National Academy of Medicine

Value Incentives and Systems Innovation Collaborative

September 16, 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 pay for quality of care over quantity of services.

**Healthier People**
Such alignment requires the participation of the entire health care community. The LAN is a collaborative network of public and private stakeholders.
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 smarter spending for patients.
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 Models
  - 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 specific sectors, such as employers/purchasers, to engage around specific topics and to identify and disseminate knowledge and best practices.
Leadership Groups
LAN has established seven groups with varying purposes.
Guiding Committee

Chairs

Mark McClellan, MD, PhD
Robert Margolis Professor of Business, Medicine, and Policy Director of the Robert J. Margolis Center for Health Policy at Duke University

Mark Smith, MD, MBA
Visiting Professor, University of California at Berkeley and Clinical Professor of Medicine, University of California at San Francisco

The Guiding Committee (GC) is the primary leadership body of the LAN. The GC meets monthly and carries out its responsibilities by establishing and overseeing work groups and by actively engaging stakeholders across the LAN to encourage commitments, share and disseminate results, and accelerate learning.

Key Activities

- Setting LAN priorities
- Establishing and overseeing work groups
- Engaging stakeholders

24 Members
Work Products

- APM Framework
  Released January 12, 2016

- Patient Attribution for PBP models
  Released August 8, 2016

- Financial Benchmarking for PBP models
  Released August 8, 2016

- Elective Joint Replacement for CEP models
  Released August 1, 2016

- Maternity Care for CEP models
  Released August 1, 2016

- Performance Measurement for PBP models
  Released August 8, 2016

- Coronary Artery Disease for CEP models
  Released August 1, 2016

- Data Sharing for PBP models
  Released August 8, 2016

- Progress Tracking
  Anticipated for Fall 2016
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 toward 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 toward 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.

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

Category 2
Fee for Service – Link to Quality & Value
A
Foundational Payments for Infrastructure & Operations
B
Pay for Reporting
C
Rewards for Performance
D
Rewards and Penalties for Performance

Category 3
APMs Built on Fee-for-Service Architecture
A
APMs with Upside Gainsharing
B
APMs with Upside Gainsharing/Downside Risk

Category 4
Population-Based Payment
A
Condition-Specific Population-Based Payment
B
Comprehensive Population-Based Payment

N = payment models in Categories 3 and 4 that do not have a link to quality and will not count toward the APM goal.

Example payment models will not count toward APM goal.
APM Goals
For Payment Reform
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.
PBP Work Group

Population-Based Payment (PBP)

16 Members

This group identified 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

- Established patient attribution and financial benchmarking standards
- Developed performance measurement guidelines
- Identified data sharing requirements

Chairs

Dana Gelb Safran, ScD
Chief Performance Measurement & Improvement Officer, Senior Vice President Enterprise Analytics, Blue Cross Blue Shield of Massachusetts

Glenn Steele, Jr, MD, PhD
Chairman, xG Health System, Immediate Past President and CEO of Geisinger

HCP LAN
Health Care Payment Learning & Action Network
Priority Areas
Population-Based Payment Work Group

Identifies the patient-provider relationship and forms the basis for performance measurement reporting and payment in a PBP model.

Set to help providers and payers to manage resources, plan investments in delivery support infrastructure, and identify inefficiencies.

The exchange of information between payers and providers to successfully manage total cost of care, quality, and outcomes for a patient population.

PBP models require a measurement system through which providers and payers monitor performance, and performance is rewarded.
Data Sharing Is Foundational For Population Based Payment Models

- **Data Sharing**
  - Population Level Data

- **Building Blocks**
  - Data Sharing
  - Patient Data
  - Patient Attribution
  - Financial Benchmarking
  - Performance Measurement

- **Structure**
  - Population-Based Payment Models

- **Result**
  - Triple Aim
    - Better Care, Smarter Spending, Healthier People

Equation: \[ \text{Foundation} + \text{Building Blocks} = \text{Result} \]
The group identified the most important elements of clinical episode payment models for which alignment across public and private payers could accelerate the adoption of these models nationally. The emphasis was on identification of best practices to provide guidance to organizations implementing clinical episode payment models.

Key Activities
- Identified the elements for elective joint replacement, maternity, and cardiac care episode payments
- Identified best practices for implementing clinical episode payment models
Purpose Of Episode Payment

Goal: The treatments the patients receive along the way reflect their wishes and cultural values.

