

ALTERNATIVE PAYMENT MODEL

APM FRAMEWORK



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Executive Summary

The Health Care Payment Learning & Action Network (LAN) was created to drive alignment in payment approaches across the public and private sectors of the U.S. health care system. The CMS Alliance to Modernize Healthcare (CAMH), the federally funded research and development center (FFRDC) operated by the MITRE Corporation, was asked by the Centers for Medicare & Medicaid Services (CMS) to convene this large national initiative.

To advance the goal of aligning payment approaches, the Alternative Payment Model Framework and Progress Tracking Work Group (the “Work Group”) was charged with creating an alternative payment model (APM) Framework (the “APM Framework”) that could be used to track progress toward payment reform. Composed of diverse health care stakeholders, the Work Group deliberated and reached consensus on many critical issues related to the classification of APMs, resulting in a rationale and a pathway for payment reform capable of supporting the delivery of person-centered care. The Work Group published the APM Framework White Paper in January 2016. Subsequently, a multi-stakeholder Advisory Group was convened to update the APM Framework and its principles based on developments that occurred since the original publication. This White Paper reflects that updated APM Framework.

Although not part of the Work Group’s explicit charge, this White Paper advances a working definition of person-centered care because it treats payment reform as one means to accomplish the larger goal of person-centered care. This working definition rests on three pillars: quality, efficiency, and patient engagement. For the purposes of this White Paper, person-centered care is nominally defined as follows: *care in which patients and their care teams form partnerships around high-quality, accessible care, which is both evidence-based and delivered in an efficient manner, and in which patients’ and caregivers’ individual preferences, needs, and values are paramount.*

Transitioning the U.S. health care system away from fee for service (FFS) and toward shared risk and population-based payment is necessary, though not sufficient, to achieve a value-based health care system. Financial incentives to increase the volume of services provided are inherent in FFS payments,

Health Care Payment Learning & Action Network

To achieve the goals of better care, smarter spending, and healthier people, the U.S. health care system must substantially reform its payment structure to incentivize quality, health outcomes, and value over volume. Such alignment requires a fundamental change in how health care is organized and delivered, and requires the participation of the entire health care ecosystem. To enable these reforms, the Health Care Payment Learning & Action Network (LAN) was established as a collaborative network of public and private stakeholders, including health plans, providers, patients, employers, consumers, states, federal agencies, and other partners within the health care community. By making a commitment to changing payment models, by establishing a common framework and aligning approaches to payment innovation, and by sharing information about successful models and encouraging use of best practices, the LAN can help to reduce barriers and accelerate the adoption of alternative payment models (APMs).

and certain types of services are systematically undervalued. This is not conducive to the delivery of person-centered care because it does not reward high-quality, individualized, and efficient care. By contrast, in many cases, population-based payments (including bundled payments for clinical episodes of care) can offer providers the flexibility to strategically invest delivery system resources in areas with the greatest return, to treat patients holistically, and to facilitate care coordination. Shared-risk payments, population-based payments, and other payment mechanisms are better suited than FFS payments to support the care delivery that patients value and incentivize the outcomes that matter to them. Therefore, the health care system should transition toward shared-risk and population-based models. In this context, the updated APM Framework will be useful to establish a common nomenclature and pathway upon which progress can be measured and successful models shared.

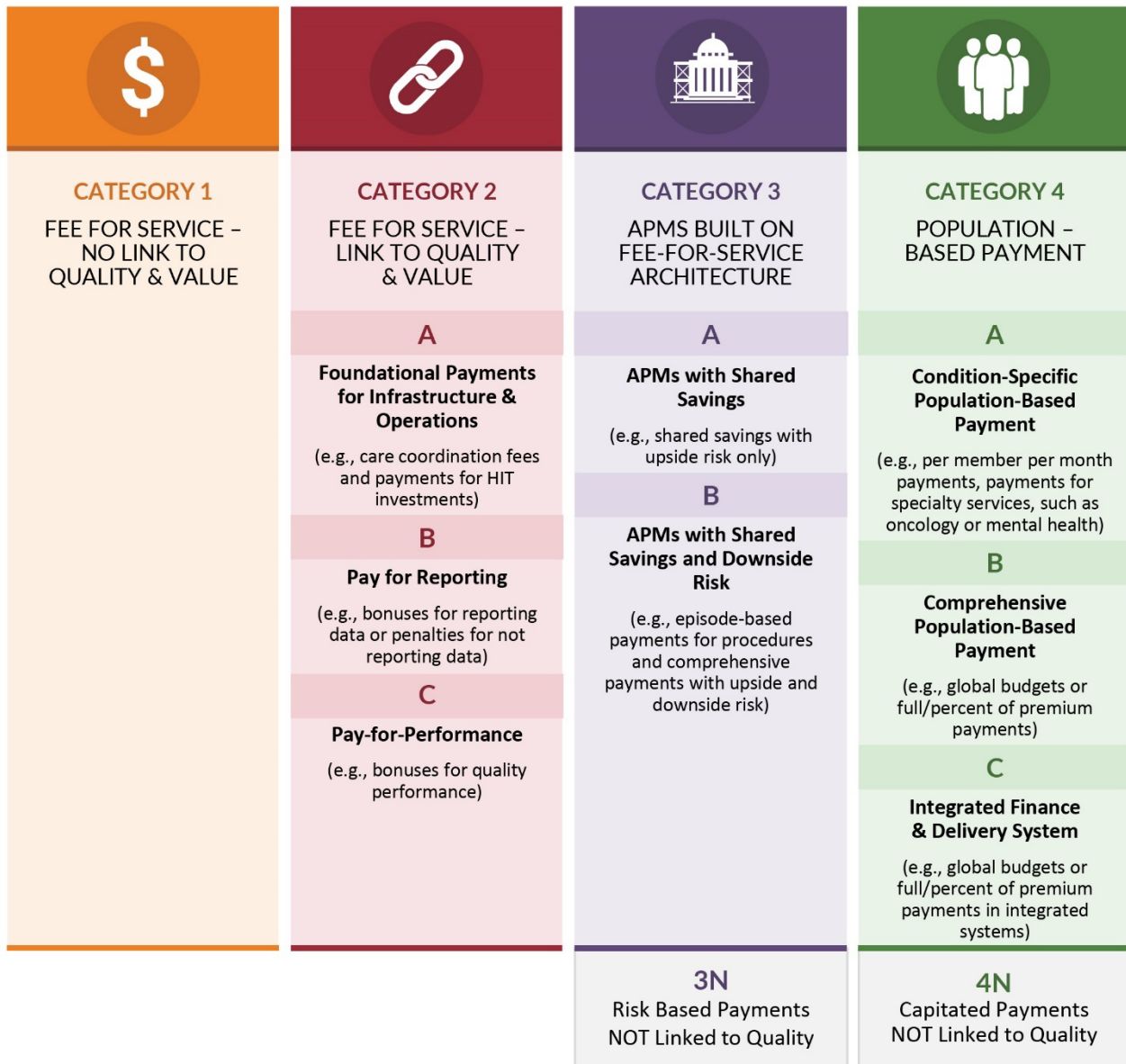
The updated APM Framework rests on eight principles which can be summarized as follows:

1. 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. Reformed payment mechanisms will only be as successful as the delivery system capabilities and innovations they support.*
3. The goal for payment reform is to transition health care payments from FFS to APMs. While Category 2C APMs can be the payment model for some providers, most national spending should continue moving into Categories 3 and 4.*
4. Value-based incentives should ideally reach care teams who deliver care.
5. Payment models that do not take quality into account are not considered APMs in the APM Framework, and do not count as progress toward payment reform.
6. Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery, without subjecting providers to financial and clinical risk they cannot manage.*
7. APMs will be classified according to the dominant form of payment when using more than one type of payment.
8. Centers of excellence, accountable care organizations, and patient-centered medical homes are examples, rather than Categories, in the APM Framework because they are delivery systems that can be applied to and supported by a variety of payment models.

* - indicates revised or new principle

With these principles in place, the Work Group began with the payment model classification scheme originally put forward by CMS, and subsequently reached a consensus on a variety of modifications and refinements. The resulting Framework is subdivided into four Categories and eight subcategories, as illustrated in the figure below (Figure 1).

Figure 1: The Updated APM Framework



Overview and Introduction to the 2017 APM Framework Refresh

A LAN Guiding Committee was established in May 2015 as the collaborative body charged with advancing the alignment of payment approaches across and within the public and private sectors of the U.S. health care system. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers that deliver higher-quality and more affordable care. The LAN’s mission is to accelerate the health care system’s transition to alternative payment models (APMs) by combining the innovation, power, and reach of the public and private sectors.

In July 2015, the Guiding Committee convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. health care system (the “APM Framework”). The Work Group brought together public and private stakeholders to assess APMs already in use across the nation, and to define terms and concepts essential for understanding, categorizing, and measuring APMs. (A roster of Work Group members, representing the diverse constituencies convened by the LAN, is provided in [Appendix C](#).)¹ Building on work initially done by CMS, the Work Group sought to create a clear and understandable APM Framework, provide a deeper understanding of payment models and how those models can enhance health and health care, and provide examples of how public and private payment models are organized.

Since the original APM Framework White Paper was released in January 2016, it has become the foundation for implementing APMs and evaluating progress toward health care payment reform. Payers, providers, and purchasers have all used the APM Framework to better understand the payment reform landscape and to set goals for participation in APMs, and health care stakeholders have used the APM Framework to identify common goals for transforming the nation’s health care system. Overall, the APM Framework’s classification system has been adopted by the health care ecosystem.

Significant and fast-moving developments have occurred since the original APM Framework White Paper was published. For example, in November 2016, CMS published the final rule on the Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (Advanced APMs) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The final rule established the criteria for determining which APMs are considered Advanced APMs under MACRA and thus offer participants an opportunity for a bonus payment. Additionally, the Center for Medicare and Medicaid Innovation (CMMI) released its annual report to Congress, which cataloged more than one hundred APMs in its portfolio, and it released a flagship, multi-payer primary care payment model (Comprehensive Primary Care Plus, or CPC+). Additionally, the Physician-Focused Payment Model Technical Advisory Committee (PTAC) has convened and begun recommending APMs for limited scale testing. Moreover, the LAN published 10 White Papers, recommending approaches for implementing population-based, clinical episode, and primary care payment models.

The LAN Guiding Committee recognizes the impact of these developments and market forces in aligning the financing and delivery of health care and in continuing the consolidation and integration of providers. As such, the Guiding Committee believed it was important to revisit the original APM Framework to ensure that it remains an indispensable tool for payment reform. To achieve this, the Guiding Committee convened a multi-stakeholder Advisory Group to reach key positions on revisions to the original APM Framework White Paper. (A roster of Advisory Group members, representing the diverse constituencies convened by the LAN, is provided in [Appendix B](#).)² Specifically, the Guiding Committee asked the Advisory Group to do the following:

¹ Please note that opinions expressed within the White Paper are those of the Work Group Members, not of the organizations with which they are affiliated.

² Please note that opinions expressed within the White Paper are those of the Advisory Group Members, not of the organizations with which they are affiliated.

- Clarify relationships between Advanced APMs under MACRA and categories in the LAN APM Framework (see discussion of Category 3 and [Appendix A](#));
- Identify opportunities for small, rural, and safety net providers to increase APM adoption (see Principles 3 and 6);
- Consider a new framework category for the growing sector of integrated finance and delivery organizations (see discussion of Category 4); and
- Identify opportunities to modify the APM Framework in ways that expedite and simplify the progress-tracking effort (see discussion of Category 2).

Overview of Changes to the APM Framework and Its Supporting Principles

The Advisory Group’s deliberations tackled both foundational principles and APM classification conventions. With respect to foundational principles, the Advisory Group focused on the importance of viewing payment as a vehicle for driving delivery system transformation, and it closely reviewed key statements in the original White Paper to be sure they did not imply that payment reform was a goal unto itself. These discussions culminated in a new Principle 2, which articulates that payment reforms are only as successful as the delivery transformations they support. Advisory Group discussions also resulted in changes to the original Principles 2 and 5. First, they clarified that Category 2 APMs can be an endpoint for certain types of providers in specific markets. They also clarified that the strength of incentives should balance the potential for delivery system transformation against the risk of physicians taking on greater financial and insurance risk than they can manage. Figure 3, which illustrates the LAN’s national goals for payment reform, has been updated to reflect greater parity in clinical outcomes and cost management in Category 3 and Category 4 APMs. The Advisory Group believes that these changes address challenges that many small, rural, and safety net providers face when participating in APMs.

