

ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Final White Paper

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Alternative Payment Model Framework
and Progress Tracking (APM FPT) Work Group

For Public Release
Version Date: 1/12/2016

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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 operated by the MITRE Corporation, was asked to convene this large national initiative.

To advance this goal, the Alternative Payment Models 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 towards payment reform. Composed of diverse health care stakeholders, the Work Group has deliberated and reached consensus on many critical issues related to the classification of APMs, resulting in a rationale and a pathway for payment reform that is capable of supporting the delivery of person centered care.

Although the Work Group was not charged with developing a working definition of person centered care, it thought that it was important to do so because it views payment reform as one means for accomplishing the larger goal of person centered care. The Work Group believes that person centered care rests on three pillars: quality, cost effectiveness, and patient engagement. For the purposes of the White Paper, the term is nominally defined as follows: *high quality care that is both evidence based and delivered in an efficient manner, and where patients’ and caregivers’ individual preferences, needs, and values are paramount*. In addition, it should be noted that the opinions expressed within the White Paper are those of the Work Group Members and not of the organizations of which they are affiliated.

The Work Group is committed to the notion that transitioning the U.S. health care system away from fee for service (FFS) and towards shared risk and population based payment is necessary, though not sufficient in its own right, to a value based health care system. Financial incentives to increase the volume of services provided are inherent in FFS payments, 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, cost effective care. By contrast, population based payments (including bundled payments for clinical episodes of care) offer providers the flexibility to strategically invest delivery system resources in areas with the greatest return, enable providers to treat patients holistically, and encourage care coordination. Because these and other attributes are very well suited to support the delivery of high valued health care, the Work Group and the LAN as a whole believe that the health care system should transition towards shared risk and population based payments. The Work Group hopes the Framework will be useful in this context to establish a common nomenclature upon which progress can be discussed and measured.

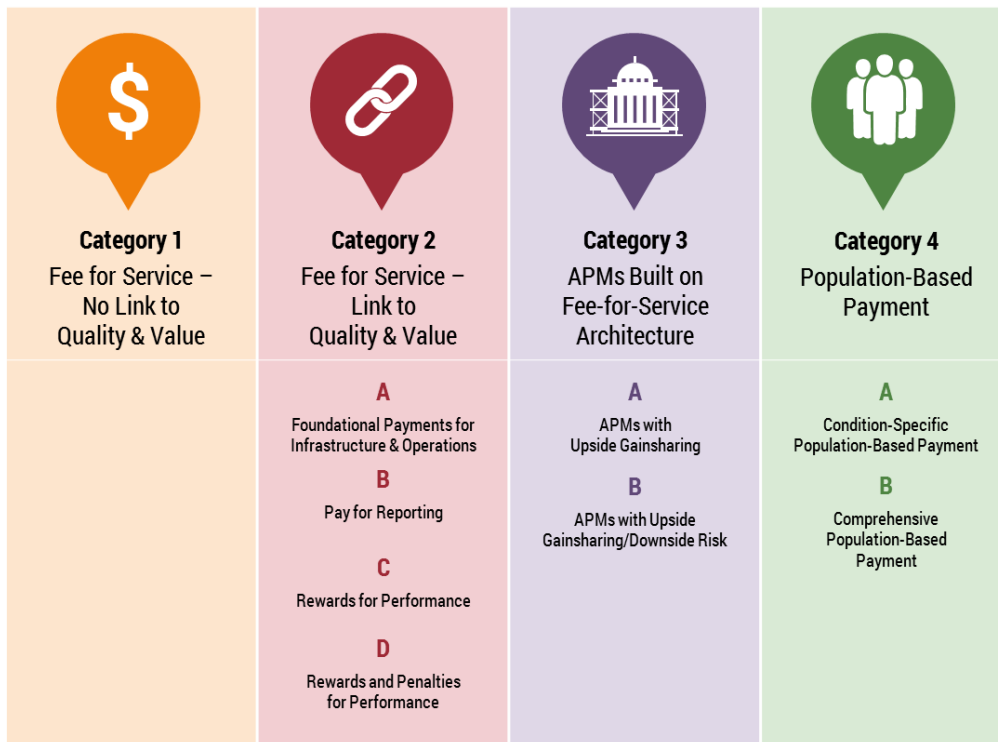
The APM Framework rests on seven principles, which can be summarized as follows:

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. The goal for payment reform is to shift U.S. health care spending significantly towards population based (and more person focused) payments.
3. Value based incentives should ideally reach the providers that deliver care.
4. 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.
5. Value based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.

6. APMs will be classified according to the dominant form of payment when more than one type of payment is used.
7. 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.

