



# ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Final White Paper

Written by:

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

For Public Release  
Version Date: 1/12/2016

## Table of Contents

Table of Contents .....	1
Executive Summary.....	1
Overview .....	3
Health Care Payment Learning & Action Network (LAN) .....	3
The Case for Reforming the Health Care Payment System .....	4
Purpose of the White Paper .....	6
Approach .....	6
Key Principles for the APM Framework .....	7
The APM Framework .....	12
❶ Fee for Service with No Link to Quality & Value (Category 1): .....	14
❷ Fee for Service Linked to Quality & Value (Category 2): .....	14
❸ APMs Built on Fee for Service Architecture (Category 3): .....	15
❹ Population Based Payment (Category 4): .....	16
Conclusion.....	18
Stakeholders and the APM Framework.....	18
Appendix A: Work Group Members and Staff .....	19
Work Group Chair.....	19
Work Group Members.....	19
CMS Alliance to Modernize Healthcare (CAMH) Staff.....	19
Catalyst for Payment Reform Staff (CPR) .....	21

---

## 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.

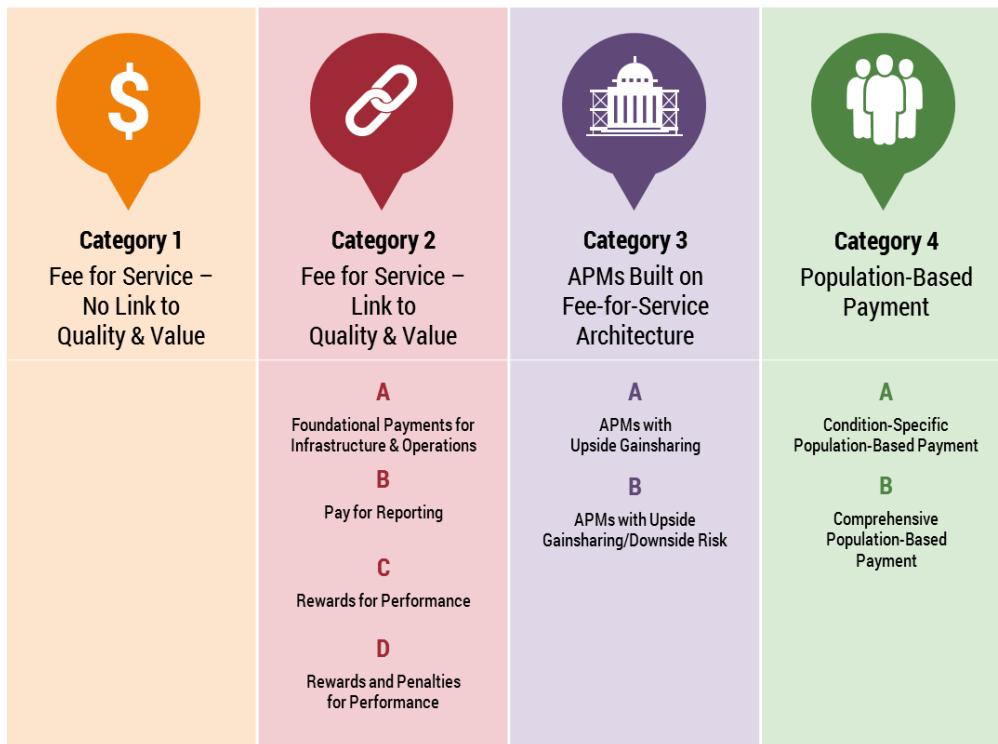
The APM Framework rests on seven principles, which can be summarized as follows:

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.