The Advisory Group also carefully considered classification conventions used in the original APM Framework. Some of these discussions involved relatively minor modifications that would simplify and improve the LAN’s Progress Tracking efforts, such as the decision to consolidate Categories 2C and 2D into a single Category 2C for “Pay-for-Performance.” Other considerations included the need for additional patient protections in APMs with cost accountability. Accordingly, the Advisory Group decided to make “appropriate care” measures a requirement for Category 3 and 4 APMs in order to give providers strong incentives to focus on eliminating care that does not help (and may harm) patients.³

The past several years have witnessed a considerable expansion of integrated finance and delivery systems – i.e., joint ventures between insurance companies and health systems, insurance companies that own provider groups, and provider organizations that offer insurance products. Notable examples include not only Kaiser Permanente and Geisinger Health System, but also Vivity (a joint venture between Anthem and seven provider groups), the Allegheny Health Network (a joint venture between Highmark Blue Cross Blue Shield and the West Pennsylvania Allegheny Health System), the University of Pittsburgh Medical Center, Intermountain Healthcare, and the Henry Ford Health System. Integrated finance and delivery systems are also expanding rapidly in the Medicare Advantage (MA) market, where

³ In this context, appropriate care measures cover topics such as unnecessary imaging, preventable hospitalizations, and adherence to clinical guidelines.

roughly 60% of new MA plans are provider-sponsored.⁴ In light of this growth and the potential for these arrangements to better coordinate care, the Advisory Group thought it important to consider a new Category to track payments in these systems. Upon consulting with organizations that are making investments in these areas, the Advisory Group determined that integrated finance and delivery systems have the potential to help build organizational culture and investment strategies around population health management; support investments in key delivery infrastructure, such as care management, and health information technology; advance linkages to community organizations/community health; and promote alignment of value-based financial incentives among plans and providers. The Advisory Group therefore created a new Category 4C, which will enable further assessment of the effectiveness of these organizations in increasing the value of care through these more highly integrated arrangements.

The APM Framework and MACRA are aligned in the goal of moving payments away from FFS and into APMs that reduce the total cost of care (TCOC) and improve the quality of care. Both MACRA and the APM Framework establish designations for APMs that consider the extent to which payments are based on value (as opposed to volume). For MACRA, Advanced APMs receive special consideration, and for the APM Framework, Categories 3 and 4 mark the goal for national payment reform. MACRA and the APM Framework also both aspire to take provider variability into account when making these designations, to ensure they are responsive to the manifold settings in which health care is delivered nationwide. Therefore, comparisons between the two systems for designating level of APM advancement, and the identification of potential incongruities, offer an opportunity to properly designate payment arrangements for particular providers that are specially designed to reward high-value care.

With one exception, all Advanced APMs under MACRA were classified in Categories 3 and 4 according to the original APM Framework. However, the two designation systems inconsistently classified the flagship CMS CPC+ Track 1 program, which fell into Category 2 in the original APM Framework. The Advisory Group therefore considered new conventions for Category 3, which highlighted opportunities for the LAN to adopt more nuanced criteria that better reflect the lessons CMS learned about implementing primary care APMs for the Medicare population. Specifically, CPC+ Track 1 showed that utilization measures can be expected to establish shared-savings arrangements without a formal financial benchmark when smaller primary care providers are unable to bear much financial risk. This type of arrangement may not be appropriate in all settings or market segments, and it will be important to evaluate whether it achieves its intended results for smaller primary care practices. However, the Advisory Group decided that CPC+ Track 1's utility for introducing cost accountability to primary care physicians taking care of the Medicare population warranted its inclusion in Category 3. Although there will be differences in the specific criteria that MACRA and the APM Framework use to categorize APMs,⁵ this modification will achieve complete alignment between designations made by MACRA and the LAN

⁴ Avalere. Provider-Sponsored Health Plans: Enrollment, Quality, and Future Impact. Available at: http://go.avalere.com/acton/attachment/12909/f-0290/1/-/-/-/20160119_Aetna%20PSP%20Paper.pdf.

⁵ Whereas both the APM Framework and MACRA focus on the structural elements of APM design, MACRA focuses more on specific technical requirements. For instance, MACRA highlights the intensity of risk as a distinguishing factor between APMs and Advanced APMs by quantifying a "more than nominal" amount of financial risk. Under the APM Framework, risk differentiates APMs (i.e., between a 3A and 3B classification), but the precise magnitude of risk is not specified.

Framework such that all Advanced APMs under MACRA fall into Categories 3 and 4 in the updated Framework.

Taken together, these changes to the original APM Framework reflect experiences and developments that have occurred since the original White Paper was released. The updates will help ensure that the APM Framework remains fundamental for payment and delivery reform. Changes are embedded in this refreshed White Paper in order to maintain a single source for the LAN's perspectives on APM classification and goals for payment reform. The Advisory Group has incorporated public comments that it received, and it thanks all commenters for providing input on this work.

The Case for Reforming the Health Care Payment System

Like many health care stakeholders, the LAN is committed to driving payment approaches that improve the quality and safety of care, and the overall performance and sustainability of the U.S. health system. Collectively, we believe that making a positive impact on patient care and health should be the ultimate goal of payment reform, and we envision a health care system that provides person-centered care. For the purposes of this paper, and recognizing that the term may encompass additional characteristics that are not captured below, person-centered care means *patients and their care teams form partnerships around high-quality, accessible care, which is both evidence-based and delivered in an efficient manner, and in which patients' and caregivers' individual preferences, needs, and values are paramount*. Person-centered care, so defined, rests upon three pillars:

- **Quality:** This term indicates that patients receive appropriate and timely care that is consistent with evidence-based guidelines and patient goals, and that results in optimal patient outcomes and patient experience. Measures of performance and impact should be meaningful, actionable, and transparent to consumers, patients, family caregivers, and other stakeholders. Ideally, quality should be evaluated using a harmonized set of appropriately adjusted process measures, outcome measures, patient-reported outcome measures, and patient experience measures that together provide an accurate and comprehensive assessment of clinical and behavioral health. Measure scores should also be meaningfully accessed, understood, and used by patients and consumers.
- **Efficiency:** Eliminating waste and delivering affordable, appropriate health care services, are vital for ensuring that the nation can support investments in education, housing, and other social determinants that can independently improve population health. Efficiency indicates the degree to which services, care delivery models, and payment arrangements achieve the core outcome goals of patients, providers, payers, and purchasers in relation to their costs. Care that is less expensive than expected but that results in poor clinical outcomes is not considered efficient. Conversely, care that is unavoidably costly but results in dramatic improvements in patient outcomes is considered efficient. For **purchasers**, efficiency (and, therefore, value) might mean comprehensive care services that support the health and productivity of their workforces. For **payers**, efficiency might mean adjusting reimbursements to incentivize the delivery of care that achieves outcomes that matter to patients, thereby improving adherence to care plans, decreasing acute episodes that require emergency room visits or hospitalization, and lowering overall costs by reducing utilization of services that do not achieve desired outcomes. For **providers**, efficiency might mean aligning payment rates and incentives to reinforce best practices and remove undesirable incentives for low-value care that does little to achieve patients' goals. And lastly, for **patients**, efficiency is about achieving the outcomes that matter to them in a manner that is affordable and accessible.

- **Collaborative Patient Engagement:** This term encompasses the important aspects of care that improve patient experience, enhance shared decision making, and ensure that patients and consumers achieve their health goals. Patient engagement should occur at all levels of care delivery: with patients and caregivers serving as partners when setting treatment plans and goals at the point of care; when designing and redesigning delivery and payment models; on governance boards and decision making bodies; and when identifying and establishing connections to social support services. Collaborative engagement involves partnering with patients and consumers so they can be informed of their health status and share in their own care; easily access appointments and clinical opinions; seek care at the appropriate site; possess the information they need to identify high-value providers and to tailor treatment plans to individual health goals; provide ongoing feedback that providers can use to improve patient experience; obtain transparent price information from their health plan about services and evidence of their value for patients and consumers based on individualized characteristics and goals; and move seamlessly among providers that are engaged in different aspects of their care. Routine communication with family caregivers and other support members is also a critical part of comprehensive, person-centered care.

As evidenced by the LAN itself, there is an emerging consensus among providers, payers, patients and consumers, purchasers, and other stakeholders that efforts to deliver person-centered care have been stymied, to a large degree, by a payment system that is oriented toward paying for volume, as opposed to value for patients and caregivers. These stakeholders agree that reconfiguring payments to incentivize value, and ensuring that valuable activities (e.g., care coordination) are compensated appropriately, will better enable providers to invest in care delivery systems that are more focused on patient needs and goals. In other words, changes in payment are necessary (though insufficient on their own) to drive delivery system transformations, which ensure that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other payers.

Shifting from traditional FFS payments (i.e., claims-based payments that are not linked to quality or value) to population-based payments (in which all or much of a person's overall care or care for related conditions is encompassed within a single payment), is a particularly promising approach to creating and sustaining delivery systems that value quality, cost effectiveness, and patient engagement. Such payments should therefore include accountability for the quality of care delivered to patients, rather than incentivizing providers to increase the volume of services they provide. Although it is not yet possible to reach a definitive, evidence-based conclusion about the impact of population-based payments on patient care, there is a widespread belief that these types of payment models hold substantial promise. This is because population-based payments give providers more flexibility to coordinate and optimally manage care for individuals and populations. In combination with substantially reduced incentives to increase volume, and stronger incentives to provide services that are currently undervalued in traditional FFS, there is a consensus that this flexibility will expedite fruitful innovations in care delivery, particularly for individuals with chronic, complex, or costly illnesses.

At present, traditional FFS payments are ill suited for initiating investments and sustaining population health management innovations, such as information technology, clinical decision support tools, patient engagement and care coordination functions, and additional opportunities to increase access to care (e.g., payments for telehealth, home visits, group visits, and additional office hours). This is because traditional FFS's price per unit of service system incentivizes providers to produce revenue by increasing

volume, which can encourage unnecessary and harmful care. Population-based payments may enable providers to develop more innovative approaches to person-centered health care delivery because such payments reward providers that successfully manage all or much of an individual's care. Innovative approaches to health care delivery stand to benefit patients and society alike, with patients coming to expect a more coordinated, more accessible, and more effective health care system, and the nation benefiting from reductions in national health care expenditures thanks to a healthier, more productive population.

New payment models require providers to make fundamental changes in the way they provide care, and the transition away from FFS may be costly and administratively difficult even though new payment models will be more efficient over the long term. Participation in shared-risk and population-based payment models involves financial risk for providers, and not all provider organizations currently possess the capacity to successfully operate in these payment models. Such providers will need assistance to develop additional capabilities. To smooth and accelerate this transition, a critical mass of public and private payers must adopt aligned approaches and send a clear and consistent message that payers are committed to a person-centered health system that delivers the best health care possible. If providers were able to participate in APMs that were consistently deployed across multiple payer networks, the administrative burden of making the transition would be reduced and investments could be applied to all patient populations, independent of payer. Aligned payment approaches and performance metrics from a critical mass of payers would enable providers to establish an infrastructure that would increase the likelihood of success for innovative delivery systems over the long term. The adoption and diffusion of these innovative delivery systems should ultimately improve the quality, efficiency, safety, and experience of patient care, while becoming sustainable business models for providers that are eager to take a more comprehensive and coordinated approach to health care delivery.

Safeguards will be needed to ensure that quality and patient engagement are not sacrificed to reduce costs, and that the care delivered is state of the art and takes advantage of valuable advances in science and technology. It will also be important to take into account the time physicians spend on administrative tasks. Physicians already spend as much time doing "desktop medicine" as they do interacting face-to-face with patients.⁶ Given the weight of the current administrative burden, particularly in primary care, it will be important to design APMs in a way that minimizes the time providers spend on administrative tasks, and restores this to time spent interacting with patients. In order to mitigate the possibility of increased administrative tasks and other unintended consequences, it will be essential to monitor the impact of population-based payment systems on patient outcomes, affordability, and other indicators of significance to patients and other stakeholders in the health care system. This shift to person-centered, population-based payment should properly be viewed as a course-correcting feedback loop between innovation, implementation, and evaluation. However, the LAN firmly believes that a shift to person-centered, population-based payments will, in concert with significant delivery system reforms, result in an acceleration of high-value care in the United States. As discussed in the next section, the APM Framework will provide a valuable tool in accelerating this process.