Episode Payment Can:

• Create incentives to break down existing siloes of care
• Promote communication and coordination among care providers
• Improve care transitions
• Respond to data and feedback on the entire course of illness or treatment

Episode Payments Reflect How Patients Experience Care:

• A person develops symptoms or has health concerns
• He or she seeks medical care
• Providers treat the condition
• The patient receives care for his or her illness or condition
**CEP Work Group Key Principles**

<table>
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<tr>
<th>Incentivizing Person-Centered Care</th>
<th>• Episode payment should be designed to support high quality care that is evidence-based, efficient, and prioritizes patients’ and caregivers’ individual preferences, needs, and values.</th>
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| Effective Care coordination        | • Episode payment should encourage providers to better coordinate care across and within care settings and focus more strongly on care quality to achieve better care, smarter spending, and healthier people.  
| • Effective care coordination is particularly important for those with chronic conditions and for other high-risk/high-need patients |
| Reward High Value Care            | • Episode payment should be designed to incentivize providers and patients to discuss appropriateness of procedures. |
| Reduce Unnecessary Costs          | • Episode payment offers incentives to examine all cost drivers across the care delivery continuum, including fragmentation of care; unnecessary duplication of services; most efficient site of service; volume of service; and overall costs and prices. |

The CEP Work Group applied these principles when developing recommendations for episode payment in elective joint replacement, maternity care, and coronary artery disease.
Episode Selection Criteria

**Empowering Consumers**
Conditions and procedures with opportunities to engage 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 and 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 and procedures for which there is high variation in the care that patients receive, despite the existence evidence based “best” practices.

**Care Trajectory**
Conditions and 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 and 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.
- **Stakeholder Perspectives:**
  Ensure that the voices of all stakeholders – consumers, patients, providers, payers, states and purchasers – are heard in the design and operation of episode payments.

- **Data Infrastructure:**
  Understand and develop the systems that are needed to successfully operationalize episode payments.

- **Regulatory Environment:**
  Recognize and understand relevant state and/or federal regulations, and understand how they support or potentially impede episode payment implementation.

- **Interaction between multiple APMs:**
  Recognize questions and issues that may arise when determining how to implement episode payment together with other alternative payment models, such as population-based payment.
Coronary Artery Disease – Timeline

Episode Timing for Percutaneous Coronary Intervention (PCI) and Coronary Artery Bypass Graft (CABG)

Starting Point
Diagnosis by non-acute event OR acute event

Stopping Point
~ 12 months

~ 12 month period (first episode may be shorter, depending on start point)

Services: Diagnostic, preventative care, medication management, care management, and lifestyle change support

~ 12 month period

Pre-Operative: varies
Procedure: varies
Post Discharge: ~ 30-90 days
Coronary Artery Disease – Price & Care

Why a Nested Cardiac Care Episode?

Type of Care

- CAD Condition Management
- Inpatient & Outpatient Hospital
- Primary Care Provider or Cardiologist
- Interventionalist (PCI) or Cardiothoracic Surgeon (CABG)
- PCI/CABG
- Active Management of Coronary Artery Disease

Nested Episode Design

- Incentive to coordinate care delivery since both parties are at risk financially
- Make value-based decisions – using quality measures and historical costs – when partnering

Additional clinicians and settings involved in CAD Care: CCC Cath Lab, Cardiac Rehabilitation Facility, others.
This group of experts will collaboratively develop recommendations on the critical components for primary care payment in category 3 or 4 alternative payment models (APMs) and make practical recommendations for accelerating adoption of these models, including steps to support implementation.
Payment Reform Evidence Hub

This group is a national collaborative initiative to identify and implement specific short-term steps and supports to enable evaluations that are transparent, faster, cheaper, and more reliable. The PRE Hub will work in collaboration with the LAN, including its Guiding Committee and Working Groups, in developing its recommendations and tools, and in finding practical evaluation opportunities to apply them.

Key Activities

- Addressing key barriers to efficient evaluation of payment reforms
- Developing recommendations and tools for evaluation
Action Collaboratives: Maternity and Primary Care

The LAN will:

- Provide Expert, neutral, and seasoned facilitation to convene a national payer platform.
- Identify common challenges to primary care APM implementation across regions in key technical domains that require payer collaboration.

