HCP LAN

Health Care Payment Learning & Action Network

LAN Update: APM Framework White Paper

January 12, 2016
12:00pm – 1:30pm ET

Welcome

Mark McClellan, MD

Co-chair, LAN Guiding Committee

Robert Margolis Professor of Business, Medicine, and Policy and Director of the Robert J. Margolis Center for Health Policy

Duke University

The Health Care Payment Learning and Action Network (LAN) was launched because….

We want better care, smarter spending, and healthier people.

In order to achieve this, we need to improve our payment structure by building one that incentivizes quality and value over volume.

Such alignment requires the participation of the entire health care community. The LAN is a collaborative network of public and private stakeholders.

Goals

2016
30%

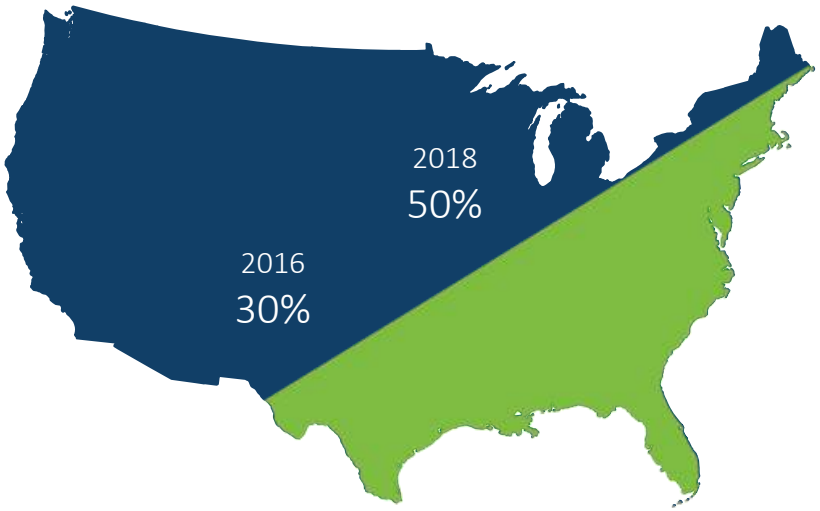
In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs

2018
50%

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

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

Adoption of Alternative Payment Models (APMs)



Better Care, Smarter Spending, Healthier People

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Work Group Representation

Physicians/Health Care Providers	Private Payers	CMS
Consumer/ Patient groups	Purchasers/ Employers	State Government

LAN Update: APM Framework White Paper

Sam Nussbaum, MD

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

Former Executive Vice President and Chief Medical Officer

Anthem, Inc.

Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group Overview and Charge

Work Group

A team of 14 public and private stakeholders

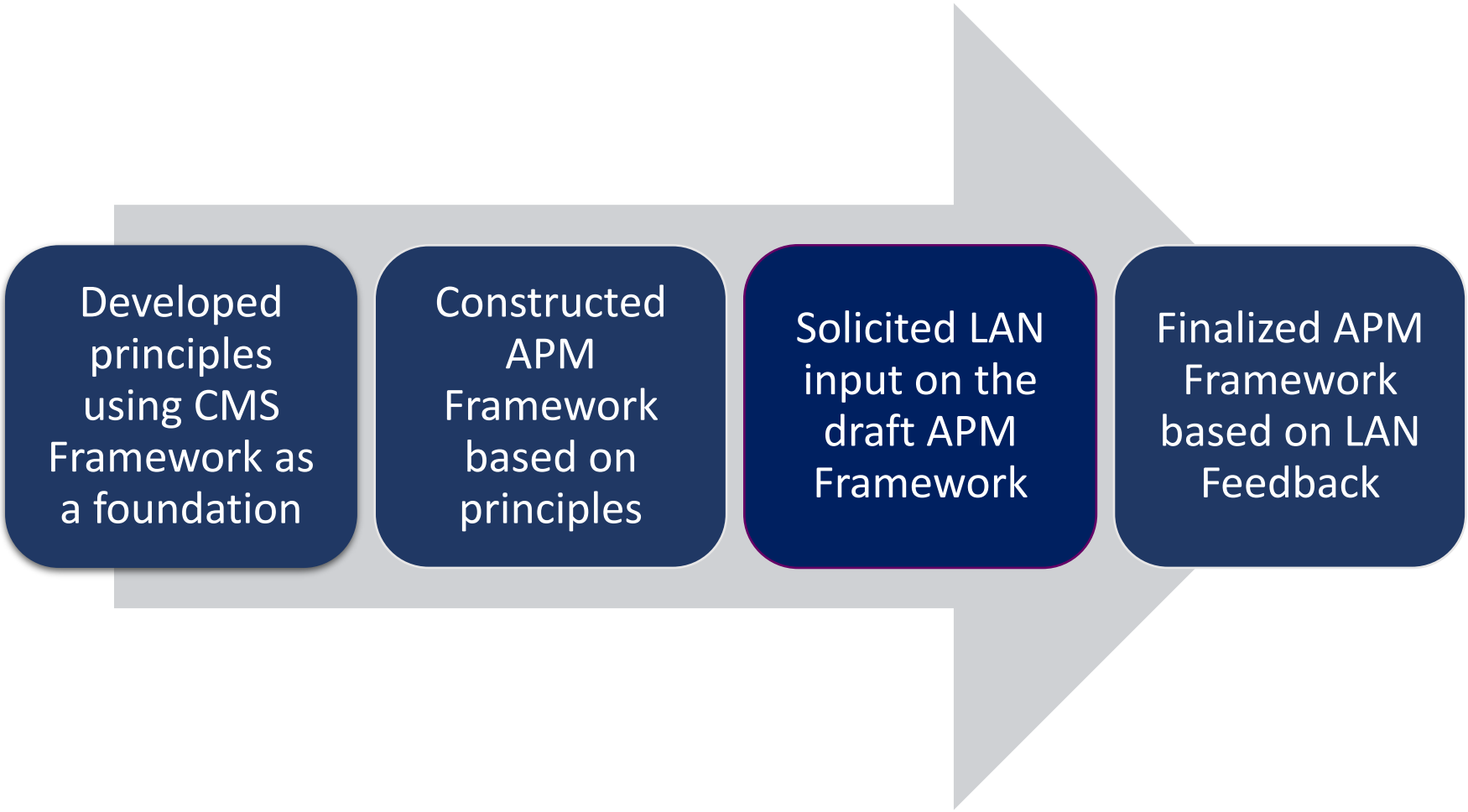
Charge

Charged with assessing APMs in use across the nation and defining terms and concepts essential for understanding, categorizing, and measuring APMs

Objective 1

Final APM Framework White Paper released **today!**

Developing the APM Framework
APM FPT Work Group Process



APM Framework White Paper
Request for LAN Feedback

In an effort to seek input at an early stage, the APM Work Group released a draft version of the White Paper on October 22, 2015. The Work Group requested specific input on:

- the **overall White Paper and proposed framework**;
- **descriptions** associated with each category;
- the **boundaries** that differentiate one category from another; and
- additional **examples and case studies** you could provide to illustrate and test each category in the framework.

- **Over 500 individuals attended the APM Framework presentation and discussion during the LAN Summit on October 26, 2015.**

- **Written feedback received on the White Paper included:**

113 Comments (285 Pages)

79 Unique Submitters

51% of Submitters Acting as Representative of their Organizations

APM Framework White Paper
LAN Feedback - Thematic Areas

Commenters focused predominantly on the three pillars of person-centered care and the Framework principles

Many commenters requested additional details about which types of providers would be less likely to accept payments in Categories 3 and 4, and about how big an incentive payment needed to be in order to be "sufficient."

Many commenters highlighted the risk associated with transitioning to APMs

Commenters representing certain provider types (e.g, primary care physicians, pediatricians, geriatricians) raised questions about where and how their practice might fit into the framework

There was a large number of recommendations (and requests for the Work Group to take a stance) on delivery system and plan design;

Final APM Framework White Paper

The final version of the White Paper reflects LAN participant comments, as appropriate, and is a much stronger document because of them.