⁶ Ming T.S. et al. (2017). Electronic Health Record Logs Indicate That Physicians Split Time Evenly Between Seeing Patients And Desktop Medicine. *Health Affairs*, 36(4), 655-662.

Purpose of the White Paper

To accelerate the transformations described above, the LAN created an APM Framework through which to describe and measure progress toward payment reform. In addition to providing a roadmap to measure progress, the APM Framework helps establish a common nomenclature and a shared set of conventions that can facilitate discussions among stakeholders and expedite the generation of an evidence base for evaluating the capabilities and results of APMs.

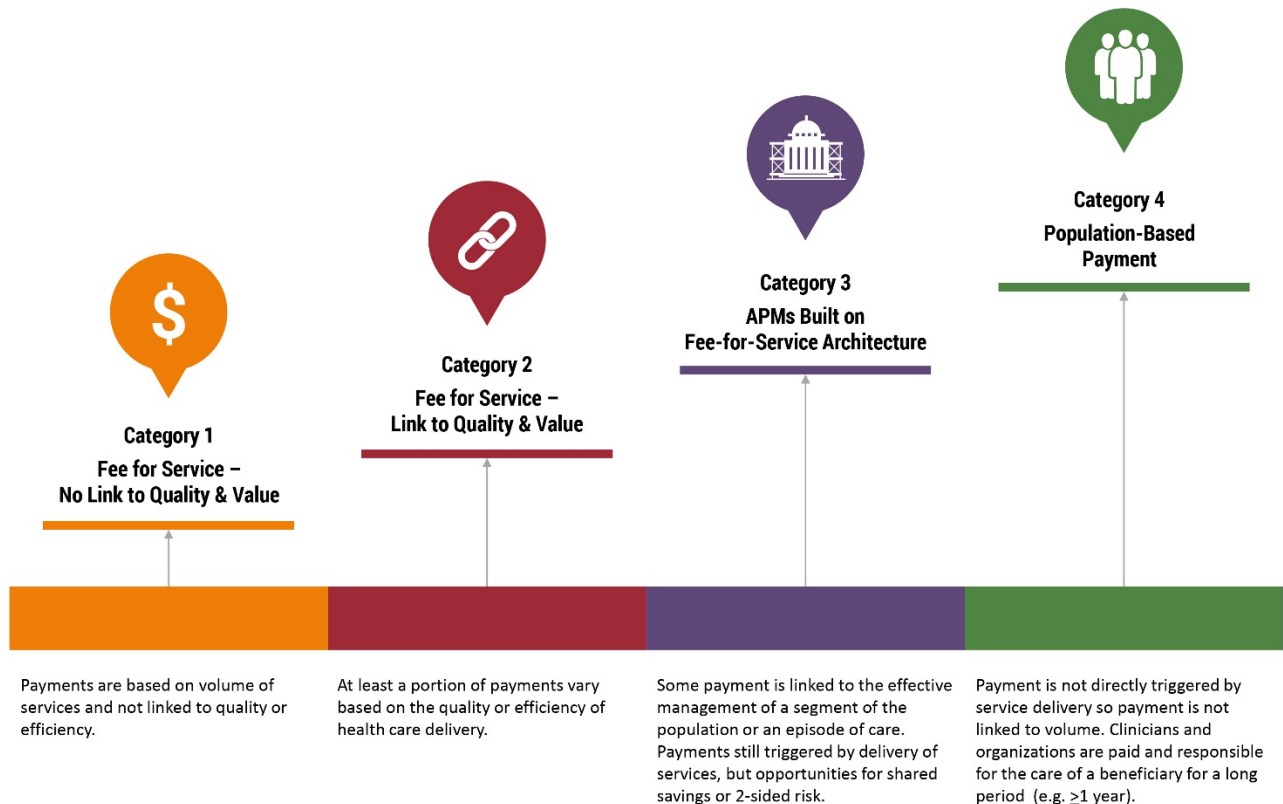
This White Paper begins by describing the approach used to develop the APM Framework, followed by the principles upon which the APM Framework is based. With these principles in mind, the White Paper differentiates categories within the APM Framework by explaining how they are defined and where their boundaries lie. The White Paper concludes with a summary of key findings and recommendations, as well as recommendations for how various stakeholders can use the APM Framework to accelerate payment reform. To further clarify the classification of individual APMs, the Work Group has separately released a [collection of APMs](#) that are currently in use as of January 2016.

Approach

When developing the APM Framework, the Work Group began with the payment model classification scheme that CMS originally advanced⁷ and expanded it by introducing refinements that are described in more detail below. As illustrated in Figure 2, the CMS Framework assigns payments from payers to health care providers to four Categories, such that movement from Category 1 to Category 4 involves increasing provider accountability for both quality and TCOC, with a greater focus on population health management (as opposed to payment for specific services).

⁷ Rajkumar R., Conway P.H., and Tavenner M. (2014). CMS: Engaging multiple payers in payment reform. *JAMA*, 311(19), 1967-8.

Figure 2: CMS's Original Payment Model



The Work Group added to and refined the CMS model by: 1) articulating key principles to explain what the APM Framework does and does not mean to convey; 2) introducing four new Categories to account for payment models that are not considered progress toward payment reform; 3) introducing eight subcategories to account for nuanced but important distinctions between APMs within a single Category; 4) delineating explicit decision rules that can be used to place a specific APM within a specific subcategory; and 5) compiling, with the help of the LAN, examples of APMs that illustrate key characteristics of each of the subcategories.

Key Principles for the APM Framework

The APM Framework is predicated on several key principles. To provide context for understanding the Framework and recommendations, these principles are delineated and explained below.

***Principle 1:** Changing payment to providers is only one way to stimulate and sustain innovative approaches to the delivery of person-centered care.*

In the future, it will be important to engage patient representatives in aspects of model design, and monitor progress in initiatives that empower patients to seek care from high-value providers (via performance metrics, financial incentives, and other means) and to encourage patients to become more active participants in shared decision-making.

Although it was necessary to focus on financial incentives for providers as a critical first step, additional efforts to engage patients and consumers will be needed to achieve a high-value, coordinated health care system. As more providers begin to participate in payment models that are divorced from traditional FFS, all stakeholders will need to collaborate on approaches to empower patients to become active partners as they strive to achieve their health goals. This includes engaging patients in ways that match their needs, capacities, and preferences. Such approaches may include strategies to clearly and meaningfully communicate, to patients and consumers, information about provider and health plan performance on clinical and patient experience measures; provide financial rewards for patients and consumers who select high-value providers and manage chronic disease with interventions that achieve outcomes that matter to patients; and enlist patients and caregivers as partners in setting health goals and developing treatment plans. This includes giving patients direct access to evidence-based tools that allow them to better understand their condition, preferences, and treatment options, as well as the benefits, risks, and out-of-pocket costs for each. Consumers, patients, families, and their advocates should be collaboratively engaged in aspects of design, implementation, and evaluation of payment and care models, and they should be engaged as partners in their own care. As models become more advanced in value-based payment, the corresponding care models should more comprehensively reflect the delivery of true person-centered care and meaningful partnership with patients and families.

To avoid unintended consequences associated with APMs, it is essential for payment models to include safeguards to prevent selection against individuals with more complex illnesses or greater need for social support, and patients and consumers should be informed of providers' financial incentives in APMs. Additional activities and monitoring will also be needed to ensure that the expansion of population-based payments does not lead to inequities in health outcomes or to a decline in access to care. APMs should therefore collect data that allows for assessment of differential impacts on, and the identification and redress of, disparities in health, health outcomes, care experience, access, and affordability.

***Principle 2:** Reformed payment mechanisms will only be as successful as the delivery system capabilities and innovations they support. APMs therefore need to be predicated on knowledge about how specific payment mechanisms drive new models and improvements in care delivery.*

Payment reform is necessary, but not sufficient on its own, for transforming the current volume-based health care system into a system that rewards providers for delivering value-based, person-centered care. This is because the relationship between APMs and the value they are intended to generate is neither deterministic nor universally applicable across provider types and patient populations. For example, payment mechanisms that are appropriate for advanced, highly integrated health systems may have different outcomes in safety-net hospitals or small primary care practices serving rural communities. The characteristics of the patient population can also be an important factor in the success of a given payment model. For example, social determinants and social needs have a much higher impact on some populations, so payments that often effectively address these needs may not work as well in different populations. For these and other reasons, it is important to base APM design on the best available evidence and information about how to optimize care delivery, and to identify payment mechanisms that are capable of stimulating infrastructure investments that maximize value (i.e., deliver the best possible quality and experience of care within the constraints of available resources) in specific clinical settings. Ultimately, positive impact on patient care and health should be paramount.

Because delivery system improvements drive the production of value in the health care system, it is important to identify evidence-based best practices for delivery components that have been demonstrated to improve care. Empirical evidence on the effectiveness of particular delivery components and competencies is still emerging, but several compendiums of best practices and essential components are beginning to be understood. For example, the Peterson Center on Healthcare and Stanford University’s Clinical Excellence Research Center identified 10 characteristics of high-value primary care providers, based on their analysis of 11 practices that provide “exceptionally high-value care.” Among other activities, these practices increase accessibility through after-hours calls and same-day appointments, provide the most support to patients who need it, refer patients to a selective list of specialists who share their commitment to value, and employ multidisciplinary care teams that work “at the top of their licenses.”⁸ Similarly, the Accountable Care Learning Collaborative (ACLC) identified competencies that are essential for the success of accountable care organizations (ACOs), based on their review of the evaluation literature.⁹ Broken into seven categories (i.e., governance and culture, financial readiness, health IT, patient risk assessment, care coordination, quality, and patient-centeredness), ACLC’s proposed list of competencies include:

- Align quality improvement initiatives with ethical obligations;
- Measure shared savings and cost sharing between providers and payers;
- Present useful and usable decision support at the point of care;
- Offer access to and integrate with behavioral health services; and
- Invest in health IT that optimizes your quality improvement and safety efforts.¹⁰

⁸ Peterson Center on Healthcare. Identification: Uncovering America’s Most Valuable Care. Retrieved from <http://petersonhealthcare.org/identification-uncovering-americas-most-valuable-care>

⁹ Accountable Care Learning Collaborative. ACLC Competencies. Retrieved from <https://www.accountablecarelc.org/aclc-competencies>

¹⁰Accountable Care Learning Collaborative. Inaugural List of Competencies Spreadsheet. Available at https://www.accountablecarelc.org/sites/default/files/ACLC%20Competencies%20for%20Public%20Comment%20FINAL_0%20%284%29%20-%202.16.17.xlsx

Payment mechanisms should be selected based on assumptions of how APMs will catalyze the development of essential delivery components and competencies for specific patient populations and provider organizations. Given the relative lack of national experience with APMs, and the time it takes to obtain results from rigorous evaluation studies, there is not at present a large volume of evidence on the relationship between specific payment mechanisms and their impact on delivery system design. However, CMMI has published a helpful list of factors that model designers should take into account (such as alignment with goals for delivery-system reform and extent of clinical transformation in model design) when selecting payment mechanisms.¹¹ Additionally, typologies of payment mechanisms can provide useful insights into the economic incentives inherent in particular payment approaches.¹² In addition to obtaining information about others' experience implementing APMs, such as through the LAN's Action Collaboratives and other multi-stakeholder networks, model designers can draw on these conceptual resources as results from program evaluations emerge.

Principle 3: The goal is to effectively transition health care payments from fee for service toward payment mechanisms that are better designed to promote the triple aim of healthier people, better care, and smarter spending, and this can include Category 2C APMs in certain cases. However, in order to achieve improvements in care coordination and support high-quality, evidence-based care, the majority of national spending should continue moving into Category 3 and 4 shared-risk and population-based payment models.

The overarching objective of the LAN is to encourage multi-payer alignment between and within the public and private sectors, as the health care system moves away from traditional FFS payment and into payment and delivery approaches that are better suited for promoting high-quality, effective care. It is useful to view this transition as a journey with origins, way stations, and destinations, both for individual providers and for national spending as a whole.