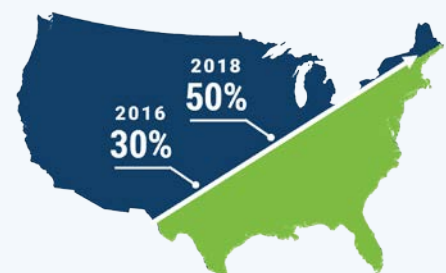
The Guiding Committee convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group (the “Work Group”) and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs 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*

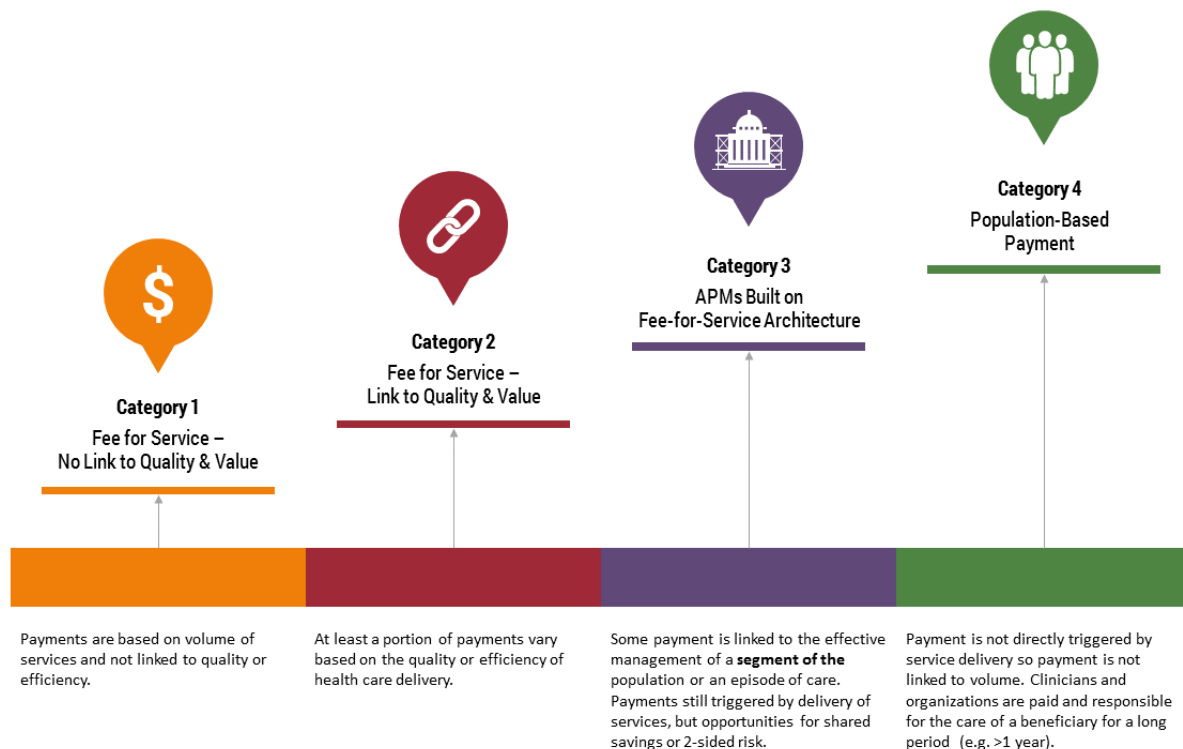
When developing the APM Framework, the Work Group began with the payment model classification scheme that CMS recently advanced,<sup>1</sup> and expanded it by introducing refinements that are described in more detail below. As illustrated in Figure 2, the CMS Framework assigns payments from plans to 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).

---

<sup>1</sup> 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.