The final APM Framework White Paper may be viewed at: www.hcp-lan.org

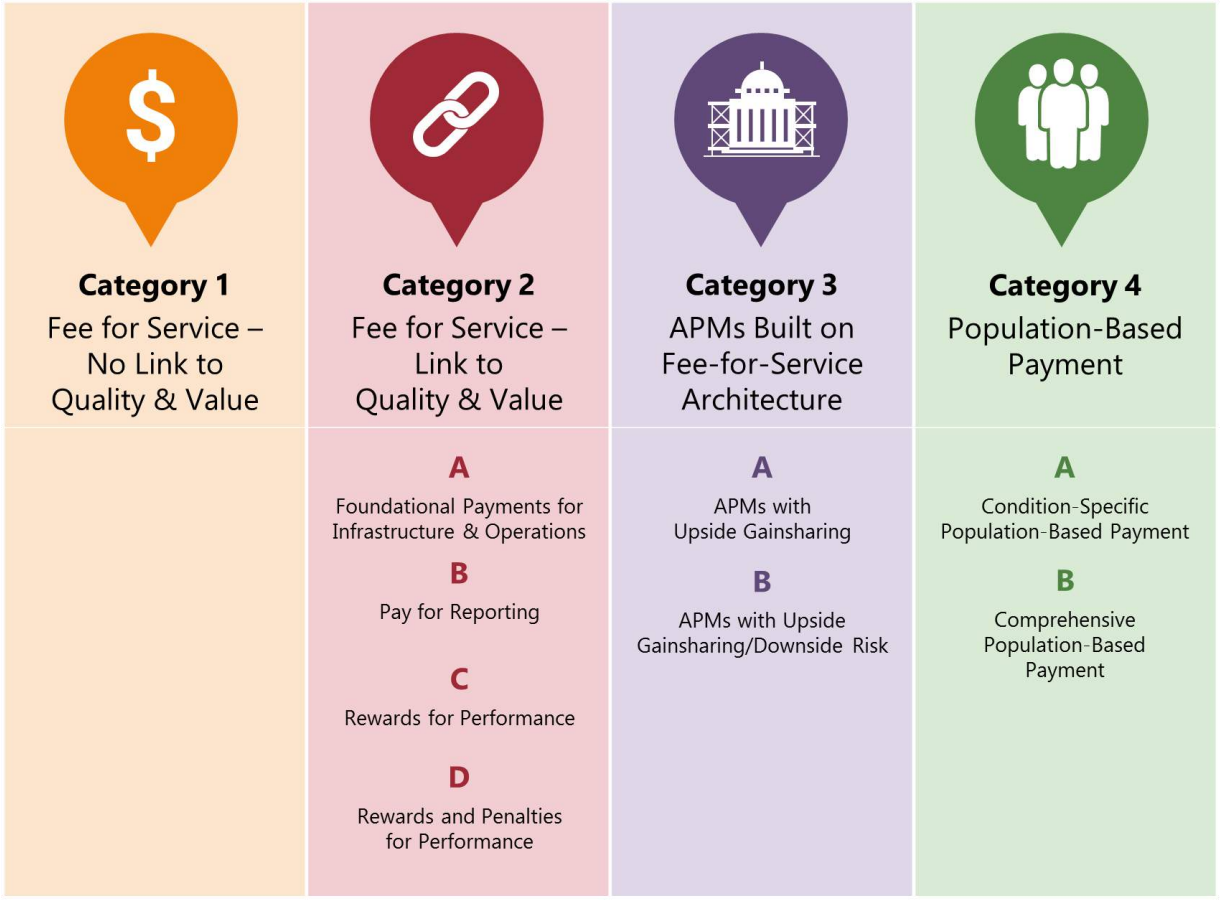
A Comment Summary is also accessible

APM Framework
Summary of Key Principles

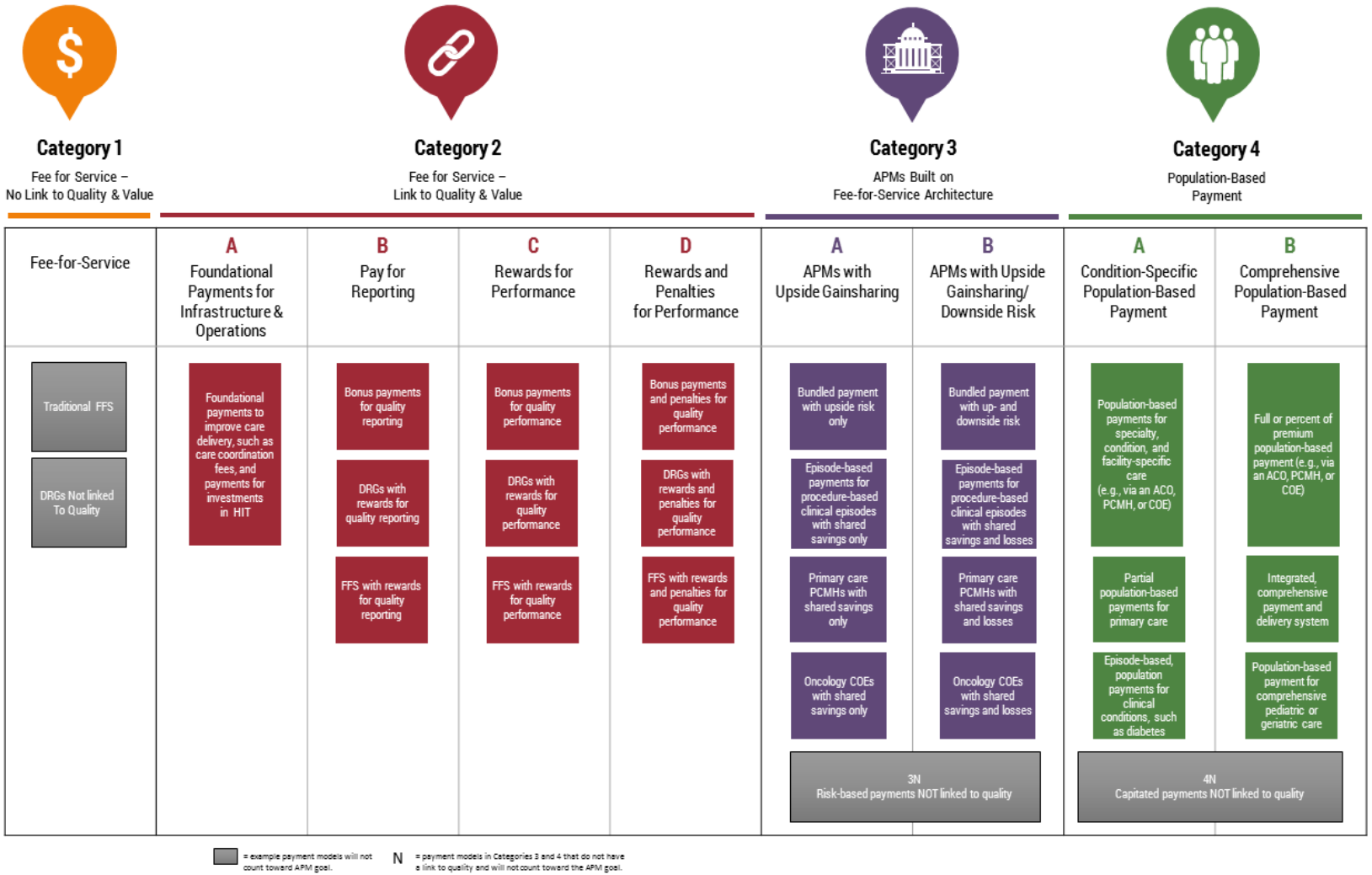
- Changing providers' financial incentives is not sufficient to achieve person-centered care, so it will be essential to empower patients to be partners in health care transformation.
- The goal is to shift U.S. health care spending significantly towards population-based payments.
- Value-based incentives should ideally reach the providers who deliver care.
- Payment models that do not take quality into account will be classified within the appropriate category and marked with an "N" to indicate "No Quality" and will not count as progress toward payment reform.
- Value-based incentives should be intense enough to motivate providers to invest in and adopt new approaches to care delivery.
- APMs will be classified according to the dominant form of payment, when more than one type of payment is used.
- Centers of excellence, accountable care organizations, and patient-centered medical homes are examples in the Framework, rather than categories, because they are delivery systems that can be applied to and supported by a variety of payment models..