Providers at the early stages of the journey may benefit from infrastructure payments to support investments in delivery components that are needed to successfully manage population health and spending. For example, primary care practices may need dedicated care managers, care coordinators, community liaisons, and practice managers, while improving health information technology and data analytic capabilities and offering additional ways to access care around the clock. Although infrastructure investments to support these sorts of activities can be considerable, providers can obtain

¹¹ The Centers for Medicare & Medicaid Services. Alternative Payment Model Design Toolkit. Available at <https://aspe.hhs.gov/system/files/pdf/234386/CMMIAPMToolkit.pdf>

¹² See, for example: Berenson R.A., Upadhyay D.K., Delbanco S.F., and Murray R. (2016). A Typology of Payment Methods. Retrieved from Urban Institute website at <http://www.urban.org/sites/default/files/publication/80316/2000779-A-Typology-of-Payment-Methods.pdf>; and Spector J.M., Studebaker B., and Menges E.J. (2015). Provider Payment Arrangements, Provider Risk, and Their Relationship with the Cost of Health Care. Available at the Society of Actuaries website at <https://www.soa.org/research-reports/2015/2015-provider-payments-arrangements-risk/>.

funding from a variety of sources, including per-member-per-month payments from insurers, their own cash reserves, capital markets, and investment funding from companies that give providers tools and resources to engage in population health management. Irrespective of their source, these initial infrastructure payments should be designed to enable early-stage providers to move into and succeed in Category 2C arrangements (pay-for-performance) by providing high quality health care for their patients. For example, CMS' Multi-Payer Advanced Primary Care Practice model provides Category 2A infrastructure payments for primary care practices to transform into patient-centered medical homes (PCMHs). Similarly, Aetna's PCMH Recognition Program provides a per-member-per-month fee to support investments in care coordination and quality of care.¹³

Certain types of providers face structural constraints and will require extensive technical and financial support to move into and beyond Category 2C arrangements. For example, some providers have difficulty accessing debt markets, cash reserves, and other sources of infrastructure funding needed to initiate the transition to APMs. Other providers lack experience with population health management, face geographic barriers to care integration and coordination, or do not care for enough patients to adequately manage clinical risk. In general, providers who face structural constraints tend to be physicians in solo and small group practices, small and medium-sized primary care practices, rural providers, and safety net providers.

Some providers facing structural constraints will be able to undergo this transformation on their own, in a way that meets their needs and the needs of their patients. New organizations are emerging which provide management services capabilities to some of these clinical practices. There are many options for practices to come together and form partnerships that support shared infrastructural investment and financial risk, which will improve care and enable success in Category 2C and more advanced payment arrangements. For example, providers can form regional collaboratives to share delivery infrastructure and launch joint care coordination and quality improvement initiatives. Providers can also enter into gain-sharing arrangements with companies that specialize and invest in population health management. In addition to providing practices with investment capital for infrastructure development, these types of companies provide practice management support, in the form of data analytics, assistance with practice transformation, and resources to improve care integration and coordination. In return for investments and technical assistance, these companies share in the financial gains the practices produce, which further aligns payers and purchasers around value-based (as opposed to volume-based) incentives for care delivery. Furthermore, smaller provider organizations can join together to achieve panel sizes large enough to allow providers to assume clinical risk they are able to manage. This can be accomplished by entering into contracts with population health management organizations, and in the future it could be accomplished through the formation of "virtual groups," such as those that will be available in CMS' Merit-Based Payment System and CareFirst's PCMH program. Both of these options provide a pathway for small groups to aggregate and receive collective score accountability (even though they may not share in the management of a common group of patients). Irrespective of how it is accomplished, moving structurally constrained providers (especially safety net providers) into Category 3 and 4 APMs

¹³ ASPE. (2016). Examples of Health Care Payment Models Being Used in the Public and Private Sectors. pp. 60-63. Available at <https://aspe.hhs.gov/system/files/pdf/208761/ExamplesHealthCarePaymentModels.pdf>.

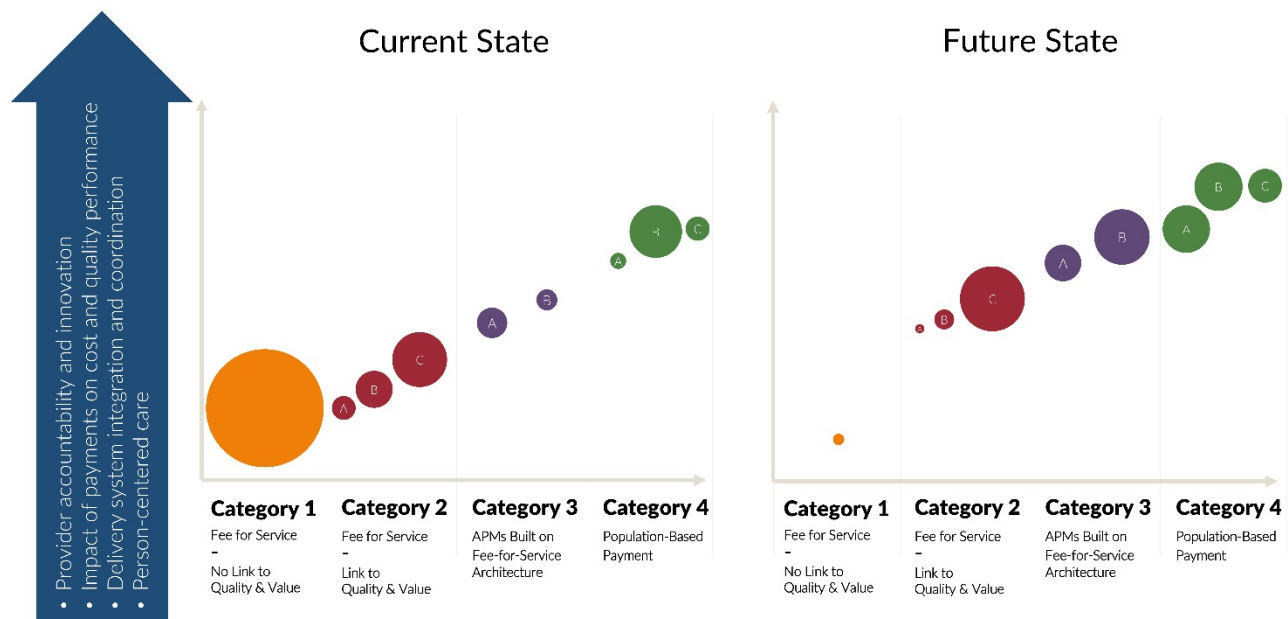
will be critical for achieving the transformations necessary to bend the cost curve and meet the triple aim. Therefore, it will be important to address barriers that today may seem insurmountable.

In addition to steps providers can take on their own, impactful reforms to the fee schedule would go a long way toward accelerating the pace of payment and delivery reform. Assigning values to services (particularly primary care services) that are based on a true indication of their impact over the long term would considerably benefit structurally constrained providers. In particular, primary care plays a critical role in achieving efficiencies for the health care system as a whole, but is undervalued in current FFS; this problem will not be solved by simply adding more codes for services such as chronic care management or behavioral health. Reforming fee schedules is important because FFS is a vital component of many APMs, which would also benefit from a reformed fee schedule.

For some structurally constrained providers (i.e., providers facing the structural constraints described above), Category 2C arrangements may support continuous delivery system improvement and therefore constitute an ultimate payment reform destination. For example, Category 2C payments may be ideally suited for driving increases in underutilized preventive services.

However, for providers who do not face structural constraints, Category 2C should be a way station on the path to Category 3 and 4 arrangements, which offer additional opportunities to improve the management of population health and target spending on care that patients value. The Work Group believes these structural constraints are not pervasive and therefore will not constitute a barrier for the majority of providers to eventually move into Categories 3 and 4, as illustrated below in Figure 3.

Figure 3: Payment Reform Goals



* Note: The values presented in the above “current state” graphic are based on available data on private plans from Catalyst for Payment Reform and Medicare FFS allocations. This graphic is meant to represent recommendations for how the health care system should change, and it accounts for the likely impact of Medicare’s Quality Payment Program and private initiatives. Values displayed in the graphic are not precise, and will depend on delivery capabilities, as described elsewhere in this document. The size of the various circles represents spending across various types of payment models. Payments are expected to shift over time from Categories 1 and 2 into Categories 3 and 4. Additionally and over time, APMs within a particular category will increase the extent to which payments are linked to provider accountability, enable more innovation in care, make a greater impact on quality and cost performance, increase coordination in delivery systems, and result in more value-based care.

Moving national spending into Categories 3 and 4 is critical for several reasons. First, given the already negative impact ineffective health care spending is having on businesses and the national economy, purchasers cannot be expected to indefinitely subsidize infrastructure without a return on investment in the form of improved cost and quality performance. Second, absent accountability for cost, utilization, and appropriate care, FFS is incompatible with person-centered care delivery. Category 2C payments do not incentivize providers either to efficiently distribute resources to the patients for whom improved care can lead to significant cost savings or to adopt measures to reduce the use of low-value care. Third, FFS is not conducive to the pursuit of care delivery innovations that are capable of better addressing complex issues, such as social determinants of health and care management for patients with multiple chronic conditions. This is because solutions to these types of issues require considerable coordination beyond the walls of the clinic or hospital, which cannot realistically be itemized on a fee schedule. By supporting successful initiatives to address social determinants and chronic comorbidities, value-based payments can improve, but not completely remediate, outcomes related to patients’ complexities. As illustrated in Figure 3, Category 4 APMs have the potential to give providers additional opportunities and flexibility when establishing and maintaining delivery system components that improve the value of

care (compared to Category 3 APMs). This is because Category 4 APMs provide stronger incentives to decrease costs while using quality and appropriateness-of-care measures to hold providers accountable for maintaining or improving quality standards. Category 4 APMs can also be more administratively efficient to pay providers prospectively, instead of reimbursing each individual claim and undergoing an extensive retrospective reconciliation at the end of the performance period. However, individual providers should not feel compelled to enter Category 4 arrangements if they believe doing so could adversely impact practices and patients. As discussed in Principle 6, providers should only assume as much risk as needed to maximize the value of care delivered, which means Category 3 will serve as an ultimate destination for some providers. Above all, the systemic imperative to move payments into Categories 3 and 4 will need to be balanced against individual providers' readiness to change payment and delivery models. Striking the proper balance between these potentially conflicting priorities will require considerable trust amongst all stakeholder groups, in order to move at the best pace for patients and consumers.

Principle 4: To the greatest extent possible, value-based incentives should reach providers across the care team that directly delivers care.

Payment reforms for quality improvement and cost reduction are most effective when they directly impact payments for clinicians who are principally responsible for providing care to patients. These incentives are effective because providers delivering patient care are best positioned to develop processes and practices, which drive well-coordinated, and high-value care that ultimately leads to better outcomes. For example, an ACO that is at risk for cost and quality would ideally design financial incentives for physicians and their care teams and hospitals that achieve outcomes that matter to patients. It may not always be possible to measure accurately the degree to which incentive payments reach front-line providers. Nevertheless, this should become a best practice, because making population-based payments to provider organizations that, in turn, pay care teams on an FFS basis will not harness the full potential of the incentives in the APM. This is particularly important in light of the recent growth in physician employment, because employed physicians often do not receive performance feedback directly.¹⁴

The question of how far incentive payments should reach, and whether it is appropriate for individual clinicians to receive incentive payments, raises difficult and complicated issues. On one hand, it is essential to reward clinicians who deliver high-value, person-centered care, because they are the ones who work directly with patients to achieve positive outcomes. On the other hand, risk-adjustment methodologies and illness severity scales do not always sufficiently account for patient complexity, so rewarding individual providers could unintentionally encourage adverse selection against patients with complex medical needs. Additionally, when compared to financial incentives for practices or physician groups, financial incentives for individuals may not be reinvested as much in improvements to care delivery. Therefore, APMs need to carefully evaluate incentive structures for provider groups and

¹⁴ See, for example: Farmer S., Darling M.A., George M., Casale P.N., Hagan E., and McClellan M.B. (2017). Existing and Emerging Payment and Delivery Reforms in Cardiology. *JAMA Cardiology*, 2(2), 210-217.

individual clinicians to ensure that there are sufficient protections for complex patients, that individual clinicians are fairly compensated for delivering exemplary care, and that incentive payments are used to sustain delivery system transformations. Additional patient protections, such as independent oversight and robust venues for voicing patient concerns, may also be needed during the transition from FFS to population-based payment.

Principle 5: Payment models that do not take quality and value into account will not be designated as value-based. They will not be considered APMs for the purposes of tracking progress toward payment reform.

