Value Incentive & System Innovation Collaborative
Washington, DC
March 1, 2016
Sam Nussbaum, MD
PURPOSE
The Health Care Payment Learning & Action Network (LAN) was launched because of the need for:

Better Care
The LAN seeks to shift our health care system from the current fee-for-service payment model to a model that pays providers and hospitals for quality care and improved health.

Smarter Spending
In order to achieve this, we need to shift our payment structure to incentivize quality and value over volume.

Healthier People
Such alignment requires the participation of the entire health care community. The LAN is a collaborative network of public and private stakeholders.
What we have to do is to share these best practices, these good ideas, including new ways to pay for care so that we’re rewarding quality. And that’s what this network is all about.

President Barack Obama
2015 LAN Launch Event
Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a health care system that delivers better care, spends health care dollars more wisely and results in healthier people. Today’s announcement [of the launch of the LAN on March 25, 2015] is about improving the quality of care we receive when we are sick, while at the same time spending our health care dollars more wisely.

Sylvia M. Burwell, HHS Secretary
OUR GOAL
Goals for U.S. Health Care

2016
30%
In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

2018
50%
In 2018, at least 50% of U.S. health care payments are so linked.

These payment reforms are expected to demonstrate better outcomes and lower costs for patients.

Adoption of Alternative Payment Models (APMs)

Better Care, Smarter Spending, Healthier People
LAN BY THE NUMBERS
(Updated February 4, 2016)

- LAN Participants: 4,844
- LAN Organizations: 3,266
- Leaders: Guiding Committee, Work Group, Affinity Group, and Payer Collaborative members

Number of organizations represented by LAN participants: 109
OPERATIONAL MODEL
Critical path to broad adoption of Alternative Payment Models (APMs)

Gather Innovations
- Leadership Groups
- Partnerships
- Research
- LAN Engagement

Establish Framework
- APM Framework
- Guiding Principles

Develop Recommendations
- Population-Based Payment Model Components
- Clinical Episode Payment Models

Drive Alignment
- Implementation Resources
- Learning & Sharing

Demonstrate Results
- Measure & Track Progress
- Payer Collaborative
- Pilot Recommendations
LEADERSHIP GROUPS
Providing leadership and coordination of LAN activities and priorities

Guiding Committee
Primary leadership body of the LAN. The GC meets monthly, establishes and oversees work groups, and actively engages stakeholders across the LAN.

Work Groups
Short-term, multi-stakeholder initiatives of 14-16 experts charged with identifying and assessing the primary barriers to adoption and outlining key steps toward the achievement of goals.

Affinity Groups
Venues for participants in each sector, such as employers/purchasers, to engage around specific topics and to identify and disseminate knowledge and best practices.
WORK GROUPS

Identifying and assessing barriers to adoption and outlining key steps toward the achievement of goals

**Alternative Payment Model Framework & Progress Tracking (APM FPT)**
This group is proposing an approach for measuring APM adoption across the U.S. health care system that includes clarity on what should be measured as well as the set of categories (Framework) that enable meaningful reporting.

**Payer Collaborative**
The Payer Collaborative brings together industry leaders from both public and private health plans to inform the LAN's approach for measuring progress of APM adoption against the LAN's goals of 30 percent adoption by 2016 and 50 percent adoption by 2018.

**Population-Based Payment (PBP)**
This group is identifying the most important elements of population-based payment models for which alignment across public and private payers could accelerate their adoption nationally, with a focus on data sharing, financial benchmarking, quality measurements, and patient attribution.

**Clinical Episodes Payment (CEP)**
This group is helping align payer and provider efforts around clinical episode-based payments. The group will focus on a limited number of clinical conditions and rely heavily on existing work in the clinical domains. This group will leverage the experience of experts in each clinical field that has been identified as an area of focus.
WORK GROUP UPDATES

APM FPT
APM Framework & Progress Tracking

✓ Final Released
  • APM Framework
✓ In Development
  • Progress Tracking
✓ Group Established
✓ APM Measurement Effort pilot initiated

Payer Collaborative

CEP
Clinical Episode Payment

✓ Sprints Launched
  • Elective Hip and Knee Replacement
✓ Future Sprints
  • Maternity
  • Cardiac Care

PBP
Population Based Payment

✓ Drafts Released
  • Patient Attribution
  • Financial Benchmarking
✓ Sprints Launched
  • Performance Measurement
  • Data Sharing
# APM FPT MEMBERS