APM Framework
At-A-Glance

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



APM Framework



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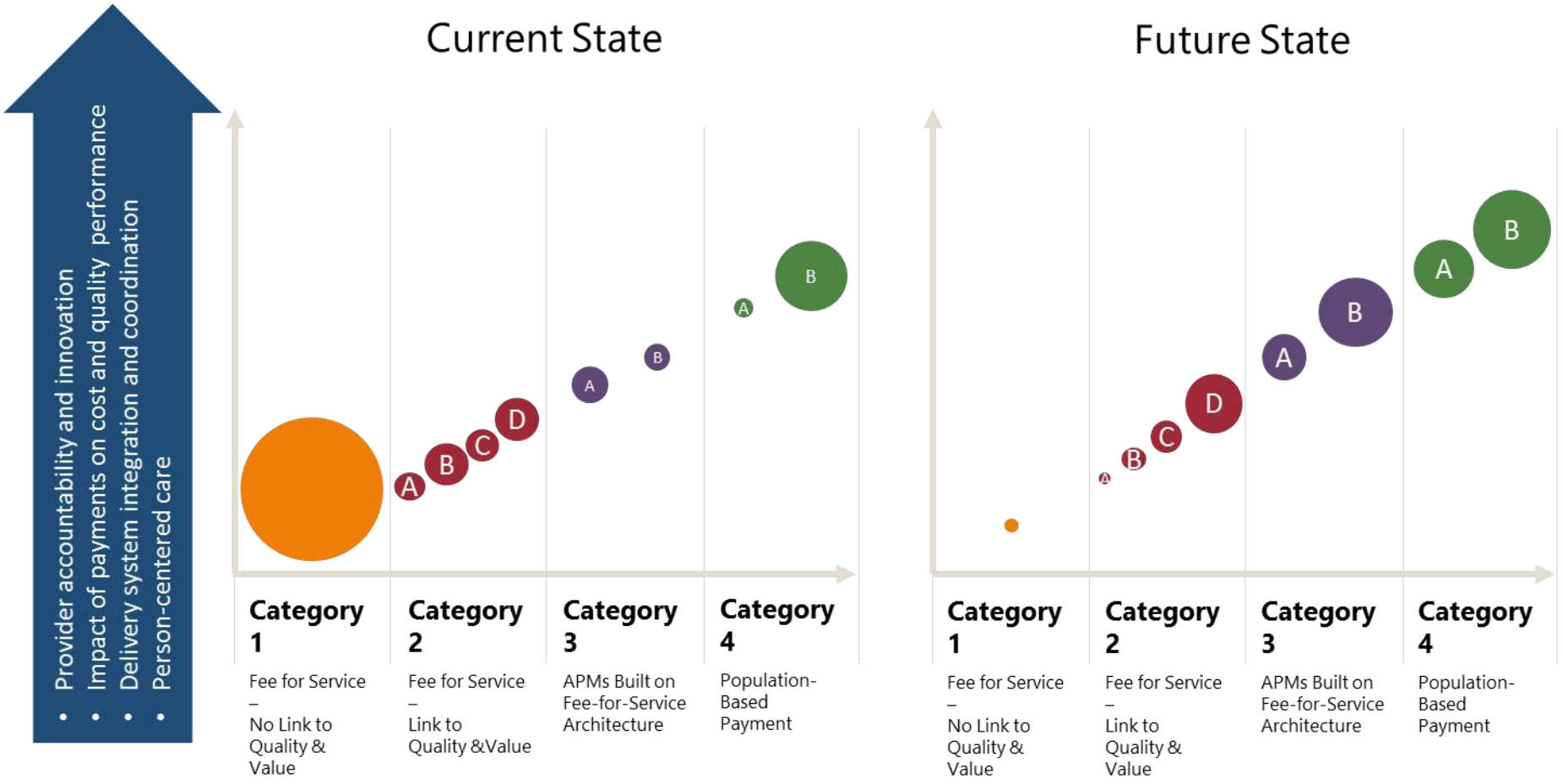
Work Group's Goals for Payment Reform



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How the APM Framework helps to achieve LAN and HHS Goals

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

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

Q&A

APM Case Studies

Jeff Rideout

President and CEO

Integrated Healthcare Association (IHA)