As illustrated in Figure 4, the APM Framework represents a continuum of payment approaches across four Categories. Category 1 represents FFS payment not linked to quality incentives. Categories 2 through 4 advance successively beyond traditional FFS payment. There is limited merit in moving toward population-based payments if the resulting payment models do not include incentives to deliver quality care based on current clinical evidence on how to achieve outcomes that matter to patients. Although specific recommendations about what constitutes meaningful quality measurement is beyond the scope of this paper, several general elements are critical. APMs should use harmonized measure sets that include measures of process, clinical outcomes, patient-reported outcomes, and patient experience of care. Quality measures should be appropriately adjusted for patient mix, and whenever possible the measures used should be nationally vetted and endorsed by professional organizations, the National Quality Forum, the Core Quality Measures Collaborative, and others involved in developing consensus on measure specifications and core sets. Measure sets should also be robust enough to provide a comprehensive portrait of a population's clinical and behavioral health. Measure sets should address the full spectrum of care, care continuity, and overall performance of specific models, but individual measures should be granular enough to enable patients to make informed decisions about providers and treatments. Payment models that represent some movement away from traditional FFS, but do not take quality and appropriateness into account, will be placed under the corresponding payment category and marked with an "N" to indicate "No Quality" considerations (e.g., population-based payments not linked to value will fall into Category 4N). Accordingly, such models will not be considered to represent progress toward true payment reform, and are not tracked as part of measuring the achievement of the LAN's goals.

Principle 6: In order to maximize the value of care that providers deliver and to reach the LAN's goals for payment reform, value-based incentives should be sufficiently meaningful for providers to invest in and implement delivery reforms, without subjecting providers to risk that is beyond their financial means and/or clinical scope of care.

When considering approaches to making value-based incentives meaningful for providers, it is useful to distinguish between two kinds of risk even though they are difficult to separate in practice (for further discussion, please see the description of Category 4 APMs below): *management risk* and *insurance risk*.

There is widespread agreement on three different principles about how risk should be deployed in APMs. First, individual providers should not be placed in the position of assuming insurance risk, because payers and large health systems are specifically designed to perform this function. Second, APMs can be effective stimuli for delivery system change because providers will develop and sustain innovative approaches to care delivery when they are subjected to certain levels of management risk. Third, excessive levels of management risk can lead to perverse consequences, such as the delivery of inappropriately intensive care (either too much or too little), and potential access problems if critical provider groups are forced out of business. Therefore, value-based incentives should avoid imposing insurance risk on providers, while seeking to find the optimal degree of management risk to maximize beneficial drivers of health care transformation and simultaneously minimizing counterproductive drawbacks. When striking this balance, the overarching objective should be to maximize the value of care for patients and consumers: levels of management risk should not be based on goals for payment reform that are dissociated from goals for improving care delivery.

When considering levels of management risk, it is important to consider attributes of the providers who will assume that risk. For example, compared to small providers, large providers are better equipped to manage financial risk by making service adjustments. Therefore, management risk will need to be higher for large providers to make meaningful transitions to value-based care delivery. Similarly, factors such as practice size, availability of cash reserves, provider readiness, scope of practice, and geography can all impact the amount of financial risk that providers are able to bear. Safety-net providers experience considerable volatility in their financial margins and typically have to operate without substantial cash reserves. These factors make it difficult and potentially counterproductive for safety-net providers to take on significant amounts of performance and financial risk. Practices with a large scope and diversity of care will have greater influence over the total costs of care for its population, which means they are able to assume more financial risk than practices that provide a narrower scope of care. Small and rural practices face similar constraints, in addition to the challenges associated with establishing coordinated networks of care over large geographical regions, which means they also may only be able to assume limited amounts of financial risk.¹⁵ As discussed above in the context of Principle 3, these types of

Types of risk for providers in APMs

Management or clinical risk: Potential monetary losses or gains for providers, based on quality and cost performance that providers can reasonably manage with the proper safeguards in place (e.g., risk adjustment, stop loss, and other mechanisms).

Insurance or actuarial risk: Unpredictable outcomes or losses, which result from outlier patients in a provider's panel who have unusual and expensive conditions.

¹⁵ Certain approaches to operationalizing financial risk may also impede providers' ability to assume it, irrespective of particular provider characteristics. For example, recouping savings from efficient providers too quickly can

providers may be able to contract with population health management companies and take other steps to increase the amount of performance and financial risk they are able to assume.

Irrespective of which mechanism is used, it is essential for providers to have as much flexibility as possible to determine the amount of financial risk they can assume. Contract negotiation between providers and private payers offers a suitable mechanism for flexibly selecting appropriate levels of risk for specific provider organizations. For public payers, the statutorily mandated use of rulemaking to select risk levels for all providers participating in a given payment model somewhat reduces this flexibility. However, this standardized approach is offset considerably by the wide variety of Medicare APMs that are available, which allows providers to select APMs with risk levels that are appropriate for them. In both the public and private markets, model transparency is critical, because providers cannot tailor financial risk without knowing the financial characteristics of the models in which they participate.

As providers obtain greater experience in advancing quality while managing costs, and as infrastructure investments begin to generate cost savings, it may be desirable to increase performance and financial risk. However, decisions to do so should be based on the performance and stability of health care delivery systems, and not dictated solely by economic imperatives to decrease costs.

Categories in the APM Framework are drawn around qualitatively different approaches to risk, and provider risk increases from one category to the next. Nevertheless, the Framework does not consider the precise, quantitative level of risk within each qualitative approach because there is not a “right” level of risk or reward that will maximize value for all providers. For example, a 10% shared-savings arrangement is classified the same as a 2% shared-savings arrangement.

Principle 7: For tracking purposes, when health plans adopt hybrid payment models that incorporate multiple APMs, the payment dollars will count toward the category of the most dominant APM. This will avoid double counting payments through APMs.

A particular payment model may utilize several APMs concurrently, especially as the model is evolving. For example, an ACO may utilize a shared-savings model in years one and two along with nominal pay for performance incentives, and then transition to a shared-risk model in year three. To track progress in such hybrid cases, the entire payment model will be placed in the category that best captures the “dominant” APM (in this case, shared savings for years one and two, and shared risk in year three). It is also possible that bundled payments may be used within upside/downside risk and population-based payment models, and that a PCMH may be supported by FFS-based care coordination fees, pay for performance, and shared savings. In these and other scenarios, payment dollars will count toward the most dominant APM in use, meaning the APM to which the greatest amount of incentive payments are directed. In classifying APMs on the basis of their constituent payments, it is important to note that

disincentivize efforts to generate such savings. Similarly, short contract cycles can have the effect of disincentivizing long term investments in preventative care, which can yield significant improvements in health outcomes and cost savings over the course of decades.

when incentive payments are linked to an FFS architecture (e.g., bonuses of quality in Category 2C or shared savings payments in Category 3A), the most advanced incentive payment and FFS payment are considered together to determine which payment is dominant. For example, if 40% of payments in an APM entail FFS with a link to quality, and 60% of the payments are population-based, then the APM would be classified in Category 4. Similarly, an APM that includes a shared-savings component will be considered 3A, even if the shared-savings payment is less than the payment for quality.

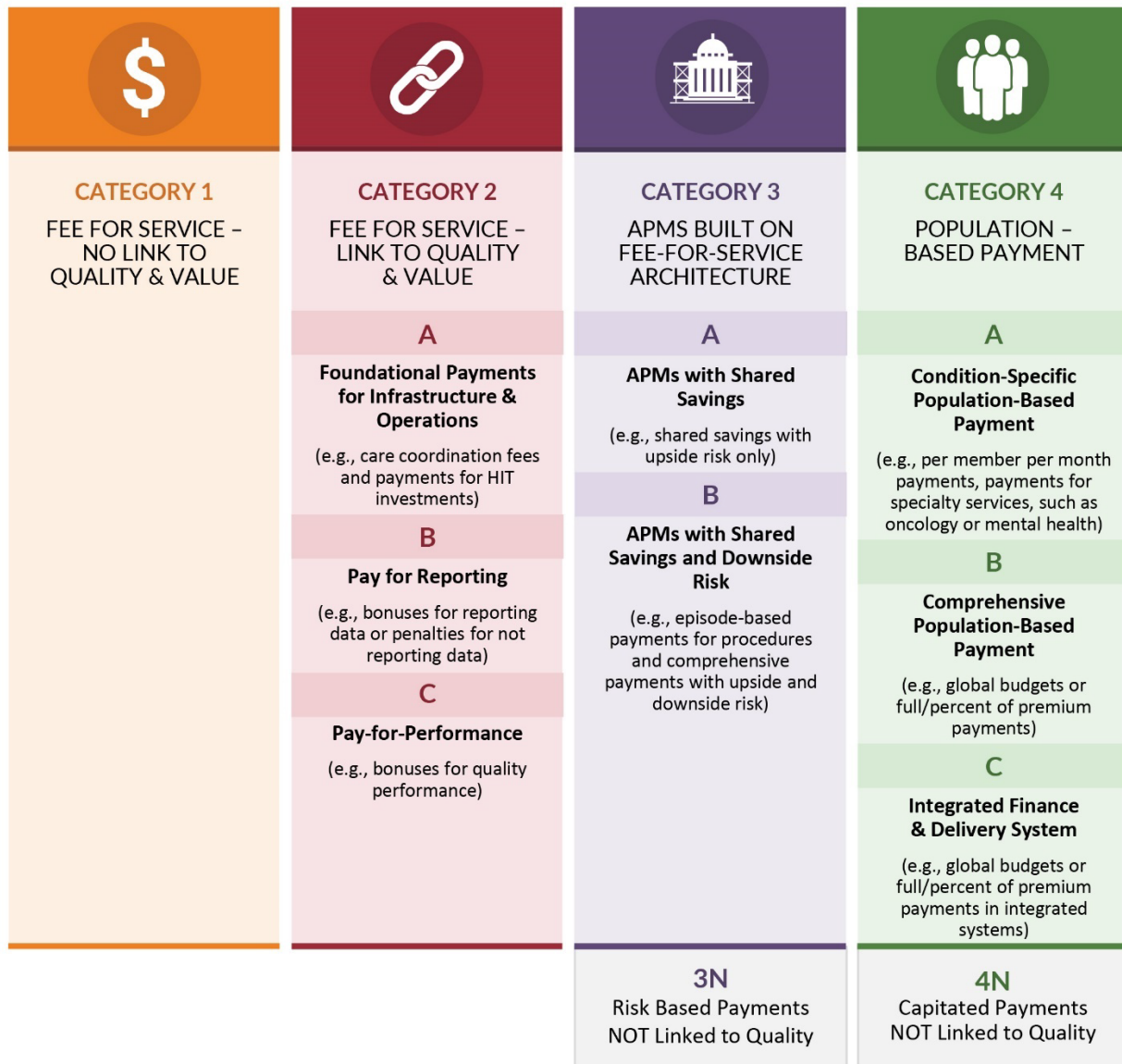
Principle 8: Centers of excellence, patient-centered medical homes, and accountable care organizations are delivery models, not payment models. In many instances, these delivery models have an infrastructure to support care coordination and have succeeded in advancing quality. They enable APMs and need the support of APMs, but none of them are synonymous with a specific APM. Accordingly, they appear in multiple categories of the APM Framework, depending on the underlying payment model that supports them.

Consistent with the mission of the LAN, the scope the APM Framework is limited to payment models, as opposed to delivery models. Because centers of excellence (COEs), PCMHs, and ACOs are delivery models that can accommodate a wide variety of payment arrangements, they are listed in the APM Framework according to their underlying payment arrangement. For example, a PCMH that participates in a shared-savings/risk model will be classified in Category 3, but a PCMH that receives population-based payments linked to value will be classified in Category 4. Although PCMHs and ACOs are commonly understood to be associated with risk-sharing payment models, clear distinctions should be maintained between concepts that describe payment models and those that describe delivery models. At the same time, these delivery models have been developed with the goal of driving care coordination and delivery improvements, and will enable more advanced payment models while at the same time requiring more advanced payment models to succeed.

The APM Framework

The APM Framework is depicted in Figure 4. The Framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the Framework captures a continuum of clinical and financial risk for provider organizations. The following discussion identifies the organizing principles that serve as the foundation for each Category, explains how the Categories are differentiated, and highlights examples of APMs in each Category.

Figure 4: The Updated APM Framework



① Fee for Service with No Link to Quality & Value (Category 1):

Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1. This is because DRGs are used to reimburse a group of services delivered within a hospitalization, and while DRGs drive efficiencies in inpatient care, hospitals typically bill DRGs in much the same way physicians bill services that are paid on a fee schedule. In both instances, the provider's incentive may be to bill for additional services because they are paid more for more volume.

Payments in Category 1 are distinguished from those in Category 2 in that the latter incentivizes infrastructure investments and/or involves some method of reporting or assessing the quality of the care delivered. Unlike payments made in Category 1, payments made in Category 2 are influenced by whether a provider invests in infrastructure, reports quality data, or achieves quality targets.