## Member Roster

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Susan Nedza, MD, MBA, FACEP</strong></td>
<td>CMIO and Senior Vice President of Clinical Outcomes Management, MPA Healthcare Solutions</td>
</tr>
<tr>
<td><strong>Steve Phillips, MPA</strong></td>
<td>Senior Director, Global Health Policy, Johnson and Johnson</td>
</tr>
<tr>
<td><strong>Richard Popiel, MD, MBA</strong></td>
<td>Executive Vice President Health Care Services and Chief medical Officer, Cambia Health Solutions</td>
</tr>
<tr>
<td><strong>Rahul Rajkumar, MD, JD</strong></td>
<td>Deputy Director, Center for Medicare and Medicaid Services</td>
</tr>
<tr>
<td><strong>Jeffrey Rideout, MD</strong></td>
<td>President and CEO, Integrated Healthcare Association</td>
</tr>
<tr>
<td><strong>Dick Salmon, MD, PhD</strong></td>
<td>National Medical Executive, CIGNA Healthcare</td>
</tr>
<tr>
<td><strong>Julie Sonier, MPA</strong></td>
<td>Director of Employee Insurance Division, Minnesota Management and Budget</td>
</tr>
<tr>
<td><strong>Lisa Woods</strong></td>
<td>Senior Director of Health Care Benefits, Walmart Stores Inc.</td>
</tr>
<tr>
<td><strong>Elizabeth Mitchell</strong></td>
<td>President and CEO, Network of Regional Healthcare Improvement</td>
</tr>
<tr>
<td><strong>Sam Nussbaum</strong></td>
<td>Former Executive Vice President of Clinical Health Policy and Chief Medical Officer, Anthem, Inc.</td>
</tr>
<tr>
<td><strong>Shari Erickson, MPH</strong></td>
<td>Vice President, Governmental and Regulatory Affairs, American College of Physicians</td>
</tr>
<tr>
<td><strong>Andrea Gelzer, MD, MS, FACP</strong></td>
<td>Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas</td>
</tr>
<tr>
<td><strong>Jim Guest, JD</strong></td>
<td>Former President and CEO of Consumer Reports</td>
</tr>
<tr>
<td><strong>Paul Harkaway, MD</strong></td>
<td>Senior Vice President, Clinical Integration &amp; Accountable Care, Trinity Health, Inc.</td>
</tr>
<tr>
<td><strong>Scott Hewitt, MPH</strong></td>
<td>Vice President, Network Standards &amp; Payment Strategy, UnitedHealthCare</td>
</tr>
</tbody>
</table>
**KEY PRINCIPLES**

APM Framework—summary of key principles

1. **Empower Patients to be Partners**
   Changing providers’ financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in health care transformation.

2. **Shift to Population-Based Payments**
   The goal is to shift U.S. health care spending significantly towards population-based payments.

3. **Incentives Should Reach Providers**
   Value-based incentives should ideally reach the providers who deliver care.

4. **Payment Models & Quality**
   Payment models that do not take quality into account will be classified within the appropriate category and marked with an “N” to indicate “No Quality” and will not count as progress toward payment reform.

5. **Motivate Providers**
   Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6. **Dominant Form of Payment**
   APMs will be classified according to the dominant form of payment, when more than one type of payment is used.

7. **Examples in the Framework**
   Centers of excellence, accountable care organizations, and patient-centered medical homes are examples in the Framework, rather than categories, because they are delivery systems that can be applied to and supported by a variety of payment models.
### APM FRAMEWORK

**At-a-Glance**

The framework is a critical first step toward the goal of better care, smarter spending, and healthier people.

- **Serves as the foundation** for generating evidence about what works and lessons learned
- **Provides a road map** for payment reform capable of supporting the delivery of person-centered care.
- **Acts as a "gauge"** for measuring progress towards adoption of alternative payment models
- **Establishes a common nomenclature** and a set of conventions that will facilitate discussions within and across stakeholder communities

The framework situates existing and potential APMs into a series of categories.

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Category 2</th>
<th>Category 3</th>
<th>Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee for Service – No Link to Quality &amp; Value</td>
<td>Fee for Service – Link to Quality &amp; Value</td>
<td>APMs Built on Fee-for-Service Architecture</td>
<td>Population-Based Payment</td>
</tr>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td>Pay for Reporting</td>
<td>APMs with Upside Gainsharing</td>
<td>A</td>
</tr>
<tr>
<td>B</td>
<td>C</td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td>Rewards for Performance</td>
<td>Rewards and Penalties for Performance</td>
<td>APMs with Upside Gainsharing/Downside Risk</td>
<td>Comprehensive Population-Based Payment</td>
</tr>
</tbody>
</table>

### Population-Based Payment

- **A**
  - Condition-Specific Population-Based Payment
- **B**
  - Comprehensive Population-Based Payment
# APM Framework

## Category 1: Fee-for-Service – No Link to Quality & Value

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundational Payments for Infrastructure &amp; Operations</td>
<td><strong>Traditional FFS</strong></td>
<td><strong>DRGs with rewards for quality reporting</strong></td>
<td><strong>Bundled payment with shared savings only</strong></td>
<td><strong>Incentive payments for primary care</strong></td>
</tr>
</tbody>
</table>

## Category 2: Fee-for-Service – Link to Quality & Value

<table>
<thead>
<tr>
<th>Fee-for-Service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay for Reporting</td>
<td><strong>Bundled payment with upside risk only</strong></td>
<td><strong>Episode-based payments for procedure-based clinical episodes with shared savings only</strong></td>
<td><strong>Primary care PCMHs with shared savings only</strong></td>
<td><strong>Incentive payments for primary care</strong></td>
</tr>
</tbody>
</table>