John Pilotte

Director, Performance-Based Payment Policy Group

Center for Medicare, Centers for Medicare & Medicaid Services

Robert McConville

Director of Population Health

Intermountain

Eileen Wood

Senior Vice President, Clinical Integration

Chief Pharmacy Officer

Capital District Physicians' Health Plan, Inc. (CDPHP)

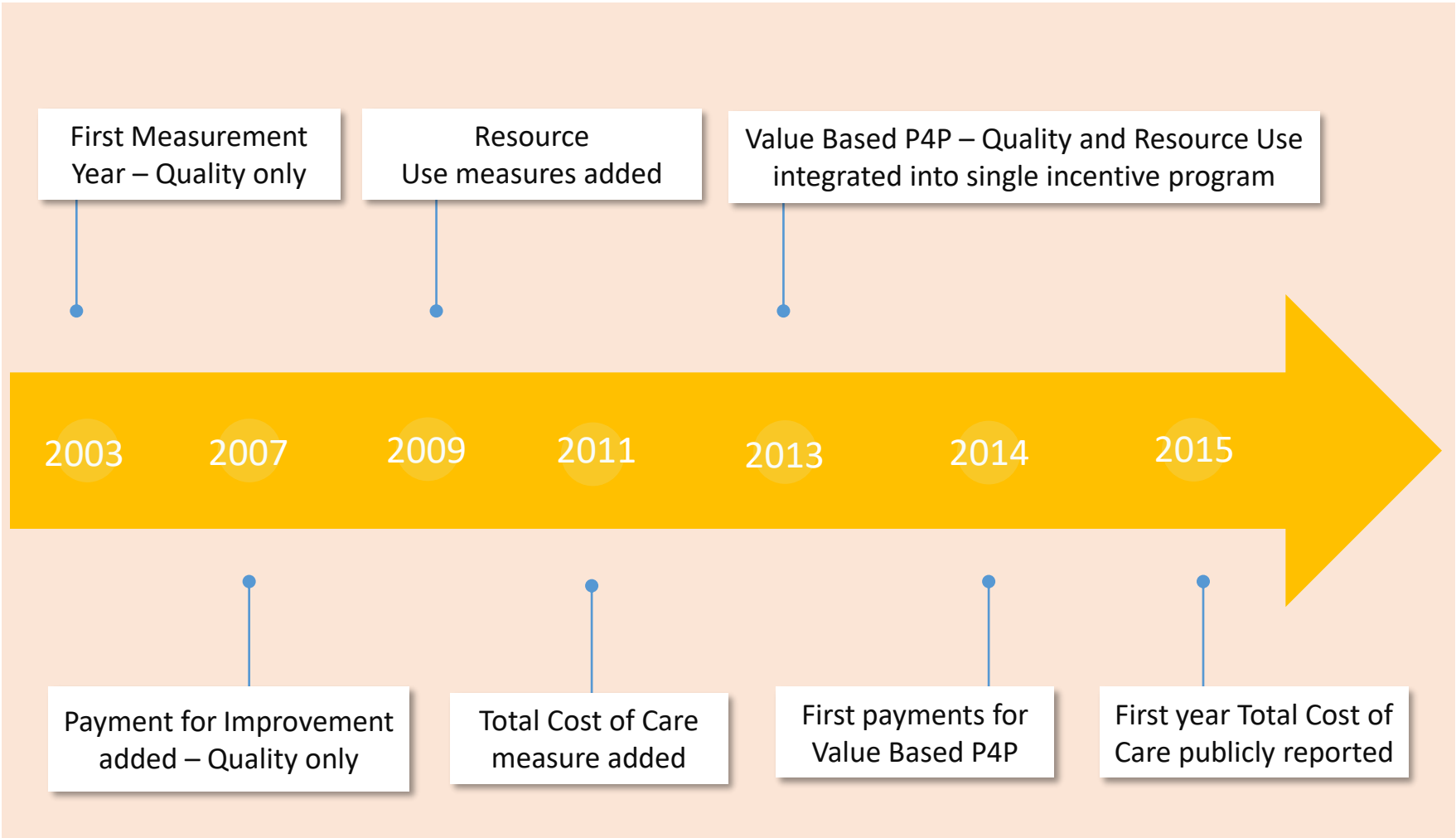
California Value Based P4P: A Model 3A Shared Savings Program

Jeff Rideout

President and CEO

Integrated Healthcare Association (IHA)

IHA's Value Based P4P Program Evolution—
In 2015 there were 10 participating health plans and 200 participating physician organizations responsible for care delivered to 9 million Californians



Common Set of Measures—

working diligently to align with MA, QRS and Medi-Cal whenever possible

Clinical (50%)

Process and outcomes measures focused on six priority clinical areas

- Cardiovascular (2)
- Diabetes (7)
- Maternity (0)
- Musculoskeletal (1)
- Prevention (8)
- Respiratory (3)

Patient Experience (20%)

Patient ratings of six components, including care overall:

- Communicating with Patients
- Coordinating Care
- Health Promotion
- Helpful Office Staff
- Overall Rating of Care
- Timely Care and Service

Meaningful Use of Health IT (30%)

- Percent of providers meeting intent of CMS Meaningful Use core requirements
- Ability to report selected e-measures (2)

Appropriate Resource Use

Utilization metrics spanning:

- Inpatient stays
- Readmissions
- ED visits
- Outpatient procedures
- Generic prescribing