With these principles in place, the Work Group began with the payment model classification scheme originally put forward by the Centers for Medicare & Medicaid Services (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 below:

Figure 1. APM Framework (At-A-Glance)



Overview

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. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers that deliver higher quality and more affordable care. In alignment with the goals of the U.S. Department of Health and Human Services (HHS), the LAN aims to have 30% of U.S. health care payments in APMs or population based payments by year 2016, and 50% by year 2018.

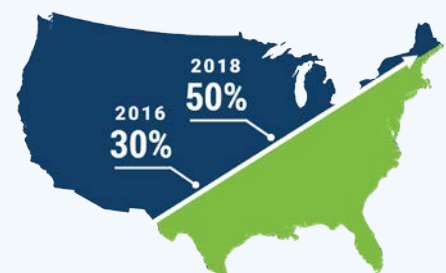
The Guiding Committee convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group (the “Work Group”) and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. health care system (the “APM Framework”). The Work Group brought together public and private stakeholders to assess APMs 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 A](#). Please note that opinions expressed within the White Paper are those of the Work Group Members not of the organizations of which they are affiliated.) The aim of the Work Group is to create a clear and understandable APM Framework, to provide a deeper understanding of payment models and how those models can enhance health and health care, and to provide examples of how public and private payment models are organized within the APM Framework.

The Work Group is aware that CMS is in the process of soliciting recommendations on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Work Group is hopeful that this White Paper will help CMS consider some of the issues involved in implementing MACRA, but stresses that providing formal recommendations on how to do so is explicitly not part of the Work Group’s charge. Although the Work Group is no longer soliciting comments on the White Paper, formal recommendations for implementing MACRA and/or other CMS programs and policies should continue to be made directly to CMS.

Health Care Payment Learning & Action Network (LAN)

To achieve the goal 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).

U.S. Health Care Payments in APMs



The Case for Reforming the Health Care Payment System

The LAN and the Work Group are unanimous in their desire to drive payment approaches that improve the quality and safety of care and the overall performance and sustainability of the U.S. health system. The Work Group, along with many other stakeholders, envisions a health care system that provides person centered care. Recognizing that the Work Group was not charged with developing a comprehensive definition of the term or its constituent components, and that these terms may encompass additional characteristics that are not captured below, the Work Group understands person centered care to mean *high quality care that is both evidence based and delivered in an efficient manner, and where patients' and caregivers' individual preferences, needs, and values are paramount*. The Work Group believes that person centered care, so defined, rests upon three pillars:

- **Quality:** This term indicates that patients receive appropriate and timely care that not only is consistent with evidence based guidelines and patient goals, but also results in optimal patient outcomes and patient experience. Ideally, quality should be evaluated using a harmonized set of appropriately adjusted process, outcome, patient reported outcome, and patient experience measures that both provide an accurate and comprehensive assessment of clinical and behavioral health, and that report results that can be meaningfully accessed, understood, and used by patients and consumers.
- **Cost Effectiveness:** This term indicates a level of severity adjusted total costs (and, when relevant, unit prices) that reflect benchmarked best achievable results, and that are consistent with robust and competitive health insurance marketplaces as characterized by the deployment of multiple affordable, attractive products across employer group, individual commercial, and government programs sectors. Care that is less expensive than expected, but that results in poor clinical outcomes, is not considered cost effective. Conversely, care that is costly but that results in dramatic improvements in patient outcomes could be considered cost effective. Affordable health care services are vital to ensuring that the nation can support investments in education, housing, and other social determinants that can independently improve population health.
- **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. Engaged patients and consumers are informed of their health status and share in their own care; they are easily able to access appointments and clinical opinions; they seek care at the appropriate site; they possess the information they need to identify high value providers and to tailor treatment plans to individual health goals; they provide ongoing feedback that providers can use to improve patient experience; they are able to obtain transparent price information about services and their value for patients and consumers; and they can 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 creation of the LAN, there is an emerging consensus among providers, payers, patients and consumers, purchasers, and other stakeholders in the health care system that efforts to deliver person centered care have been stymied, in large part, by a payment system that is oriented largely towards volume, as opposed to value for patients and caregivers. These stakeholders and the

Work Group believe that by reconfiguring payments to incentivize value, and by ensuring that valuable activities (e.g., care coordination) are compensated appropriately, providers will be able to invest in care delivery systems that are optimized for the provision of care that is more focused on patient needs. In other words, changes in payment are necessary (though insufficient on their own) to change provider behavior and drive delivery system transformations, thereby ensuring that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other payers.

