant Upfront Capital
- Capabilities Required
- Risk of the Population
The Current Landscape

STEVE TUTEWOHL, FSA, MAAA
Session 115, Provider Risk-Sharing Arrangements in Medicaid
June 27, 2018
Medicaid Spending Growth has Outpaced Most States’ General Fund Growth, Leading to Considerable Budget Strains

No signs of Medicaid spend slowing down; according to CMS actuaries, over next 10 years, Medicaid expenditures projected to increase 5.7% per year.

The Fiscal Survey of States: Spring 2017, A Report by the National Association of State Budget Officers
<table>
<thead>
<tr>
<th>Market Force</th>
<th>Effect on Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>States will use short term levers to drive Medicaid savings</td>
<td>Pressure on Rates</td>
</tr>
<tr>
<td>States will use waivers to increase program flexibility</td>
<td>Pressure on Enrollment</td>
</tr>
<tr>
<td>States will look to dial up reliance on managed care</td>
<td>Pressure on Utilization</td>
</tr>
<tr>
<td>Payers will double down on the traditional model and look to consolidate</td>
<td>Pressure on Payer Relations</td>
</tr>
</tbody>
</table>
## Two Business Models

<table>
<thead>
<tr>
<th>State Initiated</th>
<th>Payers and Providers Initiated</th>
</tr>
</thead>
<tbody>
<tr>
<td>• State program promoting provider sponsored plans</td>
<td>• Payers and Providers working together without state involvement</td>
</tr>
<tr>
<td>• State program promoting MCOs to contract with provider ACOs with risk contracts</td>
<td></td>
</tr>
<tr>
<td>• State direct contracts with provider ACOs</td>
<td></td>
</tr>
</tbody>
</table>
State Initiated Programs

Provider Sponsored Plans
- Recent Florida ITN guaranteed a provider run MCO would be awarded
- Provider Sponsored Plans judged on same criteria and against all bidding MCOs

State Promoting MCOs and ACOs
- New York VBP Innovator program

State Direct Contracts with ACOs
- Illinois ACE and CCE programs
- Massachusetts Accountable Care Partnership Plan
## Florida: Provider Service Network Sparking Innovation

<table>
<thead>
<tr>
<th>Provider-enabling Program Design</th>
<th>Yes/No</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Sponsored Health Plans are Recognized</td>
<td>✔️</td>
<td>Florida statute defines Provider Service Networks (“PSN”s) as having majority governance</td>
</tr>
<tr>
<td>Guaranteed Slot</td>
<td>✔️</td>
<td>Florida statute defines minimum of one PSN per region, if one submits a credible bid</td>
</tr>
<tr>
<td>Regional Procurement</td>
<td>✔️</td>
<td>Florida procures regionally (11 regions)</td>
</tr>
<tr>
<td>Membership Advantages</td>
<td>✔️</td>
<td>Florida uses minimum membership thresholds for new plans and auto-assignment</td>
</tr>
<tr>
<td>No HMO Licensure Required</td>
<td>✔️</td>
<td>PSNs do not need HMO license or any other certification to apply</td>
</tr>
<tr>
<td>Lower Capital Requirements</td>
<td>✗</td>
<td>PSNs held to same capital requirements as HMOs</td>
</tr>
</tbody>
</table>
Understanding Medicaid Risk Contracts

• Medicaid risk contracts work similarly to Medicare and commercial ACO like models

• A Total Cost of Care / Budget target is set and actual expenditures are tracked against it

• Delta is a savings or loss that is some way shared between the payer and provider

Key Terms in the Agreement Between Payer and Provider

• Any medical services carved out?
• Is historical data (full claims) available? Is it aligned with proposed targets?
• How is the revenue/target defined?
• How much will be transferred to cover delegated services?
• How is risk adjustment accounted for?
• How are quality measures factored in? Are they appropriate measures? Any other incentive program monies?
• Is an escrow account required?
• How will your providers be paid (by the Payor)?
• How and when will the financial reconciliation and cash transfer occur?
• What happens to drug rebates?
**Concept:** The full difference between actual experience and the target is shared with the provider, regardless of the magnitude