Total Cost of Care

Average health plan and member payments associated with care for a member for the year, adjusted for risk and geography

Value Based P4P Design and Highlights

Does the PO qualify?	▪ **Meets minimum Quality Composite Score** ▪ **TCC trend does not exceed CPI+3%** • Of the POs that didn't pass the performance gates, 14% missed the TCC trend gate and 4% missed the quality gate. • Overall TCC trend continues to slow – showing a *decline* in 2015
Did the PO improve or maintain efficient resource use?	▪ **Resource use compared to prior year** ▪ **Selected inpatient, outpatient, ED, and prescribing measures** • Bed days are the primary driver of PO net share of savings
How much is the PO's incentive payment?	▪ **Net savings across all ARU measures** ▪ **Quality determines share of savings** • Modeling suggests about 50% of POs earn an incentive • Higher quality magnifies incentive amount

Medicare Shared Savings Program (MSSP)
Centers for Medicare & Medicaid Services

John Pilotte

Director, Performance-Based Payment Policy Group

Center for Medicare, Centers for Medicare & Medicaid Services

Medicare Shared Savings Program Growing

- **434 ACOs established to date** in the Shared Savings Program
- In 2016, **100 new ACOs** joining the program and **147 ACOs renewing** their agreements
- 22 ACOs in performance based risk tracks, including 16 in new Track 3
- 54 new ACOs serving Medicare beneficiaries in rural areas in 2016
- Over **7.7 million Medicare FFS beneficiaries** receive care from providers participating in Shared Savings Program ACOs
- 15,000 additional physicians joining Shared Savings Program ACOs in 2016 bringing total to **over 180,000 physicians and other practitioners** in Shared Savings Program ACOs
- Physician, practitioner and provider networks most prominent type of ACO

Promising Results

Shared Savings Program Quality Results

- ACOs that reported in both 2013 and 2014 **improved average performance on 27 of 33 quality measures**
- Quality improvement was shown in such measures as patients' ratings of clinicians' communication, beneficiaries' rating of their doctor, screening for tobacco use and cessation, screening for high blood pressure, and Electronic Health Record use
- Achieved higher performance than other FFS providers on **18 of the 22** Group Practice Reporting Option Web Interface measures
- Clinicians participating in ACOs in 2015 avoid the PQRS payment adjustment and automatic downward Value Modifier (VM) adjustment in 2017 if their ACO satisfactorily reported quality measures. Physicians also eligible for upward, neutral, or downward VM adjustments in 2017 based on their ACO's quality performance.

Promising Results

Shared Savings Program Financial Results

- Performance Year 2014: 92 ACOs (28%) held spending $806 million below their targets and **earned performance payments of more than $341 million.**
  - An additional 89 ACOs reduced health care costs compared to their benchmark, but did not meet the minimum savings threshold.
  - ACOs with more experience in the program were more likely to generate shared savings: 37 percent of 2012 starters, compared to 27 percent of those that entered in 2013, and 19 percent of those that entered in 2014.
- Performance Year 1: 58 ACOs (26%) held spending $705 million below their targets and **earned performance payments of more than $315 million.**

Observations & Lessons Learned

- ACOs are engaging in a variety of innovative care coordination and practice redesign activities with local providers in their communities.
- ACOs identified physician engagement, patient engagement, care transitions, and post-acute care as key issues and are working on strategies to improve in these areas.
- ACOs are receiving Medicare claims data that can assist them in redesigning care and monitor their performance. Many integrate claims data with clinical data systems.
- ACOs value communication and learning opportunities, as well as transparency in methodologies.
- ACOs are supporting one another with their time and expertise in a learning network and data users group.

Enhanced Primary Care:
The CDPHP Medical Home

Eileen Wood

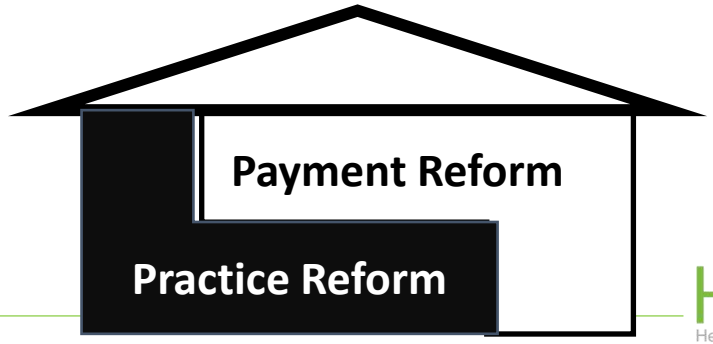
Senior Vice President, Clinical Integration

Chief Pharmacy Officer

Capital District Physicians' Health Plan, Inc. (CDPHP)

CDPHP Enhanced Primary Care (EPC)

- In 2008, EPC was piloted to address the shortage of primary care physicians (PCPs) in our area
- Replaces fee-for-service (FFS) with risk-adjusted global payments
- Moves physicians to population-based payments
- Offers opportunity for significant bonus payments for advancing the principles of the Triple Aim
- Rewards doctors for spending more time with sickest patients
- In 2012, pilot was moved to a sustainable program, which is now the predominant payment model for our PCP network
- Today, EPC includes 245,000 members — more than half our membership



