Core Questions:
1. What now? On which change principles is there greatest agreement (e.g. movement toward value-based payment), and how can progress be facilitated?
2. What are key regulatory reform opportunities that could reduce administrative burden on clinicians while fostering care and value improvement?
3. What successes have states had in advancing value-based care?

Outcomes Intended: Consider catalytic strategies, including unique opportunities for the National Academy of Medicine, to streamline regulation and facilitate stakeholder and national progress towards value-based payment.

Representative Observations
- In 2012, health care spending accounted for 17.2% of the U.S. gross domestic product and is expected to rise to 19.9% by 2022. While spending is increasing, the quality of care is stagnant, suggesting that the value of care today is lower than it was 6 years ago. (EM)
- The quality payment program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), will restructure Medicare payments for Medicare part B from fee-for-service to value-based payments for over 600,000 clinicians through two separate payment programs: the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). (PY)
  - MIPS allows physicians/physician groups to remain under the traditional Medicare payment model and earn performance-based payment adjustments by reporting data across 4 performance categories: quality, cost, improvement activities, and advancing care information. (PY)
  - Advanced APMs are innovative payment models that have shared savings, flexible payment bundles, and other desirable features. Stakeholders can submit proposals describing advanced APMs to the Physician-Focused Payment Model advisory committee, who then makes recommendations to the Health and Human Services Secretary. (CB & EM)
- As of September 2016, physician or health system preparedness to participate in MACRA was low, with only 5.7% of respondents to an American Medical Association survey indicating that they had decided on participating in one of the two payment programs. (CB)
- A number of policy barriers to moving forward with value-based payment reform include the lack of a system that supports the integration of data from different sources, the lack of aggregated claims and clinical data for physicians to access and use in managing populations and improving care, the lack of opportunity for small scale testing of new models, and transparency barriers among health plans. (EM)
- Hospitals and health systems face huge reporting and regulatory burdens with 23,531 pages of new regulations being released in 2016 alone. Therefore, when designing value-based payment policies, it is important to prioritize, streamline, and align outcome measure reporting requirements, focusing on those most useful to consumers and purchasers. (EM & AD)
  - Both the AHA and the NAM have pursued activities designed to identify measurement priorities. (AD)
- Public and private payers should attempt to align their efforts when designing and implementing value-based payment policies. (SF)
- Payers should also focus on strategies to improve value when making formulary decisions since $22 of every healthcare dollar is currently spent on prescription drug costs. Strategies include implementing outcomes-based (real world) analysis to determine which drugs improve health for plan members, value analysis to determine the lowest cost per outcome for different treatment alternatives, formulary placement with evidence development to monitor newly FDA approved drugs, and outcomes-based contracting where drug companies pay a portion of the cost for drugs without demonstrated evidence of clinical benefits for plan members. (SF)
- At the state level, Medicaid spending accounts for 20-30% of state budgets and many states recognize that the traditional fee-for-service system results in lack of coordination and poor outcomes. (HT & LB)
- In 2016, only about 18% of Medicaid payments fell within categories 3 (APMs built on fee-for-service payments) or 4 (population-based payments) of the Health Care Payment Learning & Action Network (LAN) APM Framework. (RM)
- States are implementing different value-based payment approaches ranging from transforming primary care to patient-centered medical homes, bundling payments for episodes of care, improving care coordination for high-need patients and for transitions in care, and integrating behavioral health care services and long-term services and supports into clinical care. (HT, LB & RM)
- In addition to challenges with alignment of quality measures, states face a variety of barriers in implementing value-based payment systems for Medicaid programs including issues related to data sharing, provider readiness, the current prospective payment system for safety net providers, and limited state operational capacity to implement these complex reforms. (LB)

Collaborative Activities for Consideration
The development of NAM discussion papers, exploratory meetings and/or strategy maps on the following topics:
- Advancing the concept and practice of clinical data as a public utility for accelerating health progress and the common good;
- Facilitating the liquidity of data exchange with and among health systems, payers, and communities;
- Sustaining and accelerating the movement of payment models from fee for service to models in categories 3 and 4 of the HCP-LAN model that pay for value, including improving the attractiveness of APM’s for health systems and practices
- Enhancing the seamless interface of medical and social services increasingly recognized as essential to effective management of high-need/high-cost patients and others.
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American Hospital Association
American Medical Association
American Nurses Association
American Society of Anesthesiologists
Anthem, Inc.
AtlanticCare Health System
Baystate Health
Center for Health Care Strategies

Duke-Margolis Center for Health Policy
Epic Systems Corporation
Families USA
Federation of American Hospitals
Healthcare Financial Management Association
MITRE Corporation
National Association of Medicaid Directors

National Governors Association
National Patient Advocate Foundation
Network for Regional Healthcare Improvement
Pacific Business Group on Health
Premier, Inc.
Trust for America’s Health
University of Minnesota

Federal agencies:
U.S. DHHS

- AHRQ
- CMS
- HRSA
- NIH

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