② Fee for Service Linked to Quality & Value (Category 2):

Payment models classified in Category 2 utilize traditional FFS payments (i.e., payments made for units of service), but these payments are subsequently adjusted based on infrastructure investments to improve care or clinical services, whether providers report quality data, or how well providers perform on cost and quality metrics. In addition to their capacity to stimulate and focus quality improvement initiatives, investments in quality performance assessment are also valuable because they can drive the development and expansion of health information technology (HIT).¹⁶

In certain cases, such as vaccinations and colonoscopies, FFS appropriately incentivizes increased utilization of important services. In these cases, linking FFS payments to quality indicators (e.g., measures that reinforce the right care at the right time) can be an ideal arrangement. However, for the majority of services, Category 2 should be used to smooth the transition into Category 3 and 4 APMs, and spur the delivery system improvements these payments enable.

The Work Group has split Category 2 into subcategories A, B, and C, as outlined below:

- Payments placed into **Category 2A** involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics. For example, payments designated for staffing a care coordination nurse or upgrading to electronic health records would fall under Category 2A. Because investments in these and similar delivery enhancements will likely improve patient experience and quality of care, these types of FFS or per-member-per-month (PMPM) payments are considered an important—though preliminary—step toward payment reform.

¹⁶ Although the Work Group was not tasked with developing specific recommendations on HIT or data sharing, it believes that providers should invest in interoperable systems; that administrative reporting requirements should be minimized as much as possible; that patients and caregivers should have free and ready access to patient records; and that HIT should be used to maintain patient registries and contribute to the development of clinical measures and guidelines. For additional guidance on how to approach data sharing in population-based payment models, see: LAN (2016). Accelerating and Aligning Population-Based Payment Models: Data Sharing. Available at <https://hcp-lan.org/groups/pbp/ds-final-whitepaper/>.

- Payments placed into **Category 2B** provide positive or negative incentives to report quality data to the health plan and—preferably—to the public. Providers may have initial difficulties reporting clinical data accurately. Participation in a pay-for-reporting program therefore gives providers an opportunity to familiarize themselves with performance metrics, build internal resources to collect data, and better navigate a health plan’s reporting system. Because pay-for-reporting does not link payment to quality performance, participation in Category 2B payment models should be time limited and will typically evolve into subsequent categories.
- Payments are placed into **Category 2C** if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. For example, providers may receive higher or lower updates to their FFS baseline, or they may receive a percent reduction or increase on all claims paid, depending on whether they meet quality goals. In some instances, these programs have an extensive set of performance measures that assess clinical outcomes, such as a reduction in emergency room visits for individuals with chronic illnesses or a reduction in hospital-acquired infections. Payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets, but may account for performance on a more limited set of utilization measures.

As the evaluation literature demonstrates, Category 2A and 2B payments, for HIT and other infrastructure needed to assess and improve quality performance, are often insufficient on their own to catalyze significant delivery transformations.¹⁷ Providers should therefore use Category 2A and 2B payments as an “on ramp” to participation in subsequent categories. Providers will transition into Category 2C in different ways. In the private sector, few payment plans support pay-for-reporting arrangements, and providers often move directly into pay-for-performance models. By contrast, Medicare pay-for-reporting programs typically precede and serve as the foundation for pay-for-performance programs in the same facility setting. Irrespective of how the transition occurs, it is important for providers to move quickly into Category 2C arrangements.

Payments that fall under Category 2 are distinguished from those that fall under Category 3 in two respects. First, Category 2 payments do not involve arrangements in which providers are rewarded for providing appropriate care or penalized for insufficiently reducing low-value care (e.g., shared savings or shared losses based on established cost targets). Second, FFS-based payments in Category 3 reflect, to a greater degree, care provided longitudinally, such that multiple providers are responsible for the cost and quality associated with a particular set of procedures or services. By contrast, Category 2 payments are typically limited to specific providers.

③ *APMs Built on Fee-for-Service Architecture (Category 3):*

Payment models classified in Category 3 are based on an FFS architecture, while providing mechanisms for the effective management of a set of procedures, an episode of care, or all health services provided for individuals. To accomplish this, Category 3 payments are based on cost (and occasionally utilization) performance against a target, irrespective of how the financial or utilization benchmark is established, updated, or adjusted. Additionally, payments in Category 3 are structured to encourage providers to deliver effective and efficient care. Episode-based and other types of bundled payments encourage care coordination because they cover a complete set of related services for a procedure that may be

¹⁷ See, for example: Mendelson A., et al. (2017). The Effects of Pay-for-Performance Programs on Health, Health Care Use, and Processes of Care: A Systematic Review. *Annals of Internal Medicine*, 166, 341-354.

delivered by multiple providers. Clinical episode payments fall into Category 3 if they are tied to specific procedures, such as hip replacement or back surgery.

Due to the potential that providers may curtail necessary care to meet explicit cost and/or utilization targets in Category 3 APMs, it is essential for these APMs to include safeguards that go beyond the standard types of quality measures used in Category 2 APMs. Accordingly, Category 3 APMs must hold providers financially accountable for performance on

available measures of “appropriate care.” In this context, appropriate care is delivered when patients receive the right care at the right time, in the right place, and at the right intensity. Appropriate care adheres to evidence-based guidelines and comparative effectiveness research; it avoids unnecessarily costly, harmful, and unnecessary procedures; its intensity is commensurate with patients’ goals, prognoses, and needs; and it reflects the outcome of shared decision-making among patients, their caregivers, and their clinicians. Several organizations and initiatives, including the Agency for Healthcare Research and Quality (AHRQ), the [Choosing Wisely campaign](#), the National Academy of Medicine, and AcademyHealth working with the American Board of Internal Medicine, have further developed this concept of appropriate care by compiling lists of low-value procedures and “never events,” by investigating the root causes of low-value care, by designing decision-support tools to promote appropriate care, and by designing measures to assess rates of low- and no-value care. Some of the many topics used to measure appropriate care include preventable hospital admissions, unnecessary imaging, documentation of shared-decision-making and patient goals for end of life care, adherence to clinical guidelines for pre-term labor and delivery, appropriate use of medications, and rates of never events. Although cost (and/or occasionally utilization) performance is the distinguishing component of Category 3 APMs, Category 3 payments hold providers accountable for this wider range of activities and outcomes. This is consistent with the notion that cost saving on its own is not an appropriate goal for health care reform; rather, the goal is to generate cost savings by reducing the utilization of care that provides little to no value for patients.

Measures of “Appropriate Care”

Appropriate care avoids wasteful tests and procedures that provide no benefit to patients, involves a high degree of care coordination to ensure efficient delivery, and encompasses everything patients need to achieve their personal health-related goals. Measures of appropriate care are essential for Categories 3 and 4 APMs to ensure that providers are incentivized to reduce/eliminate only care that is wasteful and potentially harmful for patients.

All Category 3 payments evaluate providers against financial benchmarks and, occasionally, utilization targets. The Category is further subdivided as follows:¹⁸

- In **Category 3A**, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers

¹⁸ Please note that this definition of a Category 3 APM has been revised in the 2017 APM Framework Refresh. Please see [Appendix A](#) for additional details.

do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met.

- In **Category 3B**, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met.

Most ACO arrangements today can be placed into either Category 3A (most often) or Category 3B, depending on whether the underlying risk arrangement includes only upside shared savings or both upside shared savings and downside risk for providers. These and other Category 3 arrangements will advance clinical integration and affordability to a greater extent than payments in Category 2, because accountability for reductions in low value care provides stronger incentives to manage health care costs and improve care coordination across the span of care.

The most important distinction between Category 3 and Category 4 payments is that the latter involve a single, predominantly prospective payment that encompasses a broad array of services, whereas providers participating in Category 3 models continue to be paid on an FFS basis with retrospective reconciliation after the period of performance. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the TCOC for treating a primary (typically chronic) condition (e.g., diabetes or cancer), a more limited set of specialty services (e.g., primary care or behavioral health), or comprehensive care for an entire population. By contrast, payments for a more limited set of services or procedures (e.g., knee and hip replacement) are classified as Category 3, even if they are population-based and patient-centered (e.g., paid for prospectively and include accountability for patient-reported outcomes). For example, a prospective, population-based primary care model would be classified in Category 4A, but a population-based bundled payment for maternity care would be classified as a Category 3B because it only addresses one aspect of a person's care and health. Similarly, population-based clinical episode and bundled payments that are tied to conditions (e.g., diabetes or cancer) fall under Category 4, whereas clinical episode payments tied to procedures (e.g., hip replacement or back surgery) fall under Category 3, even if they are paid prospectively. As such, Category 4 payments are more person-focused, insofar as they include stronger incentives to promote health and wellness throughout the care continuum.

④ *Population-Based Payment (Category 4):*

Payment models classified as Category 4 involve prospective, population-based payments, structured in a manner that encourages providers to deliver well-coordinated, high-quality, person-centered care within either a defined scope of practice (4A), a comprehensive collection of care (4B), or a highly integrated finance and delivery system (4C). For the same reasons as Category 3, Category 4 APMs require accountability for measures of appropriate care to provide additional safeguards against incentives to limit necessary care. Absent this accountability, APMs that use prospective, population-based payments will be classified in Category 4N.

Payments within Category 4 can be used to cover a wide range of preventive health, care coordination, and wellness services, in addition to standard medical procedures typically paid through claims, and this flexibility makes it easier for providers to invest in foundational and innovative delivery system components. Additionally, replacing the volume-based incentives of FFS with prospective, population-based payments creates stronger incentives for providers to maximize quality within a budget. Taken

together, these mutually reinforcing characteristics of Category 4 payments – both the freedom to practice medicine without having to rearrange care delivery to meet strict reimbursement requirements, and the incentives to maximize the quality and efficiency of care delivery – hold special promise for providers and patients who are able and willing to participate in them.

Despite the promise of Category 4 APMs, it is important to recognize that it is very difficult to limit providers’ exposure to insurance risk in these payment arrangements. When designing Category 4 APMs, it is therefore essential to recognize that providers outside of integrated finance and delivery systems are unlikely to have the administrative capabilities or risk-based capital to assume insurance risk. Certain safeguards can be taken to minimize the introduction of insurance risk into population-based payment models. First, these models will need to be carefully risk-adjusted to account for patient case-mix. Second, the models will need to “carve out” payments for essential yet extraordinarily expensive or random events, which should not be attributed to the accountable provider (e.g., in the case of patients needing a heart transplant soon after they are attributed to a provider organization). Third, stop-loss mechanisms should be put into place in order to protect providers against unexpected cost increases for warranted care (e.g., the recent entry of expensive but effective pharmaceuticals), as well as other catastrophic, unpredictable events (e.g., epidemics of infectious disease).

Category 4 is subdivided into subcategories A, B, and C, as outlined below:

- **Category 4A** includes bundled payments for the comprehensive treatment of specific conditions. For example, bundled payments for cancer care fall under Category 4A if providers are responsible for the total cost and quality of care for a patient, rather than covering, for example, only chemotherapy payments. Additionally, prospective payments are classified in Category 4A if they are prospective and population-based, and also cover all care delivered by particular types of clinicians (e.g., primary care and orthopedics).
- Payments in **Category 4B** are prospective and population-based, and they cover all an individual’s health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct.
- Payments in **Category 4C** also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization. In some cases, these integrated arrangements consist of insurance companies that own provider networks, while in other cases they consist of delivery systems that offer their own insurance products. To be effective, the finance and delivery arms will need to work in tandem to ensure that effective delivery investments are being made and that incentives and strategies within the organization are properly aligned. Additionally, it is important to note that when integrated lines of business comprise a portion of a company’s portfolio, only the integrated payments count toward Category 4C.

Integrated Finance and Delivery Systems

Integrated finance and delivery systems bring together insurance plans and delivery systems within the same organization. These systems may include joint ventures between insurance companies and provider groups, insurance companies that own provider groups, or provider groups that offer insurance products.