CDPHP Enhanced Primary Care (EPC)

Underlying Payment Approach

3(B) - replaces FFS with risk-adjusted global payment

- Currently paying 40% more on average than FFS
- Opportunity for an average 20% bonus based on goals of Triple Aim

Approaches to Cost Assessment

- Cost and efficiency assessed using risk-adjusted utilization in six categories:
  - Inpatient hospitalization
  - Emergency room
  - Medical imaging
  - Pharmacy
  - Laboratory
  - Specialists

CDPHP Enhanced Primary Care (EPC)

Approaches to Quality Assessment

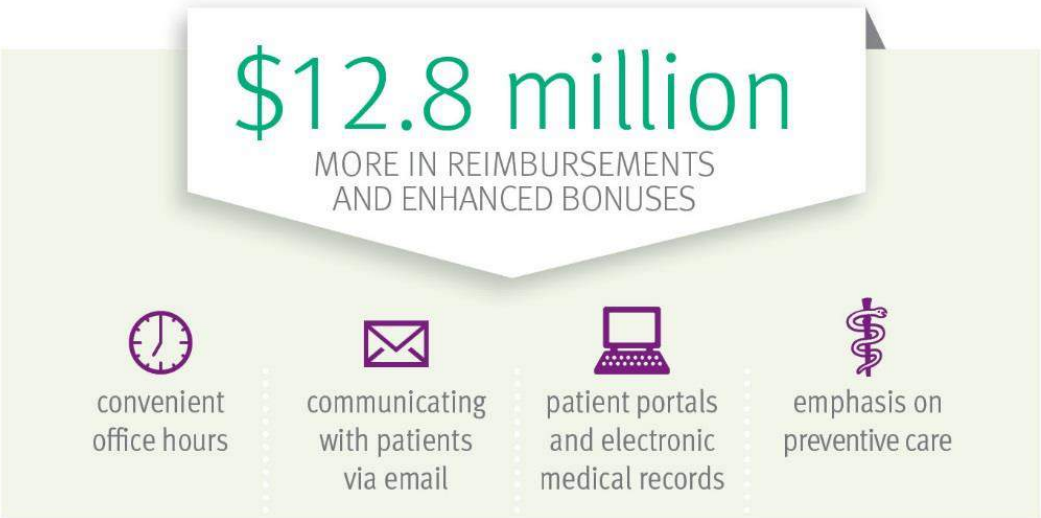
- Assessed using HEDIS metrics in four categories:
  - Population health and prevention
  - Management of chronic conditions
  - Antibiotic use
  - Behavioral health
- Assessed using experience of care composite from CAHPS survey

Additional Infrastructure and Operational Investments

- Performance management department added to support program
  - Engagement and training to achieve cultural shift
  - Support PCPs to achieve NCQA Level 3 PCMH recognition
  - Provide actionable data
  - Assist with clinical integration of care management
  - Assist with transition to value-based payments

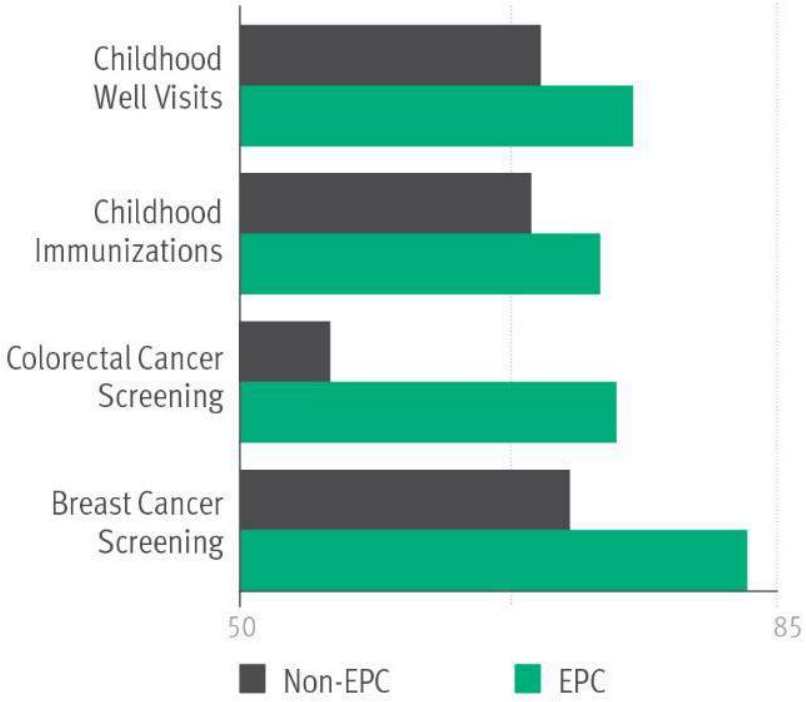
CDPHP Enhanced Primary Care (EPC)

- Program netted $20.7 million ($17.11 PMPM) in savings in 2014
- PCPs received $12.8 million more in reimbursements and bonuses
- 1.5 fewer primary care visits per 1,000 members
- Visits increased for sickest 10% — exactly what we wanted to happen!



