Presentation of the Alternative Payment Models (APM) Framework

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Purpose of Today’s Session

• Review the LAN Work Group’s work to date, including a proposed framework for categorizing Alternative Payment Models (APMs)

• Gain your feedback on the following:
  - Overall White Paper and proposed framework
  - Descriptions associated with each category
  - Boundaries that differentiate one category from another

• Understanding where your work fits into the framework
  - Please provide additional case studies to illustrate and test each category in the framework
Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group Overview

Charge of the APM FTP Work Group
The Work Group will propose an approach for measuring APM adoption across the U.S. health care system that includes clarity on what should be measured as well as a set of categories (Framework) that enable meaningful reporting.

APM FTP Work Group Outcomes
- Framework for Categorizing Payment Models
- Approach for Measuring Adoption of Alternative Payment Models
CMS Payment Framework

Category 1: Fee-for-Service – No Link to Quality
Payments are based on volume of services and not linked to quality or efficiency.

Category 2: Fee-for-Service – Link to Quality
At least a portion of payments vary based on the quality or efficiency of health care delivery.

Category 3: APMs Built on Fee-for-Service Architecture
Some payment is linked to the effective management of a segment of the population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk.

Category 4: Population-Based Payment
Payment is not directly triggered by service delivery as volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., 21 years).

Key Principles for the Draft APM Framework
Principle One

The Work Group recognizes that changing the financial reward to providers is only one way to stimulate and sustain innovative approaches to the delivery of patient-centered care. In the future, the Work Group believes it will be important to monitor progress in initiatives that empower patients (via meaningful performance metrics, financial incentives, and other means) to seek care from high-value providers and become active participants in clinical and shared decision-making.
As delivery systems evolve, the goal is to drive a shift towards shared-risk and population-based payment models, in order to incentivize delivery system reforms that improve the quality and efficiency of patient-centered care.
Key Principles for the Draft APM Framework
Principle Three

*To the greatest extent possible, value-based incentives should reach providers who directly deliver care.*
Key Principles for the Draft APM Framework
Principle Four

Payment models that do not take quality and value into account will be classified in the appropriate category with a designation that distinguishes them as a payment model that is not value-based. They will not be considered APMs for the purposes of tracking progress towards payment reform.
Key Principles for the Draft APM Framework
Principle Five

In order to reach our goals for health care reform, the intensity of value-based incentives should be high enough to influence provider behaviors and it should increase over time. However, this intensity should not be a determining factor for classifying APMs in the Framework. Intensity will be included when reporting progress toward goals.
Key Principles for the Draft APM Framework

Principle Six

When health plans adopt hybrid payment reforms that incorporate multiple APMs, the payment reform as a whole will be classified according to the more dominant APM. This will avoid double counting payments through APMs.
Key Principles for the Draft APM Framework
Principle Seven

Centers of Excellence, Patient-Centered Medical Homes, and Accountable Care Organizations are delivery models, not payment models. These delivery system models enable APMs and, in many instances, have achieved successes in advancing quality, but they should not be viewed as synonymous with a specific APM. Accordingly, they appear in multiple locations in the framework, depending on the underlying payment model that supports them.
# Draft APM Framework

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Fee-for-Service – No Link to Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong>: Payments for Infrastructure &amp; Operations</td>
<td>Traditional FFS</td>
</tr>
<tr>
<td></td>
<td>DRGs-HGT linked to Quality</td>
</tr>
<tr>
<td><strong>B</strong>: Pay for Reporting and Rewards for Performance</td>
<td>DRGs with rewards for reporting or quality performance</td>
</tr>
<tr>
<td></td>
<td>FFS with rewards for reporting or quality performance</td>
</tr>
<tr>
<td><strong>C</strong>: Rewards for Performance</td>
<td>Bonus payments for quality performance</td>
</tr>
<tr>
<td></td>
<td>DRGs with rewards for quality performance</td>
</tr>
<tr>
<td><strong>D</strong>: Rewards and Penalties for Performance</td>
<td>Bonus payments and penalties for quality performance</td>
</tr>
<tr>
<td></td>
<td>DRGs with rewards and penalties for quality performance</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Category 2</th>
<th>Fee-for-Service – Link to Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong>: APMs with Upside Risk</td>
<td>Bundled (e.g., episode-based) payment with upside risk only</td>
</tr>
<tr>
<td><strong>B</strong>: APMs with Upside/Downside Risk</td>
<td>ACOs with upside risk only</td>
</tr>
<tr>
<td><strong>C</strong>: APMs with Upside/Downside Risk</td>
<td>PCMHs with upside risk only</td>
</tr>
<tr>
<td><strong>D</strong>: APMs with Upside/Downside Risk</td>
<td>CFFs with upside risk only</td>
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<tr>
<th>Category 3</th>
<th>APMs Built on Fee-for-Service Architecture</th>
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<tbody>
<tr>
<td><strong>A</strong>: Limited Population-Based Payments</td>
<td>Risk-based payments NOT linked to quality</td>
</tr>
<tr>
<td></td>
<td>Captured payments NOT linked to quality</td>
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</tbody>
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<tr>
<th>Category 4</th>
<th>Comprehensive Population-Based Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong>: Payment model is in Categories 3 and 4 that do not have a risk to quality and will not count toward APMs.</td>
<td></td>
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</tbody>
</table>
Pathway to Patient-Centered Care

CURRENT STATE

FUTURE STATE

Provider risk and innovation
Impact of payment on quality
Performance delivery system integration and coordination
Patient-centric care

Category 1
Fee for Service—No Link to Quality

Category 2
Fee for Service—Link to Quality

Category 3
APMs Built on Fee-for-Service Architecture

Category 4
Population-Based Payment

HCP LAN
Health Care Payment Learning & Action Network

For Public Release
Panel Discussion

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Q&A
How You Can Provide Input and Feedback

• The APM FPT Work Group will be collecting feedback through November 20

• Submit your comments at HCP-LAN.org

• Other opportunities to provide feedback include:
  - via the LAN Learnings webinar Tuesday, November 10th
  - online through a discussion forum on Handshake
  - by email directly to PaymentNetwork@MITRE.org