Category 4A may be an appropriate endpoint when smaller provider organizations with targeted skill sets deliver patient care that revolves around the management of chronic conditions, such as cancer or heart disease. Nevertheless, in many instances it is preferable to compensate providers for maintaining health and managing illness for an entire population, rather than compartmentalizing and subdividing payments into distinct conditions. Additionally, condition-specific payments should, in time, become part of a comprehensive approach to improving health and reducing costs for an entire population, such that Category 4A arrangements evolve into Category 4B arrangements. Based on interviews with companies involved in integrated finance and delivery arrangements, it appears that Category 4C payments have the potential to carry significant advantages. For example, these arrangements can expedite investments in crucial care delivery infrastructure, such as population health management support, programs to improve care coordination and care transitions, HIT, and community health initiatives. Additionally, highly integrated arrangements can provide important foundations for organizational cultures and strategies directed toward population health management, and they can create stronger alignments between physician groups and hospitals. On the other hand, widespread growth of integrated finance and delivery systems could potentially result in market consolidation, which could, in turn, lead to decreased choices and lack of access for patients, as well as increased costs. Evidence on the effectiveness of highly integrated systems is still in its early stages, and preliminary results are inconclusive. Therefore, Category 4B and 4C APMs should be considered equally effective vehicles for increasing the value of care through delivery system improvements.

Taken together, Categories 4A, 4B, and 4C represent the furthest departure from traditional FFS payments, while they simultaneously ensure that providers possess the strongest possible incentives to deliver high-quality and efficient care. Nevertheless, as discussed above, Category 4 payments are not necessarily appropriate for all providers and markets. To be successful, providers will necessarily travel at different paces and along different trajectories in the collective journey of health payment and delivery reform. But over time, Category 4 APMs will offer an appealing destination for more and more providers and other stakeholders in the health care system.

Conclusion

As set forth in this document, transitioning from FFS to population-based payments is critical for health care transformation.

Keeping in mind the underlying principles, the APM Framework provides a high-level mapping of payment approaches, as well as a pathway for payment reform and a foundation for measuring progress. These tools should be useful and enduring for all stakeholders as they navigate the health care ecosystem.

Although the Framework identifies and encompasses all models of payment reform, new developments in the health care sector may result in a need for further refinement in future years. Nevertheless, the Framework should be robust enough to accommodate foreseeable changes and become the overarching framework for discussing and evaluating payments in the U.S. health care system. The LAN intends to continue compiling and periodically releasing case studies of payment models. (See [APM Framework White Paper Addendum](#).) This is important because it will disseminate lessons learned and provide the nation with models to consider as public and private plans align around common payment approaches.

Stakeholders and the APM Framework

Patient Advocacy Groups can use the APM Framework to understand the context behind plan and benefit design so they can identify and communicate desirable elements and participate in decisions about how to design payment plans and delivery systems.

Providers can use the APM Framework to appreciate the types of payment reforms underway; to achieve a better understanding of where they are situated; to begin to conceive of where they might like to end up; and, most importantly, to plan for the future.

Payers can use the APM Framework to drive payment and contracting models and as a financial tool to track spending and the distribution of members/beneficiaries and providers. This is crucially important because adopting a common classification scheme represents a first step toward the alignment of payment approaches.

Purchasers can use the APM Framework to engage and educate their employees about the health insurance landscape and to share information for population-based plans, along with the information on the safeguards and benefits that would motivate them toward enrolling in such plans.

Appendix A: Category 3 “Incentive-at-Risk” APMs

Because MACRA and the LAN APM Framework share the goal of transitioning away from FFS and into APMs that achieve better outcomes at lower costs, comparisons between the two systems for designating APM advancement can illuminate alternative ways to effectively tether payment to value, and take better account of variation among providers. Given that CPC+ Track 1 was the only Advanced APM (by MACRA standards) that was not classified as a Category 3 or 4 in the original framework, the Advisory Group closely examined how it used payment to hold providers accountable for quality and cost. As a result of these discussions, the Advisory Group determined that payments in CPC+ Track 1 drive value in a manner that is functionally equivalent to shared-savings arrangements in Category 3A. The Advisory Group therefore decided to classify CPC+ Track 1 and other “incentive-at-risk” APMs in Category 3A.

Incentive-at-risk APMs give providers the opportunity to share in a portion of the savings they generate as a direct result of meeting utilization targets. These APMs possess two important characteristics. First, utilization measures that provide very strong proxies for TCOC take the place of formal financial benchmarks. Second, incentive payments for performance on utilization measures are used to reallocate derived savings (if any) between payers and providers. Because incentive payments (as opposed to payments made through the FFS architecture) are at risk for utilization performance, incentive-at-risk APMs are classified in Category 3A (as opposed to Category 3B). These incentive-at-risk APMs are particularly appropriate for smaller practices and other situations in which upfront investment might be necessary to provide adequate resources for providers to undertake care transformation, and in which it is not ideal to hold providers directly accountable for meeting benchmarks based on TCOC.

Primary care in the Medicare population involves a unique set of circumstances that make incentive-at-risk APMs effective vehicles for improving quality while decreasing costs. First, a greater proportion of TCOC for the Medicare population is driven by fewer categories of health care utilization. Emergency department usage and inpatient stays account for roughly 40% of TCOC in the Medicare population, while these categories account for only about 20-25% of TCOC in the population covered by commercial insurance. This means that inpatient utilization measures provide more robust proxies for TCOC with fewer utilization targets for practices to track and work to achieve. Primary care practices also have the capability to focus on and influence these measures to a much greater degree than some other cost drivers under an expansive TCOC benchmark. CPC+ practices may also improve utilization performance by partnering with value-oriented specialty providers who appropriately use tests and interventions.

Primary care providers also tend to practice in small groups, and their patient panels are typically too small to manage the financial risk of outlier patients’ disproportionate impact on TCOC. Additionally, Medicare’s previous experience with its Comprehensive Primary Care Classic model suggested that although the formation of “virtual groups” achieved panel sizes large enough to mitigate this risk and allowed for cost accountability, pooling patients across providers in a region appeared to dampen the driving force for cost savings. This may have been attributable to the diffusion of responsibility among multiple practices within a virtual group. Additionally, behavioral economics research strongly supports the notion that receiving an uncertain amount of incentive payments after a period of performance

would be less motivational than providing defined payments up front and reconciling them after the fact, because providers are more likely to be motivated by potential losses than potential gains.¹⁹

Track 1 of Medicare's CPC+ model takes these unique factors into consideration in the design of a Category 3A arrangement that generates cost savings by tying incentive payments to reductions in utilization. In addition to payments made through Medicare's standard fee schedule, primary care practices receive prospective care management fees (Category 2A), as well as prospective performance-based incentive payments (Category 2C). Fifty percent of the incentive payment is based on providers' performance on two utilization measures: inpatient hospitalization utilization per 1,000 attributed beneficiaries and emergency department utilization per 1,000 attributed beneficiaries. This means providers are able to share in a significant proportion of Medicare's savings from reduced hospital utilization as a result of improved care coordination or greater availability of office visits, telephone, or telemedicine consultation. Conversely, providers who perform poorly on these two utilization measures risk paying back Medicare some or all of the utilization portion of the incentive payment. Cumulatively, these payments and risk place CPC+ Track 1 in Category 3A.

Figure 5 illustrates the expected payment implications in CPC+ Track 1 when a provider maintains utilization at average levels, reduces utilization significantly more than average, or increases utilization slightly more than average.

¹⁹Please note: So long as incentive payments for performance on key utilization measures effectively create a shared-savings arrangement they will be classified in Category 3A, irrespective of whether they are made prospectively or retrospectively.

Figure 5: Impacts of Utilization on Payments in CPC+ Track 1

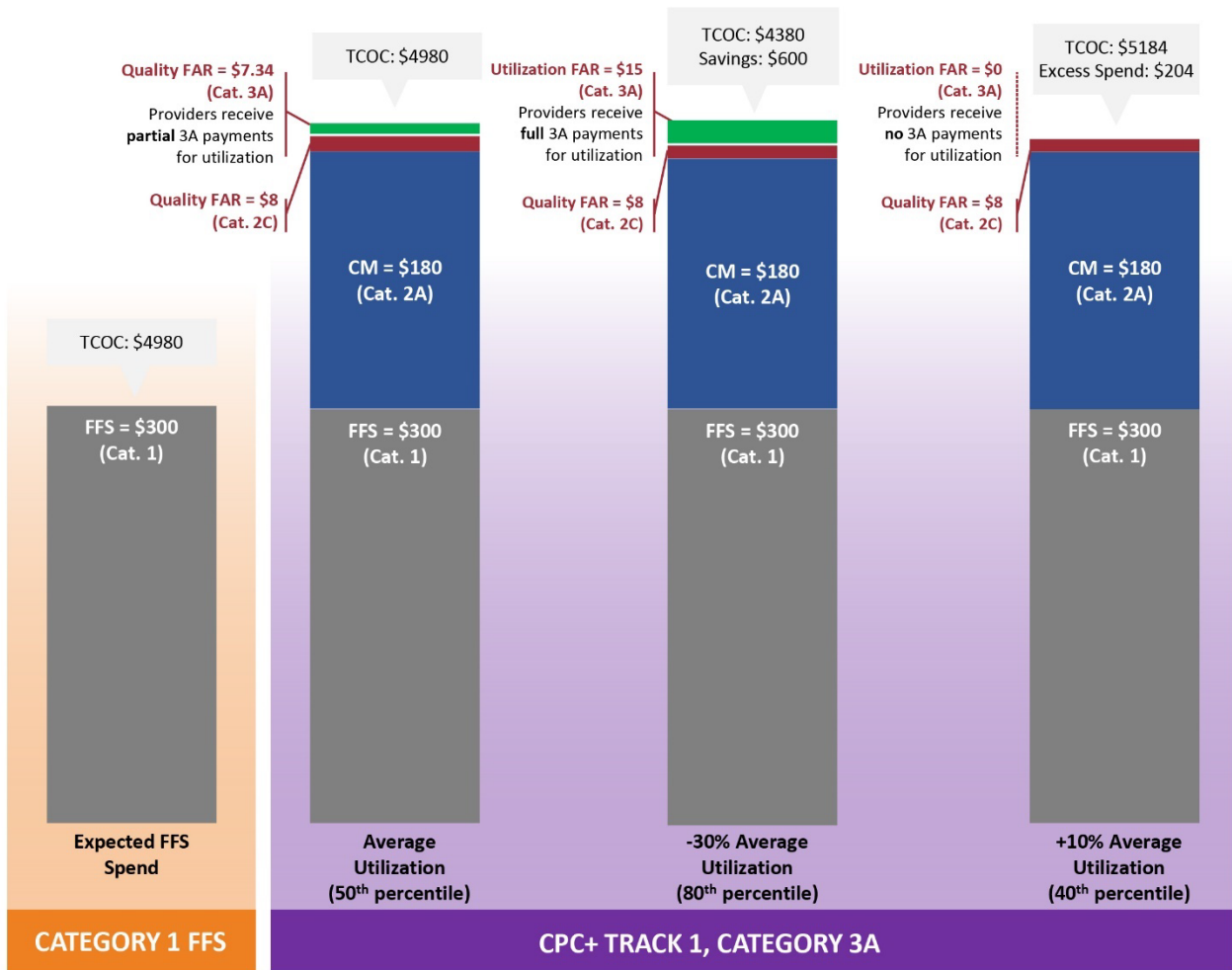


Figure 5 depicts payments in CPC+ Track 1. These numbers illustrate average annualized, per-beneficiary Medicare payments for primary care services. In Track 1, Category 2A care management (CM) payments are intended to support care management activities. By contrast, Category 2C fee-at-risk (FAR) payments are prepaid and tied to quality/experience, as well as utilization performance. These FAR payments may need to be paid back.

This example assumes that providers receive FAR payments corresponding to average quality/experience performance at different levels of utilization performance. CPC+ Track 1 is a Category 3A APM because providers must clear quality gates before becoming eligible to keep FAR payments, and because performance on utilization measures directly results in savings that are shared with providers.

It is important to note that reducing utilization (especially hospital utilization) is not intrinsically indicative of increased value, as this could theoretically be achieved through reductions in necessary care. To avoid the unintended consequences of rewarding reductions in utilization alone in CPC+, CMS

- 1) requires practices to meet quality benchmarks applicable to their entire practice population (not limited to Medicare beneficiaries) before they can keep a utilization incentive payment;
- 2) actively monitors claims activity to detect potentially unwarranted reductions in utilization; and
- 3) employs contractual agreements with providers that include additional patient protections.

Just as with TCOC reduction incentives, these and other safeguards are essential for incentive-at-risk APMs that use utilization as a proxy for cost, in order to ensure providers either are incentivized to only reduce unnecessary care or achieve efficiencies and prevent avoidable hospitalization and emergency room visits through care coordination and access.

