Exhibit C
Total Payments to Providers in Dollars and Percentage of Revenue, by Payment Category
Requirement for RFP Section 4.3.3.2

LO and Partners* **Defined Population & # Served** **(Medicaid, Medicare, PEB, commercial etc.)**	**Category 1: FFS, No adjustments (no link to quality)**	**Category 2: FFS Value-Adjusted (link to quality and/or costs) but no down-side risk**	**Category 3: Alternative payment models built on FFS payments, with down-side risk**	**Category 4: Population-based payment/Capitation**	**Total Dollars**
Example: **Partner XYZ**	$80 million/80% of revenue 50% Medicaid 40% Commercial 8% PEBB 2% Medicare	$15 million/15% of revenue 50% Medicaid 40% Commercial 8% PEBB 2% Medicare	$3 million/3% of revenue 50% Medicaid 40% Commercial 8% PEBB 2% Medicare	$2 million/2% of revenue 50% Medicaid 40% Commercial 8% PEBB 2% Medicare	$100 million
Lead Organization					
Partner #1					
Partner #2					
Partner #3					
Total					

* Add rows for additional partners

Definition of Categories:

- Category 1: Traditional fee-for-service payment systems to providers that are based on volume of service delivery and not linked **at all** to quality or efficiency of health care delivery (i.e., payments are driven by volume of services). Please include Hospital DRGs here.
- Category 2: Same as Category 1, except that at least a portion of payments vary based on the quality/efficiency of health care delivery. Examples include Patient-Centered Medical Home/Pay for Performance/other quality-related programs, but none have downside risk for providers.
- Category 3: At least a portion of payment is linked to the effective management of care for a group of beneficiaries and/or an episode of care with downside risk for providers. While payments are linked to quality and efficiency or additional care management services, payments are still generally triggered by delivery of services. These payments are then reconciled in a shared savings or two-sided risk payment model.
- Category 4: Provide care within a specified "budget." Payment is not directly triggered by service delivery, but rather by responsibility for the care of a beneficiary (regardless of the volume of services). Substantial risk/reward for the cost of care shifts from the payer to the provider(s).