---

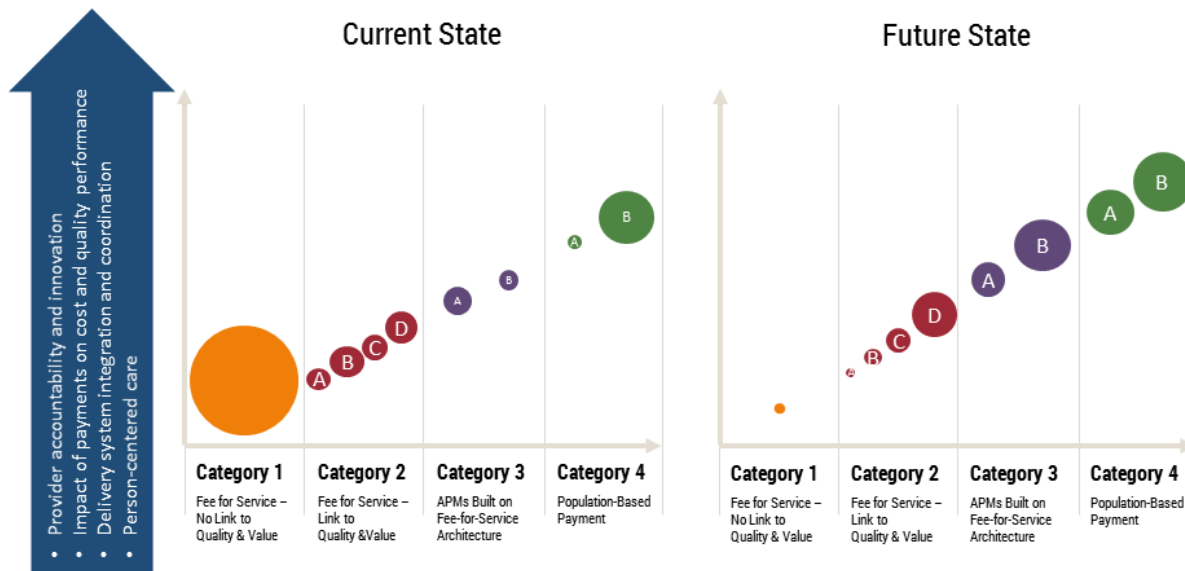
*Principle 2: As delivery systems evolve, the goal is to drive a shift towards shared risk and population based payment models that incentivize improvements in the quality and efficiency of person centered care.*

---

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 concerted 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.*

---

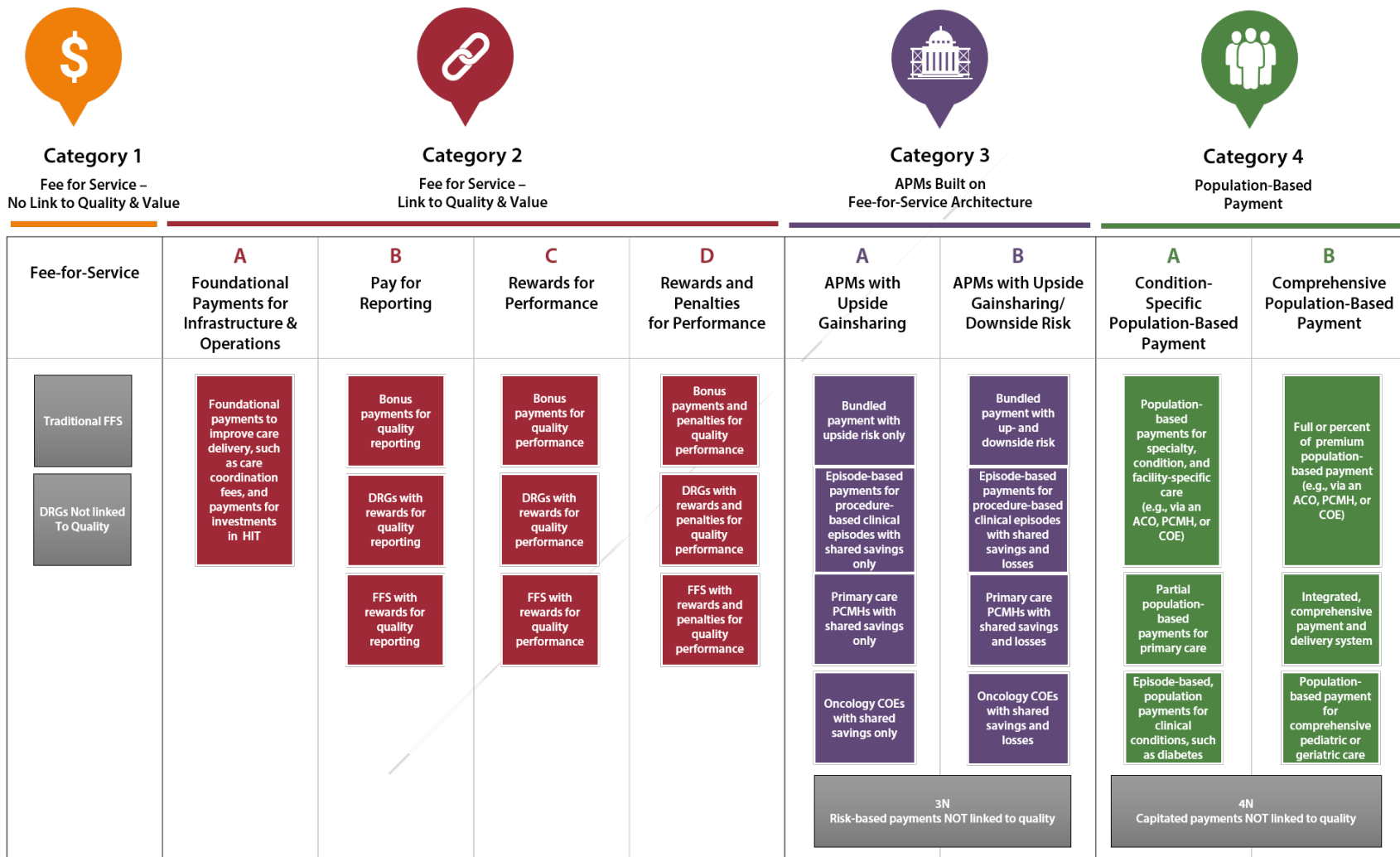
Consistent with the mission of the LAN, the Work Group limited the scope of the APM Framework to payment models, as opposed to delivery models. Because centers of excellence (COEs), patient centered medical homes (PCMHs), and ACOs are delivery models that can accommodate a wide variety of payment arrangements, 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.