**Historical**
- Used to set the payor’s premium
- Not specific to the attributed population

**Current**
- Adjust premium for negotiated amounts based on covered medical and admin services

**Future**
- Premium changes will be based on changes in the payor’s market, not just your experience

<table>
<thead>
<tr>
<th>TOTAL</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Current year attributed patients</td>
<td>11,000</td>
</tr>
<tr>
<td>Premium PMPM</td>
<td>$427.61</td>
</tr>
<tr>
<td>Carve outs</td>
<td>($10.00)</td>
</tr>
<tr>
<td>Loss ratio % of Premium</td>
<td>88%</td>
</tr>
<tr>
<td>TCOC to Provider</td>
<td>$367.50</td>
</tr>
<tr>
<td>Total Admin</td>
<td>$51.31</td>
</tr>
<tr>
<td>% delegated</td>
<td>33%</td>
</tr>
<tr>
<td>Admin to provider</td>
<td>$16.93</td>
</tr>
<tr>
<td>Total to provider PMPM</td>
<td>$384.43</td>
</tr>
<tr>
<td>Actual Cost of Care</td>
<td>$365.00</td>
</tr>
<tr>
<td>Actual Cost of Admin</td>
<td>$20.00</td>
</tr>
<tr>
<td>Total actual cost for provider</td>
<td>$385.00</td>
</tr>
<tr>
<td>Net Impact</td>
<td>($74,778)</td>
</tr>
</tbody>
</table>
Keys to Success

- Acquire your historical data
  - Understand your starting point
  - Understand your population

- Negotiate terms following actuarial soundness principles

- Employ clinical programs that leverage and extend your current infrastructure

- Manage the network that is utilized

- Act like an insurer
Key Risks

• The state materially changes the rate setting methodology
• The historical data cannot be obtained or is not accurate
• The population acuity shifts, or adverse selection occurs, and risk adjustment does not move proportionally
• Risk of small numbers / high dollar cases
• Provider ACO clinical efficiency is deteriorating
Case Studies

PUNEET BUDHIRAJA, ASA, MAAA
Session 115, Provider Risk-Sharing Arrangements in Medicaid
June 27, 2018
Discussion Topics

• Introduction to CDPHP

• CDPHP Value Based Care (VBC) initiatives
  • Enhanced Primary Care (EPC)

• Current State of VBC Programs in NY Medicaid
  • Delivery System Reform Incentive Payment (DSRIP) Program
About Capital District Physicians’ Health Plan, Inc. (CDPHP)

Physician-founded, not-for-profit, mission-driven

24  400,000+  825,000+
Awards and Recognitions

**NCQA’s Private Health Insurance Plan Ratings 2017-2018**
- CDPHP HMO: 4.5 out of 5
- CDPHN HMO/POS: 4.5 out of 5

**NCQA’s Medicaid Health Insurance Plan Ratings 2017-2018**
- CDPHP HMO: 4.5 out of 5 – top-rated in NYS

**NCQA’s Medicare Health Insurance Plan Ratings 2017-2018**
- CDPHP HMO: 4.5 out of 5

**CMS Star Ratings**
- CDPHP Medicare Choices HMO: 4.5 out of 5 stars

*Medicare evaluates plans based on a 5-star rating system. Star Ratings are calculated each year and may change from one year to the next. The HMO plan is offered to individuals and employer groups; while the PPO plan is offered through employer groups.*
Where does CDPHP want to be on the Risk Continuum?

- **Higher CDPHP Risk**
  - Fee Schedule
  - EPC Capitation: Pilot program started in CY2008
  - Shared Savings (TCOC): Pilot programs started in CY2016
  - Global Capitation
- **Higher Provider Risk**
Enhanced Primary Care (EPC)
In 2008, CDPHP created Enhanced Primary Care to address the shortage of primary care doctors

✓ Departs from traditional fee-for-service
✓ Moves doctors to value-based payments
✓ Offers doctors opportunity for enhanced bonus money
✓ Rewards doctors for spending more time with sickest patients

Leading Enhanced Primary Care physician

Adetutu Adetona, MD
A Model of Care that Revolves Around the Patient

Members benefit from:

- More time with their doctors and care team
- Expanded practice office hours
- Enhanced doctor-patient relationships
- Improved electronic communications

\[ \text{Higher Quality of Care} = \text{Lower Cost of Care} \]
EPC Practices and Practitioners

* More than 235,000 members are a part of an EPC practice
Multiple transformation efforts occurring simultaneously

- EPC is at the center and intersects with all transformation efforts
- CDPHP is one of only a few payers in the U.S. that pays primary care a replacement for FFS
- Available tools and resources will help you succeed in all programs
EPC (Enhanced Primary Care)