The Work Group believes that shifting from traditional fee for service (FFS) payments to person focused 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 thus include accountability for the quality of care at the population level, rather than for the volume of particular services. 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 belief that these types of payment models are designed in a way that holds substantial promise. This is because person focused, population based payments give providers more flexibility to coordinate and manage care for individuals and populations. In combination with substantially reduced incentives to increase volume, and increased incentives to provide services that are currently undervalued in 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, 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, and additional office hours). This is because FFS incentivizes providers to optimize volume. As a result, FFS may at times discourage the perspective that patients require individualized and highly coordinated care. Population based payments may enable providers to develop more innovative approaches to person centered health care delivery because they reward providers that successfully manage all or much of an individual's care. Provided that safeguards are put in place 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, these innovative approaches to health care delivery stand to benefit patients and society alike. Patients may come to expect a more coordinated, more accessible, and more effective health care system, and the nation would benefit from reductions in national health care expenditures, and a healthier, more productive workforce.

The Work Group recognizes that new payment models require providers to make fundamental changes in the way they provide care, and that the transition away from FFS may be costly and administratively difficult. The Work Group also recognizes that participation in shared risk and population based payment models involves financial risk for providers, that not all provider organizations possess the capacity to successfully operate in these payment models, and that providers will need assistance to develop additional capabilities. In order to smooth and accelerate this transition, the Work Group believes that 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 population based 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, this would reduce the administrative burden of making the transition and allow investments to be applied to all patient populations, independent of payer. Aligned payments 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 Work Group

expects that 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 medical practice.

The Work Group believes that a shift to person focused, population based payments will, in concert with other reforms, result in an expansion of high value care in the United States. The Work Group recognizes the possibility that shifts in payment can result in unintended and unanticipated consequences, such as cost increases owing to provider consolidation, reduced provider willingness to exchange data, and a potential reduction in costly but effective medical services. The Work Group believes that it is therefore absolutely essential to monitor the impact of population based payment systems on patient outcomes, health care costs, and other indicators of significance to patients and other stakeholders in the health care system. The Work Group envisions the shift to person focused, population based payment as a course correcting feedback loop between innovation, implementation, and evaluation; it also anticipates that its forthcoming effort to measure progress will help accelerate this process. The Work Group is hopeful this, the first in a series of LAN publications, will help align stakeholders in the public and private sectors and support the implementation of payment systems that promote person centered care.

Purpose of the White Paper

In order to accelerate the transformations described above, the Guiding Committee charged the Work Group with creating an APM Framework through which progress towards payment reform can be described and measured. 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 evidence based knowledge about the capabilities and results of APMs.

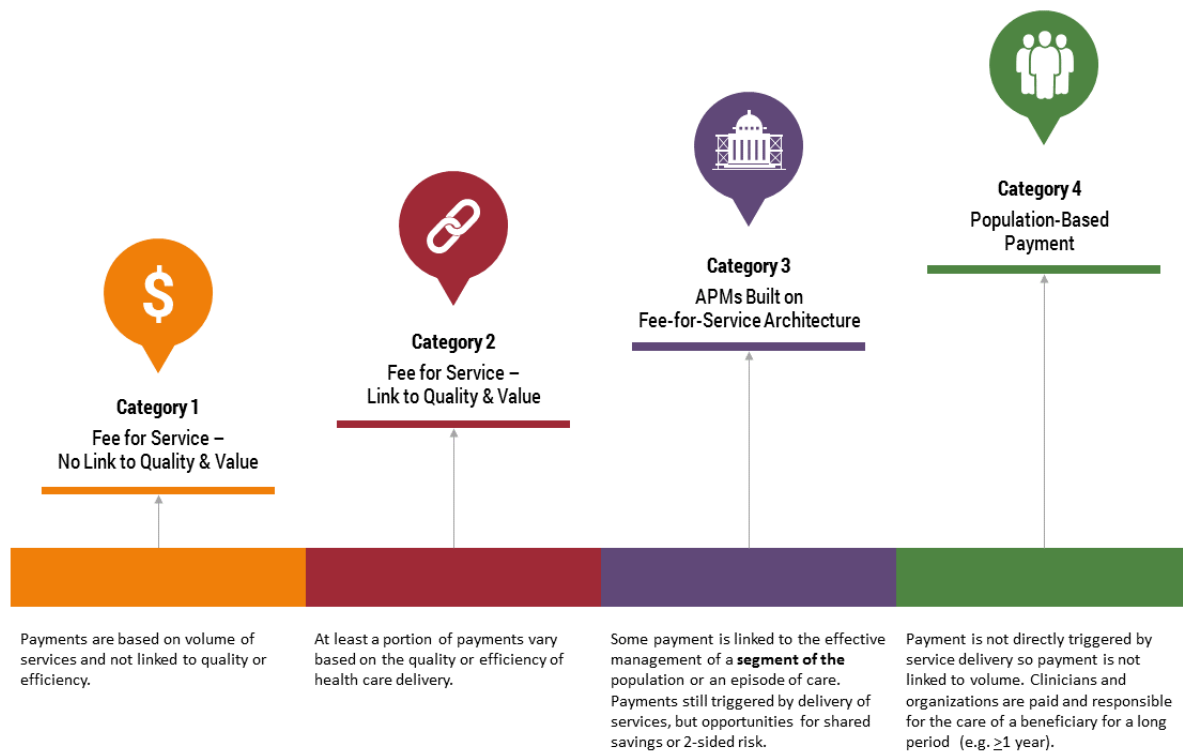
The White Paper begins by describing the approach that the Work Group used to develop the APM Framework, and then describes the principles upon which the APM Framework is based. With these principles in mind, the White Paper differentiates the Categories within the APM Framework by explaining how the Categories are defined and where their boundaries lie. The White Paper concludes with a summary of the Work Group's key findings and recommendations, as well as recommendations for how various stakeholders can use the 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.