CDPHP Enhanced Primary Care (EPC)

- Beyond cost, EPC produced impressive quality results:
  - Quality scores at EPC sites rose from 71% to 77%
  - Quality scores at non-EPC sites rose from 65% to 68%



Shared Accountability:
Intermountain Health

Robert McConville

Director of Population Health

Intermountain Health

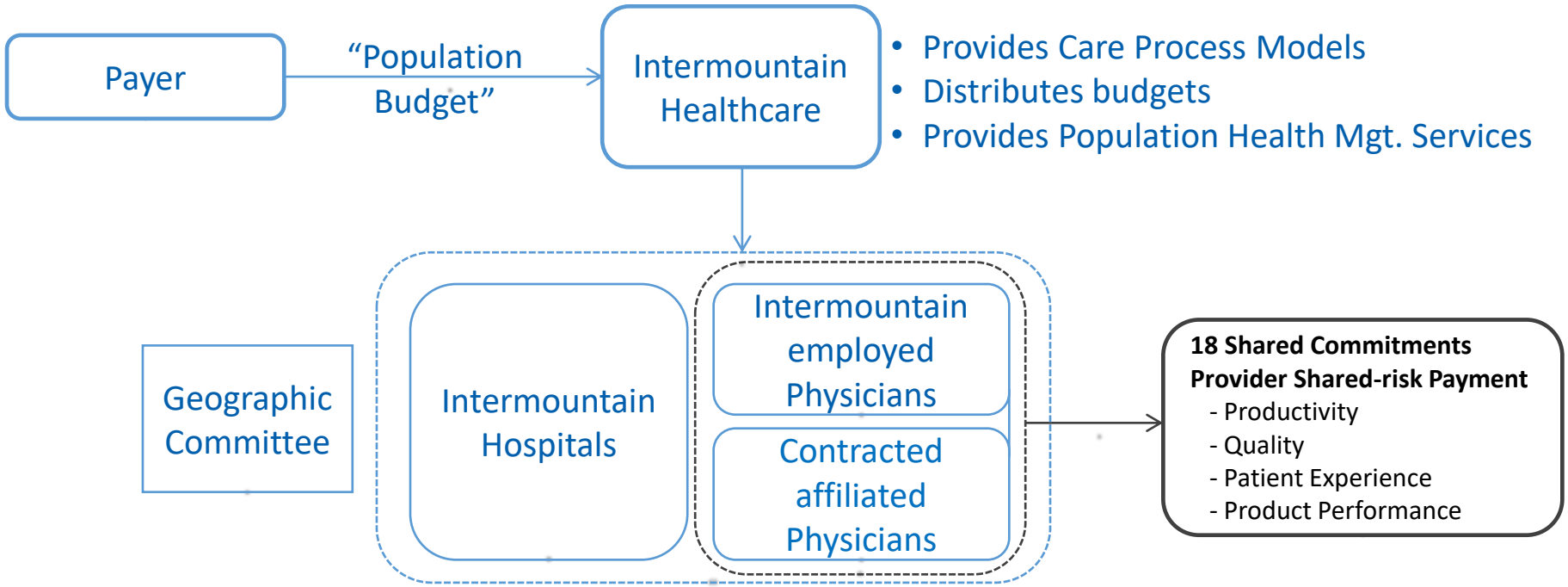
18 Shared Commitments

Intermountain Healthcare is initiating a Shared Accountability strategy to provide high-value healthcare. Physicians will help lead this effort by providing evidence-based care and by helping patients become more engaged in their care. The strategy includes a payment model rewarding providers for delivering evidence-based care and engaging patients.

Intermountain Healthcare
Healing for Life

selecthealth

Shared Accountability Regional Financial Model



Payer Strategy

Medicare selecthealth.

- Medicare Advantage – January 2013
- ACO – considering

Medicaid selecthealth.

- "ACO" model – January 2013

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Commercial

- selecthealth. – January 2016
- Followed by others

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Q & A

What's Next?

Way Forward includes:

- ☐ Continue building on our set of case studies of payment models
- ☐ Developing strategy for measuring adoption of APMs
  - Refining draft metrics
  - Establishing payer collaborative to define how best to report on APMs
  - Piloting strategy with a small, diverse group of health plans
- ☐ Revisiting the APM Framework White Paper on the one-year anniversary of its release to take into account new developments in the health care sector

Call to Action

We need to continue to **work together to move payment towards value and quality** in the U.S. Health System

You can help in many ways

- ✓ Committing to use APMs
- ✓ Using the Framework to further the discussion on payment reform
- ✓ Participating in/supporting efforts to report on progress towards national goals
- ✓ Sharing models and best practices
- ✓ Staying involved by joining the conversation on Handshake and by participating in future LAN webinars

Upcoming LAN Products

Population-Based Payment (PBP) Work Group

Sprints Launched
- ✓ Patient Attribution
- ✓ Financial Benchmarking

Future Sprints
- ✓ Performance Measurement
- ✓ Data Sharing

Clinical Episode Payment (CEP) Work Group

Sprints Launched
- ✓ Elective Hip and Knee Replacement

Future Sprints
- ✓ Maternity
- ✓ Cardiac Care

Get Involved!

Register online

http://innovationgov.force.com/hcplan

Visit our site

https://www.hcp-lan.org

Ask a question

PaymentNetwork@MITRE.org