- The CDPHP® Enhanced Primary Care (EPC) initiative is an innovative patient-centered medical home (PCMH) model that offers increased value for members and financial rewards for physicians.
EPC (Enhanced Primary Care)

EPC Practices vs Non-EPC Practices

- Childhood Well Visits
- Childhood Immunizations
- Colorectal Cancer Screening
- Breast Cancer Screening

$20.7 million SAVINGS IN 2014
New Products Encourage Members to See EPC Providers

**Commercial Members**
- $0 copay for members who visit a CDPHP EPC practice
- Members who see providers that don’t participate in EPC will incur a copay
- An estimated 70 to 80 percent of providers in the CDPHP service area are EPC providers
- EPC practices can be found on findadoc.cdphp.com

**Medicare Members**
- CDPHP launched a campaign to educate Medicare Choices members on the benefits of our Enhanced Primary Care program
- Effective January 1, 2018, members will have a copay reduction between $5 and $10 on most plans when they see an Enhanced Primary Care provider
Total Cost of Care (TCOC) Shared Savings
Payment Model Success Factors

- CDPHP entered into first TCOC shared savings contract in CY2016
- Payment model incents the provider to improve quality and lower the medical cost trend.
- Provider groups and CDPHP will be completely transparent with information and data.
- Requires good data systems to effectively measure results
- Timely data and ongoing performance measurement
- Redirection of patients to appropriate “lowest” cost setting, e.g., telemedicine opportunities
Provider Group Risk Adjustment in Shared Savings

- Risk adjustment is a method for adjusting expenditures to account for differences in expected health costs of individuals.
- Adjustment can take into account demographic information (age, sex, eligibility) and health status (diagnoses).
- Account for changes in severity and case mix over time and to more accurately set ACO performance targets.
- Expect better coding from the providers.

- Risk score models
  - Commercial
  - Medicaid
  - Medicare
Delivery System Reform Incentive Payment (DSRIP) Program
NY State: Reining in Medicaid Healthcare Costs
Delivery System Reform Incentive Payment (DSRIP)

- HHS approves pilot programs for Medicaid (if budget neutral)
- Programs go beyond routine medical care
- Approved for initial 5 year period and can be extended for 3-5 more years

- MRT waiver generated $17.1B in federal savings. $8B to be reinvested over 5 years
- DSRIP – mechanism by which waiver is implemented
- Promotes community level collaboration
- Goal is to achieve 25% reduction in avoidable hospital use over 5 years
- Funds based on performance linked to achievement of milestones

- PPS Payments depend on:
  - Meeting targets
  - Earning AVs Achievement Values
- PPS earns share of project payments based on relative AV share of project
- Earning Achievement Values:
  - Process measures (include organizational and project specific milestones)
  - Performance measures (Include P4R – pay for reporting and P4P – pay for performance)

- Partnered with 175 community healthcare providers
- 11 DSRIP projects over 5 years

- Goals are:
  - Reduce avoidable ED use by 25%
  - Enhance patient experience and clinical outcomes
  - Transition to VBC
  - Provide community care based approach
- Waiver revenue over 5 years $133.9 M
BHNNY Performance Measurement

Figure 1: Albany Medical Center DSRIP Project Selection

<table>
<thead>
<tr>
<th>Project</th>
<th>Project Description</th>
</tr>
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<tbody>
<tr>
<td>2.a.i</td>
<td>Create Integrated Delivery Systems that are focused on Evidence-Based Medicine / Population Health Management</td>
</tr>
<tr>
<td>2.a.iii</td>
<td>Health home at-risk intervention program: proactive management of higher risk patients not currently eligible for Health Homes through access to high quality primary care and support services.</td>
</tr>
<tr>
<td>2.a.v</td>
<td>Create a medical village/alternative housing using existing nursing home infrastructure</td>
</tr>
<tr>
<td>2.b.iii</td>
<td>ED care triage for at-risk populations</td>
</tr>
<tr>
<td>2.d.i</td>
<td>Implementation of patient activation activities to engage, educate and integrate the uninsured and low/non-utilizing Medicaid populations into community based care.</td>
</tr>
<tr>
<td>3.a.i</td>
<td>Integration of primary care and behavioral health services</td>
</tr>
<tr>
<td>3.a.ii</td>
<td>Behavioral health community crisis stabilization services</td>
</tr>
<tr>
<td>3.b.i</td>
<td>Evidence-based strategies for disease management in high risk/affected populations (adult only)</td>
</tr>
<tr>
<td>3.d.iii</td>
<td>Implementation of evidence-based medicine guidelines for asthma management</td>
</tr>
<tr>
<td>4.b.i</td>
<td>Promote tobacco use cessation, especially among low socioeconomic status populations and those with poor mental health</td>
</tr>
<tr>
<td>4.b.ii</td>
<td>Increase access to high quality chronic disease preventive care and management in both clinical and community settings</td>
</tr>
</tbody>
</table>