Approach

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

¹ Rajkumar R, Conway PH, Tavenner M. [CMS: Engaging multiple payers in payment reform](#). JAMA. 2014 May 21: 311(19):1967-8.

Figure 2. CMS Payment Framework



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 towards 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 Work Group’s Framework is predicated on several key principles. To provide context for understanding the APM Framework and the Work Group’s recommendations, these principles are delineated and explained below.

Principle 1: *Changing the financial reward 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 monitor progress in initiatives that empower patients to have a voice in model design, to seek care from high value providers (via performance metrics, financial incentives, and other means), and to become active participants in shared decision making.*

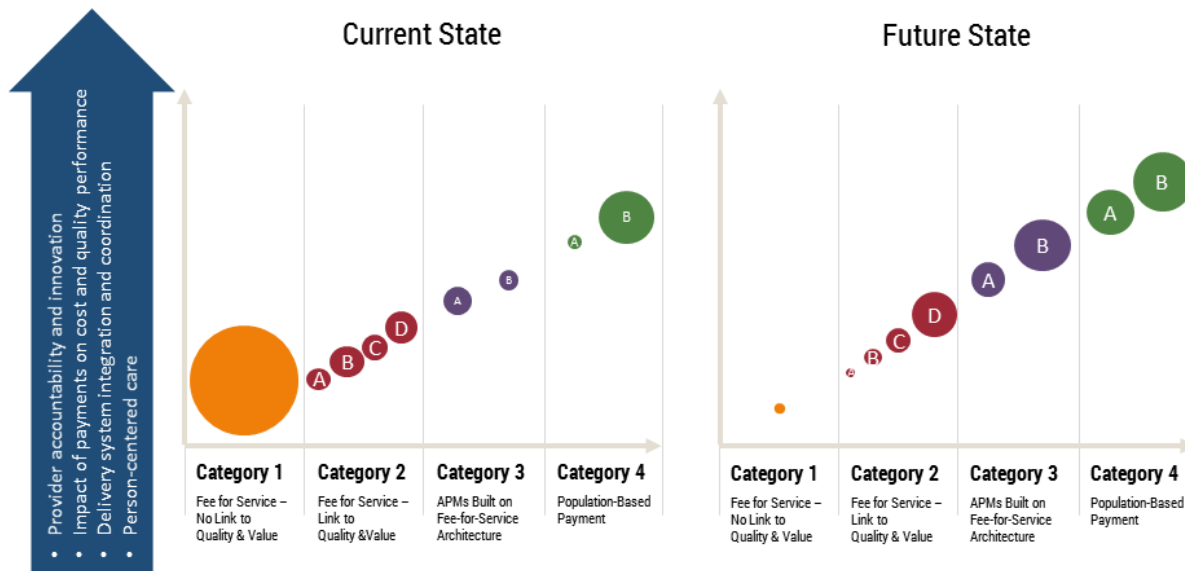
Although it was necessary to focus on financial incentives for providers as a critical first step, the Work Group recognizes that additional efforts to engage patients and consumers will be needed to achieve a high value, coordinated health care system. As more providers begin to participate in payment models that are divorced from traditional FFS, the Work Group expects all stakeholders to collaborate on approaches to empower patients to become active partners as they strive to achieve their health goals. 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; financial rewards for patients and consumers to select high value providers and to successfully manage chronic diseases; and efforts to enlist patients and caregivers as partners in the setting of health goals and the development of treatment plans. In order to avoid unintended consequences associated with APMs, the Work Group also believes it is essential for payment models to include safeguards to prevent selection against individuals with more complex illnesses or a greater need for social support, and that patients and consumers will 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 disparities in health outcomes or to a decline in access to care.