Appendix B: APM Framework Refresh Advisory Group Members and Staff

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CMS Alliance to Modernize Healthcare (CAMH) Staff

The MITRE Corporation, as the operator of the CAMH Federally Funded Research and Development Center (FFRDC), convenes and independently manages the LAN on behalf of CMS. MITRE is a not-for-profit organization operating strictly in the public interest. Catalyst for Payment Reform is an independent, nonprofit corporation working on behalf of large employers and other health care purchasers to catalyze improvements in how health services are paid for and to promote higher-value care in the United States.

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Appendix D: Other LAN Content

The LAN has written a suite of papers to help align payment reform efforts. The papers referred to in this appendix include recommendations on the design of population-based payments and clinical episode payments, as well as a toolkit on data sharing for alternative payment models. These recommendations are the result of input from a wide variety of persons and organizations that have either direct experience implementing payment reform or deep experience in the health care field.

CAMH convened two Work Groups, the Population-Based Payment (PBP) Work Group and the Clinical Episode Payment (CEP) Work Group, to develop recommendations for the implementation of these types of payment models. Their recommendations focus on specific design elements, many of which overlap and upon which there was much common agreement even as the Work Groups deliberated separately. Each of the four PBP White Papers described below focuses on a separate design element (financial benchmarking, patient attribution, performance measurement, and data sharing) in a PBP context. In a PBP arrangement, an accountable entity takes responsibility for the care for a defined population over a specified period of time (typically a year) for the full continuum of care. These design elements should be considered as a whole for effective PBP implementation as they interact considerably.

The CEP Work Group also divided their recommendations into design elements, but included several operational considerations along with 10 design elements. The recommendations were organized in chapters in the comprehensive White Paper and applied to three clinical areas where clinical episode payment models would be most effective: elective joint replacement, maternity care, and coronary artery disease (CAD). While the clinical focus is more targeted here, the underlying concepts for setting the episode price (including the level and type of risk), defining the population and services included in the episode, patient engagement and quality metrics, and the data infrastructure are similar to those of the four PBP White Papers.

The LAN convened the Data Sharing Requirements Initiative (DSRI) to gather information on recent approaches and experiences building data-sharing capacity. The DSRI leadership team incorporated input from interviews with organizations engaged in data sharing in support of APMs, and reviewed material on critical developments in technology and policy. The resulting toolkit is meant to be of practical value for those planning and developing future data sharing activities.

Below are the links and a brief overview of each of the papers written by the LAN Work Groups. By reading the full suite of products, readers will be better able to make decisions about the most effective payment model(s) to implement and the key issues to consider when designing those models. Visit the [LAN website](#) for an up-to-date list of LAN [work products](#).

Population-Based Payment (PBP) Models:

Accelerating and Aligning Population-Based Payment (PBP): [Patient Attribution](#)

The Patient Attribution White Paper describes the method by which patient populations are assigned to providers who are accountable for total cost of care and quality outcomes for their designated populations in a PBP model. The paper recommends that active, intentional identification, or self-reporting by patients, should be considered first. The paper also outlines nine additional

recommendations that payers and providers can use when making decisions on attribution in their PBP models.

Accelerating and Aligning Population-Based Payment (PBP): [Financial Benchmarking](#)

The Financial Benchmarking White Paper describes approaches for setting an initial benchmark and updates over time, as well as addresses risk-adjustment considerations. The White Paper discusses the need to balance voluntary participation with the movement toward convergence in a market with providers at different starting points.

Accelerating and Aligning Population-Based Payment (PBP): [Data Sharing](#)

The Data Sharing White Paper offers several guiding principles and recommendations that highlight the future development of data sharing arrangements in PBP models. The paper also outlines use cases which describe particular types of data sharing arrangements in both their current and aspirational states. The goal is to create an environment where data follows the patient and is available to stakeholders (patients, providers, purchasers, and payers) in a timely manner.

Accelerating and Aligning Population-Based Payment (PBP): [Performance Measurement](#)

The Performance Measurement White Paper offers both short-term action recommendations and a long-term vision for accelerating alignment around APMs. The paper offers a way forward that could lead to radical change in how performance is measured across the board in order to enable the implementation of effective population-based payments. The White Paper describes how to evolve from granular measurement systems of the full continuum of care, which focus on narrow and specific care processes, to more macro-level measurement systems oriented on outcomes. The paper also makes strong recommendations for immediate action steps by describing four key performance measurement principles and seven recommendations for building and sustaining a performance measurement system that supports and encourages collaboration among stakeholders.

Clinical Episode Payment (CEP) Models:

Accelerating and Aligning Selected [Clinical Episode Payment \(CEP\) Models](#)

This paper provides high-level recommendations for designing clinical episode payment models. A clinical episode payment is a bundled payment for a set of services that occur over time and across settings. The paper outlines design elements and operational considerations for three selected clinical areas: elective joint replacement, maternity care, and coronary artery disease. Recommendations are organized according to design elements and operational considerations. Design elements address questions stakeholders must consider when designing an episode payment model, including the definition, the duration of the episode, what services are to be included, and others. Operational considerations relate to implementing an episode payment model, including the roles and perspectives of stakeholders, data infrastructure issues, and the regulatory environment in which APMs must operate.

Several key principles drove the development of the recommendations across all three episodes: 1) incentivizing person-centered care; 2) improving patient outcomes through effective care coordination; 3) rewarding high value care by incentivizing providers and patients, together with their family caregivers, to discuss the appropriateness of procedures; and 4) reducing unnecessary costs to the patient and the health care system.

The recommendations are designed to speak to a multi-stakeholder audience with the goal of supporting broad clinical episode payment adoption.

[Elective Joint Replacement](#)

The elective joint replacement recommendations emphasize using functional status assessments (both pre- and post-procedure) and shared decision-making tools to determine whether a joint replacement is the appropriate treatment for a given patient.

[Maternity Care](#)

The maternity care recommendations emphasize the need for patient engagement, education, and parenting support services (in addition to clinical maternity care) to achieve a number of critical goals. These include increasing the percentage of full-term births and the percentage of vaginal births, while decreasing the percentage of pre-term and early elective births, complications, and mortality.

[Coronary Artery Disease](#)

The coronary artery disease (CAD) recommendations are based on a CAD condition-level episode, which includes a “nested” bundle for procedures like percutaneous coronary intervention (PCI) and coronary artery bypass graft (CABG). The recommendations emphasize overall condition management designed to reduce the need for procedures, and strong coordination and communication between the surgeons who perform cardiac procedures and the providers who deliver follow-up and long-term cardiac care.

Primary Care Payment Models (PCPM):

[Accelerating and Aligning Primary Care Payment Models](#)

Primary care is a critical link in health care delivery. Often patients’ first point of contact with the health care system, primary care practitioners make decisions that broadly impact both patient health and total health care spending. The Primary Care Payment Model (PCPM) White Paper views primary care teams as uniquely positioned to serve as catalysts for innovative care as well as effective stewards of health care resources. The paper offers principles and recommendations for implementing PCPMs that can help overcome the barriers to effective primary care tied to traditional FFS payments based on the volume of services provided rather than the quality and value of care.

Data Sharing Requirements Initiative (DSRI):

[Collaborative Approaches to Advance Data Sharing](#)

One of the key insights from the DSRI findings is the essential role, in developing data sharing capacity, of collaboration, shared goals, and shared solutions to enable sustainable APM success. Unlike FFS payment models that largely limit accountability to a single setting (such as hospital or physician’s office), APMs require providers to understand and/or be accountable for patients across the medical neighborhood and over time. While the toolkit is not a “how to” guide, as the specifics for each organization and region differ, it will be helpful in the strategic planning process to identify the APM functions that require data sharing, to assess current capacity and barriers, and to consider strategies within and across organizations to fill gaps in necessary data sharing functionality.

Appendix E: Principles for Patient- and Family-Centered Payment

The following principles, produced by the LAN's Consumer and Patient Affinity Group, are intended to help guide the development of new payment strategies. They provide guidance and aspirational direction to ensure that we address the needs and priorities of patients and families as we transition to value-based payment. The principles rest on the conviction that consumers, patients, and families are essential partners in every aspect of transforming health care and improving health.

Consumers, patients, families, and their advocates should be collaboratively engaged in all aspects of design, implementation, and evaluation of payment and care models, and they should be engaged as partners in their own care.

The collaboration in design of payment and care models should include oversight, governance, and interface with the communities where care is delivered. At the point of care, patients and families should be engaged in ways that match their needs, capacities, and preferences. Collaborative care should be aligned with patient goals, values, and preferences (including language), and should reflect shared care planning and decision-making throughout the care continuum.

Positive impact on patient care and health should be paramount.

The central consideration in all payment design should be improving patient health outcomes, experience of care, and health equity, while also ensuring the most effective use of health care resources.

Measures of performance and impact should be meaningful, actionable, and transparent to consumers, patients, and family caregivers.

New payment models should be assessed using measures that are meaningful to patients and families. They should prioritize the use of measures derived from patient-generated data that address both care experience and outcomes. Measures should also address the full spectrum of care, care continuity, and overall performance of specific models. Measures should be granular enough to enable patients to make informed decisions about providers and treatments.

Primary care services are foundational and must be effectively coordinated with all other aspects of care.

Payment models should foster this coordination, particularly between primary and specialty care, in order to promote: optimal coordination, communication, and continuity of care; trusted relationships between clinicians and patients/families; concordance with patient goals, values, and preferences; integration of non-clinical factors and community supports; and coordination of services delivered through non-traditional settings and modalities that meet patient needs. Effective delivery and coordination of primary care services should promote better care experience, optimal patient engagement, better health outcomes, and increased health equity.

Health equity and care for high-need populations must be improved.

New payment models should foster health equity, including access to innovative approaches to care and preventing any discrimination in care. They should collect data that allow for assessment of differential

impacts and the identification and redress of disparities in health, health outcomes, care experience, access, and affordability.

Patient and family engagement and activation should be supported by technology.

New payment models should promote use of information technology that enables patients and their designated caregivers to easily access their health information in a meaningful format that enables them to use the information to better manage and coordinate their care. The technology should also enable patients to contribute information and communicate with their providers, and it should foster the patient-clinician partnership in ongoing monitoring and management of health and care.

Financial incentives used in all models should be transparent and promote better quality as well as lower costs.

Financial incentives for providers and patients should be fully disclosed so that patients and consumers understand how new payment approaches differ from traditional FFS models, and how certain incentives may impact the care providers recommend or provide. Financial incentives should be developed in partnership with patients and consumers in order to reflect how patients define value, and to reduce financial barriers to needed care and ensure that patients are not steered to lower-cost care without regard for quality.

Appendix F: About the CMS Alliance to Modernize Healthcare

The Centers for Medicare & Medicaid Services (CMS) sponsors the CMS Alliance to Modernize Healthcare (CAMH), the first federally funded research and development center (FFRDC) dedicated to strengthening our nation’s health care system. CAMH is the convener of the LAN. The CAMH FFRDC enables CMS, the Department of Health and Human Services (HHS), and other government entities to access unbiased research, advice, guidance, and analysis to solve complex business, policy, technology, and operational challenges in health mission areas. The FFRDC objectively analyzes long-term health system problems, addresses complex technical questions, and generates creative and cost-effective solutions in strategic areas such as quality of care, new payment models, and business transformation.

Formally established under Federal Acquisition Regulation (FAR) Part 35.017, FFRDCs meet special, long-term research and development needs integral to the mission of the sponsoring agency—work that existing in-house or commercial contractor resources cannot fulfill as effectively. FFRDCs operate in the public interest, free from conflicts of interest, and are managed and/or administered by not-for-profit organizations, universities, or industrial firms as separate operating units. The CAMH FFRDC applies a combination of large-scale enterprise systems engineering and specialized health subject matter expertise to achieve the strategic objectives of CMS, HHS, and other government organizations charged with health-related missions. As a trusted, not-for-profit adviser, the CAMH FFRDC has access (beyond what is allowed in normal contractual relationships) to government and supplier data, including sensitive and proprietary data, and to employees and government facilities and equipment that support health missions.

CMS conducted a competitive acquisition in 2012 and awarded the CAMH FFRDC contract to The MITRE Corporation (MITRE). MITRE operates the CAMH FFRDC in partnership with CMS and HHS, and maintains a collaborative alliance of partners from nonprofits, academia, and industry. This alliance provides specialized expertise, health capabilities, and innovative solutions to transform delivery of the nation’s health care services. Government organizations and other entities have ready access to this network of partners. This includes select qualified small and disadvantaged businesses. The FFRDC is open to all CMS and HHS Operating Divisions and Staff Divisions. In addition, government entities outside of CMS and HHS can use the FFRDC with the permission of CMS, CAMH’s primary sponsor.