Project Domain: System Transformation Projects (Domain 2)
Project ID: 2.a.v
Project Title: Create a medical village/alternative housing using existing nursing home infrastructure

<table>
<thead>
<tr>
<th>Year, Quarter</th>
<th>DY1, Q1</th>
<th>DY1, Q2</th>
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<tr>
<td>PPS Reported</td>
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<td>Baseline Commitment</td>
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<td>2,474</td>
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<tr>
<td>Quarterly Update</td>
<td>0</td>
<td>623</td>
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<tr>
<td>Percent(%) of Commitment</td>
<td>0.00%</td>
<td>20.10%</td>
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<tr>
<td>IA Approved</td>
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<td></td>
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<tr>
<td>Quarterly Update</td>
<td>0</td>
<td>620</td>
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<tr>
<td>Percent(%) of Commitment</td>
<td>0.00%</td>
<td>20.00%</td>
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2.x Checklist

<table>
<thead>
<tr>
<th>Domain</th>
<th>Component</th>
<th>Review Status</th>
<th>AVs Available</th>
<th>AVs Awarded</th>
<th>Percentage AV</th>
<th>Domain Funding % (DY1)</th>
<th>Domain Funding % (DY1, Q2)</th>
<th>Payment Available ($)</th>
<th>Net Payment Earned ($)</th>
</tr>
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<tbody>
<tr>
<td>Domain 1</td>
<td>Organizational</td>
<td>Complete</td>
<td>5.00</td>
<td>5.00</td>
<td>100%</td>
<td>40%</td>
<td>89%</td>
<td>811,446</td>
<td>676,295</td>
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<tr>
<td>Project Implementation Speed</td>
<td>N/A</td>
<td>0.00</td>
<td>0.00</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Patient Engagement Speed</td>
<td>Complete</td>
<td>1.00</td>
<td>1.00</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Domain 2</td>
<td>Pay for Reporting (POR)</td>
<td>Complete</td>
<td>15.00</td>
<td>15.00</td>
<td>100%</td>
<td>60%</td>
<td>60%</td>
<td>202,861</td>
<td>202,861</td>
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<tr>
<td>Domain 2</td>
<td>Pay for Performance (PFP)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Domain 2 Subtotal</td>
<td>15.00</td>
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<td>100%</td>
<td>60%</td>
<td>20%</td>
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<td>202,861</td>
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<tr>
<td>Total</td>
<td>Complete</td>
<td>21.00</td>
<td>20.00</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>1,014,307</td>
<td>879,066</td>
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# VBP Levels

<table>
<thead>
<tr>
<th>Options</th>
<th>Level 0 VBP</th>
<th>Level 1 VBP</th>
<th>Level 2</th>
<th>VBP Level 3 VBP (only feasible after experience with Level 2; requires mature VBP contractor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Care for General Population</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings when quality scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Global capitation (with quality-based component)</td>
</tr>
<tr>
<td>Integrated Primary Care</td>
<td>FFS (plus PMPM subsidy) with bonus and/or withhold based on quality scores</td>
<td>FFS (plus PMPM add-on) with upside- only shared savings based on bundle of care (savings available when quality scores are sufficient)</td>
<td>FFS (plus PMPM add-on) with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>PMPM capitated payment = (with quality-based component)</td>
</tr>
<tr>
<td>Maternity Bundle</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings based on bundle of care (savings available when quality scores are sufficient)</td>
<td>FFS with risk sharing based on bundle of care (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Prospective bundled payment (with quality-based component)</td>
</tr>
<tr>
<td>Total Care for Subpopulation</td>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings when quality scores are sufficient</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)</td>
<td>Global capitation (with quality-based component)</td>
</tr>
</tbody>
</table>