Principle 2: As delivery systems evolve, the goal is to drive a shift towards shared risk and population based payment models that incentivize improvements in the quality and efficiency of person centered care.

The overarching objective of the LAN is to encourage alignment between and within the public and private sectors as the health care system moves away from traditional FFS payment. Consistent with this objective, the Work Group recommends that over time, the U.S. health care system should move concertedly towards APMs in Categories 3 and 4. Nevertheless, the Work Group strongly believes that providers should clearly understand the requirements for financial and clinical participation in APMs, as well as that participation in APMs should be voluntary and that providers should not take on risk that they are not prepared to accept. The Work Group also recognizes that market forces have led to different levels of delivery system organization and integration, and investment in infrastructure and management will be required to build the capabilities that will ensure greater success of more robust population health payments. Therefore, APMs in Categories 3 and 4 will not be readily achievable in every market, for every clinical domain (e.g., dental care), or for every patient population. Furthermore, the Work Group anticipates that some regional markets may be slower to make the transition to these Categories. In particular, the Work Group expects participation in Category 3 and 4 APMs to be more limited for rural providers and for certain small or solo practices. Additionally, the transition may be more challenging for safety net providers, given the broad array of other services needed by their patient populations that are not integrated into health care, unless such services can be better integrated into payment reform.

A more detailed depiction of the Work Group's goals for the health care system appears in Figure 3.

Figure 3. The Work Group’s Goals for Health Care Reform



** 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 the Work Group’s belief of how the health care system should change, and it takes into account the likely impact of Medicare’s Merit Based Incentive Payment System. The Work Group cautions that values displayed in the graphic are not precise, nor are they intended to lay out specific targets for health care reform.*

In Figure 3, the size of the various circles represents spending across various types of payment models. As Figure 3 illustrates, payments are expected to shift over time from Categories 1 and 2 into Categories 3 and 4. Additionally, the Work Group expects that, 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.

Principle 3: *To the greatest extent possible, value based incentives should reach providers across the care team that directly delivers care.*

Based on the experience of members of the Work Group, payment reforms for quality improvement and cost reduction are most effective when they directly impact payments for providers that are principally responsible for providing care to patients. These incentives are effective because providers delivering patient care are best positioned to develop mechanisms that drive person centered, well-coordinated, and high value care that ultimately lead to better outcomes. For example, an accountable care organization (ACO) that is at risk for cost and quality would ideally design financial incentives for individual physicians and hospitals in a way that aligns with the ACO’s incentives as an organization. The Work Group recognizes that it may not always be possible to measure accurately the degree to which incentive payments reach individual practitioners. Nevertheless, the Work Group considers this a best practice and affirms that all delivery systems participating in Category 3 and 4 APMs should commit to

this principle. The Work Group believes that making population based payments to provider organizations that, in turn, pay individual providers on an FFS basis will not harness the full potential of the incentives in the APM.

Principle 4: Payment models that do not take quality and value into account will be classified within the appropriate category with a designation that distinguishes them as a payment model that is not value based. They will not be considered APMs for the purposes of tracking progress towards payment reform.

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 are organized according to the degree to which they advance beyond traditional FFS payment. The Work Group believes strongly that there is limited merit in moving toward population based payments if the resulting payment models do not include incentives to deliver quality health care based on current clinical knowledge. Although the Work Group was not charged with making specific recommendations about what constitutes meaningful quality measurement, it believes that APMs should use harmonized measure sets that include process, clinical outcome, patient reported outcome, and patient experience of care measures. Quality measures should be appropriately adjusted for patient mix, and whenever possible the measures used should be endorsed by professional organizations, the National Quality Forum, the Core Quality Measures Collaborative, and others involved in developing consensus. Measure sets should also be robust enough to provide a comprehensive portrait of a population's clinical and behavioral health. Payment models that represent some movement away from traditional FFS, but that do not take quality (and therefore value) into account, will be placed under the appropriate 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 the Work Group will not track them as part of measuring the achievement of the LAN's goals.

Principle 5: In order to reach the LAN's goals for health care reform, value based incentives should be intense enough for providers to invest in and implement delivery reforms, and they should increase over time. However, the strength of incentives does not affect the classification of APMs in the APM Framework.

The Work Group believes that APMs can be effective stimuli for delivery system change if providers are given meaningful incentives to develop and sustain innovative approaches to care delivery, and it acknowledges that shifting to person focused, population based payment systems will require substantial investments on the part of providers. Accordingly, it is critical that value based incentives be large enough to motivate providers to invest in and adopt new approaches to care delivery, and—over time—to outweigh profits that could be generated by increasing FFS billing. For example, the Work Group believes that a two sided incentive of plus or minus 10% is likely to promote change to a greater extent than a plus or minus 2% incentive. To accelerate and sustain progress throughout the entire health care system, the Work Group also believes that the size of this incentive should grow over time, as providers obtain greater experience in advancing quality while managing costs. A similar principle

applies to the setting of cost and quality benchmarks, in the sense that higher expectations for quality improvements and cost reductions are more effective at stimulating innovative approaches to care delivery.

