1. **What is the evidence for payment reform improving health outcomes?**
* UPMC Health Plan PCMH pilot – pilot sites outperformed the rest of network on improvements in hospital readmissions and a number of HEDIS measures (all four diabetes, HbA1c, eye exam, LDL screen, nephrology monitoring, breast cancer screen, management of acute depression).[1](#_ENREF_1)
* A collaboration between Aetna and NovaHealth, an independent physician association based in Portland, Maine, focused on shared data, financial incentives, and care management to improve health outcomes for approximately 750 Medicare Advantage members. The patient population in the pilot program had 50 percent fewer hospital days per 1,000 patients, 45 percent fewer admissions, and 56 percent fewer readmissions than statewide unmanaged Medicare populations. NovaHealth's total per member per month costs across all cost categories for its Aetna Medicare Advantage members were 16.5 percent to 33 percent lower than costs for members not in this provider organization. Clinical quality metrics for diabetes, ischemic vascular disease, annual office visits, and post-discharge follow-up for patients in the program were consistently high.[2](#_ENREF_2)
* Analyzing 234 practices that provided care for 133,703 diabetic patients, we found a net savings of $51 per patient with diabetes per year for every one-percentage-point increase in a score of the quality of care. Cholesterol testing for all versus none of a practice’s patients with diabetes, for example, was associated with a dramatic drop in avoidable hospitalizations. These results show that improving the quality of care for patients with diabetes does save money.[3](#_ENREF_3)
1. **What difference do care coordinators make?**
* Four of eleven programs that were part of the Medicare Coordinated Care Demonstration reduced hospitalizations by 8–33 percent among enrollees who had a high risk of near-term hospitalization. Results suggest that incorporating these approaches into medical homes, accountable care organizations, and other policy initiatives could reduce hospitalizations and improve patients’ lives.[4](#_ENREF_4)
* Among families with children with special health care needs asked about CC, 68.2% reported receiving some type of CC help. Of these, 59.2% reported receiving adequate CC help, and 40.8% reported inadequate CC. Families that reported adequate compared with inadequate CC had increased odds of receiving family-centered care, experiencing partnerships with professionals, and satisfaction with services. They had decreased odds of having problems with referrals for specialty care, missing >6 school days because of illness (previous year), and visiting the emergency department more than twice in the previous 12 months (P < .001). Those who reported adequate compared with inadequate CC had decreased odds of the following: more than $500/y of out-of-pocket expenses, family financial burden, spending more than 4 hours/week coordinating care, and stopping/reducing work hours. CONCLUSIONS: Parental report of adequate CC was associated with favorable family-provider relations and family/child outcomes.[5](#_ENREF_5)
1. **How is this payment reform different from an HMO or other previously tried payment reforms?**
* Payer-provider partnership
* Complete transparency with respect to service utilization & costs
* Upfront payments to cover supports & services needed to enhance the quality of care
* Consumer direction
1. **What is required of us to participate?**
* Provide input on best practices
* Review data and summary reports
1. **What is the benefit to us for participating?**
* Provision of data and summary reports
* Potential shared savings
* Improvements in quality of care, including patient satisfaction
* $15,000 in grant funding to offset physician time spent preparing for and attending project meetings and other project-related activities
* Experience on leading edge of payment reform innovation

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**2.** Claffey TF, Agostini JV, Collet EN, Reisman L, Krakauer R. Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan. *Health Affairs.* September 1, 2012 2012;31(9):2074-2083.

**3.** Kralewski JE, Dowd BE, Xu YW. Medical Groups Can Reduce Costs By Investing In Improved Quality Of Care For Patients With Diabetes. *Health Aff.* August 1, 2012 2012;31(8):1830-1835.

**4.** Brown RS, Peikes D, Peterson G, Schore J, Razafindrakoto CM. Six Features Of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions Of High-Risk Patients. *Health Aff.* June 1, 2012 2012;31(6):1156-1166.

**5.** Turchi RM, Berhane Z, Bethell C, Pomponio A, Antonelli R, Minkovitz CS. Care Coordination for CSHCN: Associations With Family-Provider Relations and Family/Child Outcomes. *Pediatrics.* December 2009 2009;124(Supplement 4):S428-S434.