Creating an environment that allows for learning about strategy, solutions, and promising practices from fellow payers in other CPC+ regions, as well as from stakeholders outside of the PAC.

Forging connections between payers and subject matter experts in the myriad issues related to CPC+ and primary care APM adoption.

Providing practical tools for amplifying the discussions that take place among payers in the PAC activities.

Tracking regional & national payer collaboration toward shared multi-payer primary care APM milestones, such as those set by the CPC+ initiative, identifying opportunities for learning and improving, and taking action to leverage these opportunities as appropriate.

The LAN’s Aim:
Accelerate the adoption of primary care APMs, and deliver the support clinical practices need to succeed using those models.
AFFINITY GROUPS

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

Consumer & Patient Affinity Group (CPAG)
The Consumer and Patient Affinity Group (CPAG) is a channel for consumer and patient advocacy groups to provide important insights into the impact of APMs on patients and consumers, describe better health outcomes from the perspective of consumers and patients and define the care experience that APMs should deliver. CPAG members identified consumer priorities and principles for APMs that are informing the work of the Guiding Committee and Work Groups.

Purchasers/Employers Affinity Group (PAG)
The Purchaser Affinity Group acts as a link between purchasers and the LAN, creating a bi-directional flow, in order to ensure that the purchaser community is informed and aware of the LAN’s work, and that LAN Work Group recommendations and outputs incorporate perspectives and recommendations of diverse set of purchasers and those who work with purchasers. In addition, the PAG will build on and bolster existing tools to help both public and private employers become more effective value-based purchasers.

State Engagement Group
The State Engagement Group is open to all state government and state-affiliated LAN Participants. Members of this group will be able to join in discussions with other state-affiliated LAN participants by commenting on LAN work group products, posing questions to colleagues, providing feedback to other participants, sending suggestions for state-oriented webinars or resources, and leaving feedback for the Guiding Committee.
CPAG
Consumer and Patient Affinity Group (CPAG)

Leadership

Alan Balch, MD, PhD
Chief Executive Officer, Patient Advocate Foundation

Nancy LeaMond, MA
Chief Advocacy & Engagement Officer, AARP

Debra Ness, MS
President, National Partnership for Women & Families

The Consumer and Patient Affinity Group (CPAG) is a venue for consumer and patient groups to provide important insights into the impact of the alternative payment models (APMs) on patients and consumers.

Key Activities

- Holding monthly Leadership Committee meetings
- Developing consumer and patient principles
The Purchasers/Employers Affinity Group (PAG) supports purchasers of all sizes and types that want to advance the use of alternative payment models as part of value-based purchasing strategies, and to ensure that activities and recommendations of the LAN reflect purchaser perspectives.

Key Activities
- Linking purchasers with the LAN
- Ensure purchasers are informed about LAN activities
- Provide input to LAN recommendations and outputs
The State Engagement Group is open to all state government and state-affiliated LAN Participants. Members of this group will be able to join in discussions with other state-affiliated LAN participants, leaving feedback for the Guiding Committee.

Key Activities

- Comment on LAN Work Group Products
- Sign on as Committed Partners
- Provide feedback and send suggestions
Committed Partners

These organizations are recognized for establishing their own goals in support of APM adoption and sharing them with the LAN.
SOME CONSIDERATIONS REGARDING ALTERNATE PAYMENT MODELS

✓ Are incentives reaching front-line providers? Example: Population-based payments with fee-for-service payments to physicians based on RVUs

✓ How do account for the increasing costs of drugs in these models and build innovative payment models to include drug costs which are approximately 20% of all medical costs?

✓ What impact will MACRA, specifically MIPS, have on accelerating APMs?

✓ Will we see increased integration and care collaboration amongst specialty and primary care or will new models lead to dynamic tension regarding financial accountability?

✓ How will hospitals invest in APMs when there will likely be significant decreases in inpatient and outpatient revenues as physicians seek lower costs for services in alternative sites, such as free-standing labs, imaging, surgical centers and home care?
Aligning for Action

LAN SUMMIT
Health Care Payment Learning & Action Network

- LAN Fall Summit
- October 25, 2016

Washington Marriott Wardman Park Hotel

- Registration now open!
- Updates from the LAN Primary Care Payment Model Work Group and the Action Collaborative
- Opportunities to network with LAN leaders and other health care payment experts
- Discussions about real-world experience with outcomes-based payment models

https://www.lansummit.org