At this time the Work Group classifies APMs without considering the intensity of the associated incentive payments because it believes that doing so would unnecessarily complicate the APM Framework. Using the example above, an episode based payment with a 10% financial risk/reward is classified the same as an episode based payment with a 2% financial risk/reward. The Work Group believes that more experience and analysis will be needed to determine what the “right” risk/reward level is to promote progress, while also recognizing that it may be different for hospitals and health systems than for physician organizations and health professionals. Nevertheless, the Work Group believes that a minimal threshold of risk and reward should be 5%, but likely greater.

Principle 6: For tracking purposes, when health plans adopt hybrid payment models that incorporate multiple APMs, the payment dollars will count towards the category of the most dominant APM. This will avoid double counting payments through APMs.

The Work Group recognizes that 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. For the purpose of tracking 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 gainsharing, shared risk, and population health models, and that a patient centered medical home may be supported by FFS based care coordination fees, pay for performance, and shared savings. In these and other scenarios, payment dollars will count towards the most dominant APM in use, meaning the APM to which the greatest amount of incentive payments are directed.

Principle 7: 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.

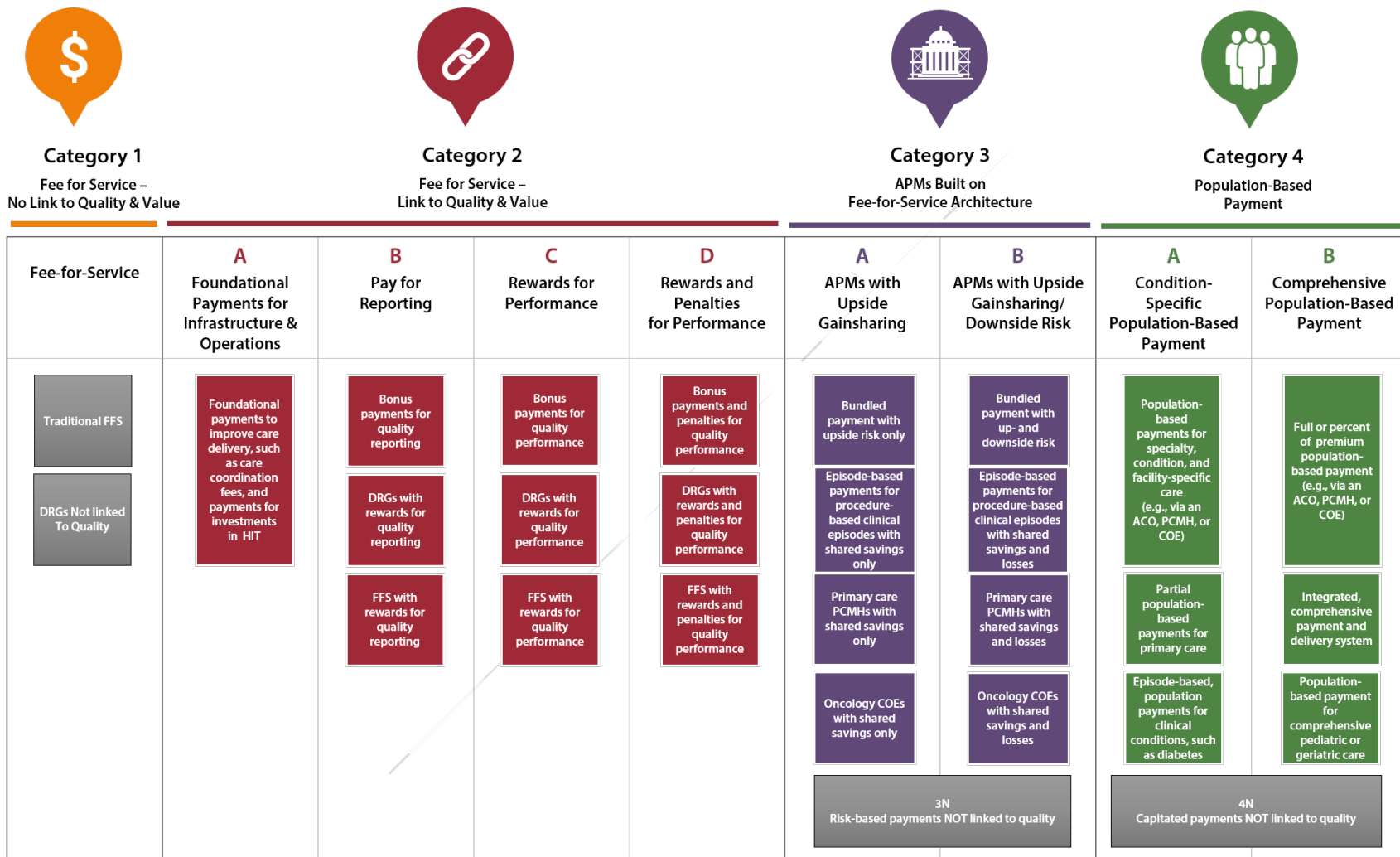
Consistent with the mission of the LAN, the Work Group limited the scope of the APM Framework to payment models, as opposed to delivery models. Because centers of excellence (COEs), patient centered medical homes (PCMHs), and ACOs are delivery models that can accommodate a wide variety of payment arrangements, they will be listed according to their underlying payment arrangement when they appear in the APM Framework. 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. The Work Group recognizes that PCMHs and ACOs are commonly understood to be associated with risk sharing payment models. Nevertheless, the Work Group strongly