## Category 3: APMs Built on Fee-for-Service Architecture

<table>
<thead>
<tr>
<th>fee-for-service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>APMs with Upside Gainsharing</td>
<td><strong>Bundled payment with upside risk only</strong></td>
<td><strong>Episode-based payments for procedure-based clinical episodes with shared savings only</strong></td>
<td><strong>Primary care PCMHs with shared savings only</strong></td>
<td><strong>Incentive payments for primary care</strong></td>
</tr>
</tbody>
</table>

## Category 4: Population-Based Payment

<table>
<thead>
<tr>
<th>fee-for-service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>APMs with Upside Gainsharing/Downside Risk</td>
<td><strong>Bundled payment with upside risk only</strong></td>
<td><strong>Episode-based payments for procedure-based clinical episodes with shared savings only</strong></td>
<td><strong>Primary care PCMHs with shared savings only</strong></td>
<td><strong>Incentive payments for primary care</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>fee-for-service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition-Specific Population Based Payment</td>
<td><strong>Population-based payments for specialty conditions, and specialty specific care</strong></td>
<td><strong>Episode-based payments for procedure-based clinical episodes with shared savings only</strong></td>
<td><strong>Primary care PCMHs with shared savings only</strong></td>
<td><strong>Incentive payments for primary care</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>fee-for-service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Population-Based Payment</td>
<td><strong>Full or percent of premium population-based payments, e.g., via an HCS, PCMH, or COO</strong></td>
<td><strong>Partial population-based payments for primary care</strong></td>
<td><strong>Episode-based payments for primary care</strong></td>
<td><strong>Incentive payments for primary care</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>fee-for-service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizationally Integrated, Comprehensive, and Delivery System</td>
<td><strong>Incentive payments for comprehensive care, such as diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>fee-for-service</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-based payments</td>
<td><strong>Incentive payments for comprehensive care, such as diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** APMs stand for Accountable Payment Models. The model in Category 1 and 2 should not have a link to quality and will not reward for the quality.
WORK GROUP’S GOALS FOR PAYMENT REFORM
The LAN intends to use the APM Framework as a "gauge" for measuring progress towards adoption of APMs.

A diverse group of health plans assembled to inform the LAN's approach for measuring adoption of APMs.

A subset of Payer Collaborative participants will take part in an exercise to further inform and test the feasibility of the approach.

The resulting approach will be used to measure the nation's progress towards the goals of 30 percent adoption by 2016 and 50 percent adoption by 2018.
This group is identifying the most important elements of population-based payment models for which alignment across public and private payers could accelerate their adoption nationally, with a focus on data sharing, financial benchmarking, quality measurements, and patient attribution.

Key Activities
- Establishing patient attribution and financial benchmarking standards
- Developing performance measurement guidelines
- Identifying data sharing requirements
The draft white paper titled *Accelerating and Aligning Population-Based Payment Models: Financial Benchmarking* describes approaches for setting an initial benchmark and updates over time and also addresses risk adjustment considerations. The white paper discusses the need to balance voluntary participation with the movement towards convergence in a market with providers at different starting points.

**Key Components**
- Principles
- Recommendations

**FINANCIAL BENCHMARKING**
For population-based payment models

- **Development**

- **Draft Release**
  - Feb. 8, 2016

- **Public Comment**
  - Feb. 8–Mar. 7, 2016

- **Revise**
  - March–April 2016

- **Final Release**
  - April 2016
CEP Work Group
Clinical Episode Payment (CEP)

Chair

Lewis Sandy
Senior Vice President, Clinical Advancement, UnitedHealth Group

This 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 the set of categories (Framework) that enable meaningful reporting.

Key Activities
- Identifying the elements for elective joint replacement, maternity, and cardiac care episode payments
- Identifying best practices for implementing clinical episode payment models
EPISODE SELECTION CRITERIA

Empowering Consumers
Conditions & procedures with opportunities to include patients and family caregivers' through the use of decision aids support for shared decision-making; goal setting and support for identifying high-value providers.

High Volume, High Cost
Conditions & procedures for which high cost is due to non-clinical factors such as inappropriate service utilization and poor care coordination that correlate with avoidable complications, hospital readmissions and poor patient outcomes.

Unexplained Variation
Conditions & procedures for which there is high variation in the care that patients receive, despite the existence evidenced based “best” practices.

Care Trajectory
Conditions & procedures for which there is a well-established care trajectory, which would facilitate defining the episode start, length and bundle of services to be included.

Availability of Quality Measures
Conditions & procedures with availability of performance measures that providers must meet in order to share savings which will eliminate the potential to incentivize reductions in appropriate levels of care.
LAN SUMMIT
https://www.lansummit.org

Spring LAN Summit
April 25-26, 2016

Sheraton Hotel
8661 Leesburg Pike
Tysons, VA 22182
Tysons, VA

- Save the Date
- Presentations Planned from Work Groups on Work Products
- Call for Sessions Coming Soon! (end of February)
CONTACT US
We want to hear from you!

Website
www.hcp-lan.org | www.lansummit.org

Twitter
@Payment_Network

Linked-In
https://www.linkedin.com/groups/8352042

YouTube
http://bit.ly/1nHSf1H

Email
PaymentNetwork@mitre.org