recommends maintaining a clear distinction between concepts that describe payment models and those that describe delivery models. At the same time, the Work Group believes 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. In recognition of their dramatic potential to improve the delivery of high quality and efficient health care, the Work Group elected to represent ACOs, PCMHs, and COEs in multiple categories, where corresponding APMs exist today and, likely, in the future.

The APM Framework

The Work Group's 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. Please note that the examples in Figure 4 are not meant to be exhaustive, but are rather intended to give a sense of possible arrangements in each of the subcategories.

Figure 4. APM Framework



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

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 are made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor for 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 the Work Group has determined that 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 that 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 that are 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 they perform on cost and quality metrics.

The Work Group has split Category 2 into subcategories A, B, C, and D 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, the Work Group considers these types of FFS or per member per month (PMPM) payments an important—though preliminary—step toward payment reform.
- 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, the Work Group maintains that participation in Category 2B payment models should be time limited and that participation in Category 2B payment models will often evolve into subsequent categories.
- Payments are placed into **Category 2C** if they provide rewards for high performance on clinical quality measures. Much like pay for reporting programs, pay for performance programs that only reward high performance on quality metrics give providers an opportunity to acclimate themselves to the applicable reporting systems and measures before they are subject to penalties for low performance. 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 a hospital acquired infections.

- Payments placed into **Category 2D** 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 lower updates to their FFS baseline or may receive a percent reduction on all claims paid if they do not meet quality goals. (Please note that payments in this subcategory are not subject to rewards or penalties for provider performance against aggregate cost targets, but may take into account performance on a more limited set of cost measures.)

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). Although the Work Group was not tasked with developing specific recommendations on HIT and 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.

As indicated in the discussion above, the Work Group expects that providers receiving Category 2A and 2B payments are investing in the HIT and other infrastructure needed to assess and improve quality performance, and that payments in these categories will be an “on ramp” to participation in subsequent categories. In other words, the Work Group expects that under most circumstances, providers and provider groups will transition quickly into Categories 2C and 2D, though they may do so 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. Because data from the former determine payment adjustments in the latter, providers paid under that Medicare arrangement are typically eligible to receive both Category 2B and Category 2D payment adjustments. The Work Group stresses that the payment models in Categories 2A through 2C will prepare providers to take on the additional accountability and financial risk associated with APMs in Categories 3 and 4. This concept of Categories 2A and 2B as an “on ramp” for subsequent categories will be assessed as the Work Group measures and tracks progress towards adoption of APMs.

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 assume either shared savings or shared losses based on established cost targets. Second, FFS based payments in Category 3 reflect, to a greater degree, care that is 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 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. In addition to taking quality considerations into account (as in Category 2), Category 3 payments are based on cost performance against a target, irrespective of how the financial benchmark is established, updated, or adjusted. For APMs in Category 3, providers that meet their cost and quality targets are eligible for shared savings, and those that do not may be held financially accountable.

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 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.

The Work Group has split Category 3 into subcategories A and B as outlined below:

- **Category 3A** gives providers an opportunity to share in the savings they generate. If a provider participating in a Category 3A APM meets quality targets but does not meet cost targets, then the provider is not held financially responsible for excess spending.
- Payments in **Category 3B** involve both upside gainsharing (i.e., positive payment adjustments) and downside risk (i.e., negative payment adjustments) based on performance on cost measures.

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 gainsharing or both upside gainsharing and downside risk for providers. The Work Group believes payments in Category 3 will advance clinical integration and affordability to a greater extent than payments in Category 2 because risk sharing arrangements provide stronger incentives to manage health care costs and reward 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 payment that encompasses a broad array of services, whereas providers participating in Category 3 models are eligible for only a portion of the losses and/or savings they generate. Additional conditions must be met before a payment model can be placed into Category 4. Specifically, Category 4 payments reflect the total cost of care for treating a primary (typically chronic) condition, or for maintaining the health and managing the illness of an entire population. By contrast, even if they are fully capitated, payments that cover a more limited set of specialty services (including primary care) would be classified in Category 3. For example, a Category 4 model for pediatric care would have to cover a wide range of medical, preventive, and developmental services, whereas a population based payment model for primary care would fall under Category 3 if it did not hold primary care providers accountable for care coordination and the appropriate utilization of specialty services. Similarly, clinical episode payments 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 made on a per member per month basis. 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 population based payments, structured in a manner that encourages providers to deliver well-coordinated, high quality person level care within a defined (4A) or overall (4B) budget. This holds providers accountable for meeting quality and, increasingly, person centered care goals for a population of patients or members. Payments within Category 4 are intended to cover a wide range of preventive health, health maintenance, and health improvement services, and these payments will likely require care delivery systems to establish teams of health professionals to provide enhanced access and coordinated care. Additionally, and in contrast to capitated arrangements in Category 4N, providers participating in Category 4A and 4B APMs are held accountable for delivering high quality, clinically necessary, and appropriate care.

The Work Group has split Category 4 into subcategories A and B as outlined below:

- **Category 4A** payments are limited to certain sets of condition specific services (e.g., asthma, diabetes, or cancer), but they remain person focused in the sense that they hold providers accountable for the total cost and quality of care related to that condition. 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 only chemotherapy payments. The Work Group recognizes that in certain instances patient care will predominantly revolve around the management of particular types of conditions, such as cancer or heart disease. In such cases, we recognize that Category 4A may become a suitable and justifiable endpoint, especially for smaller provider organizations which may never be able to deliver certain types of care (such as transplants). Nevertheless, the Work Group maintains that providers should ideally be paid to maintain health and manage illness for an entire population, rather than compartmentalizing payments according to particular conditions. We also believe that condition specific payments should, in time, become part of a comprehensive approach to improving health and reducing costs for an entire population. For highly integrated delivery systems, the Work Group envisions that Category 4A payments will evolve into Category 4B.
- Payments in **Category 4B** are capitated or population based for all of the individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements with varying degrees of integration between plans and provider groups. On one end of the spectrum, plans and providers in Category 4B models may be virtually integrated. On the other end of the spectrum are highly integrated arrangements that are characterized by vertical integration of financing and care delivery, common ownership, and strong linkage across strategy, clinical performance, quality, and resource use. These groups may also have a higher percentage of salaried physicians. After reviewing the literature and discussing these highly integrated arrangements with people who operate within them, the Work Group has reached the conclusion that they can be ideally suited for delivering person centered care because they: 1) force transformational thinking about delivery system reform; 2) optimize coordination of infrastructure investments; 3) most fully remove financial incentives for volume; and 4) expedite community investment and engagement. Although the underlying payment approaches were not sufficiently distinct to warrant the creation of a separate subcategory for highly integrated payment and delivery systems, the Work Group believes that these arrangements yield key benefits and efficiencies, because they have a greater impact on organizational responses to quality and value incentives.

Category 4 represents the furthest departure from traditional FFS payments, while simultaneously ensuring that providers possess the strongest possible incentives to deliver high quality and efficient care. Nevertheless, the Work Group recognizes that not every market currently is suited to support APMs in Category 4, and that the journey to Category 4 will occur along different trajectories in different markets, based in significant part on the organization of care delivery systems.

Conclusion

As set forth in this document, the Work Group is committed to the concept that 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. The Work Group envisions that these mappings will be useful for all stakeholders and prove enduring as they navigate the health care ecosystem.

While the Work Group believes that this Framework identifies and encompasses all models of payment reform and will be enduring, Work Group members hope to return to the White Paper at a later date to take into account new developments in the health care sector. Nevertheless, the Work Group intends the APM Framework to be robust enough to accommodate foreseeable changes, and it strongly believes that this should 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.) The Work Group believes 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 that they can identify and communicate desirable elements and become empowered to participate in decisions about how to design payment plans and delivery systems.

Providers can use the APM Framework to make sense of 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.

Plans can use the APM Framework to drive payment and contracting models and as an accounting tool to track spending and the distribution of members/beneficiaries and providers. This is crucially important, because adopting a common classification scheme would represent a first step towards 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 safeguards and benefits that would tip them towards enrolling in such plans.

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