---

## Appendix A: Work Group Members and Staff

### *Work Group Chair*

**Samuel R. Nussbaum, MD**

Former Executive Vice President, Clinical Health Policy and Chief Medical Officer, Anthem, Inc.

### *Work Group Members*

**Shari M. Erickson, MPH**

Vice President, Governmental Affairs and Medical Practice, American College of Physicians

**Andrea Gelzer, MD, MS, FACP**

Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas

**James Guest**

Former President and CEO of *Consumer Reports*

**Paul Harkaway, MD**

Senior Vice President, Clinical Integration and Accountable Care, Trinity Health, Inc.

**Scott Hewitt**

Vice President, Value Based Contracting Strategy, UnitedHealthcare

**Susan Nedza, MD, MBA, FACEP**

CMIO and Senior Vice President of Clinical Outcomes Management, MPA Healthcare Solutions

**Steve Philips**

Senior Director, Global Health Policy, Government Affairs and Policy, Johnson and Johnson

**Richard Popiel, MD, MBA**

Executive Vice President, Health Care Services and Chief Medical Officer, Cambia Health Solutions and Regence Health Insurance Company

**Rahul Rajkumar, MD, JD**

Deputy Director, Center for Medicare & Medicaid Innovation

**Jeffrey Rideout, MD, MA, FACP**

President and CEO, Integrated Healthcare Association

**Dick Salmon, MD, PhD**

National Medical Director, Performance Measurement and Improvement, CIGNA

**Julie Sonier**

Director Employee Insurance Division, Minnesota Management and Budget

**Lisa Woods**

Senior Director Health Care Benefits, Wal-Mart Stores, Inc.

### *CMS Alliance to Modernize Healthcare (CAMH) Staff*

CAMH, sponsored by CMS, is an FFRDC operated by The MITRE Corporation. MITRE is chartered to work in the public interest.

**Jamel Morris, MS, MBA**

Lead, LAN APM FPT Work Group

**Lauren Icard, MHS**

Lead, LAN APM FPT Work Group

**Grischa Metlay, PhD, MA**

Lead Health Care Policy Analyst and Technical SME

**Chris Izui, MS**

Lead, LAN Population Based Payment Work Group

**Anne Gauthier, MS**

LAN Project Leader

**Amy Aukema, MPP**

LAN Deputy Project Leader



*Catalyst for Payment Reform (CPR) Staff*

CPR is an independent, nonprofit corporation working on behalf of large employers and other health care purchasers to catalyze improvements in how we pay for health services and promote higher-value care in the U.S.

**Suzanne F. Delbanco, PhD**

Executive Director, Catalyst for Payment Reform

**Andréa Caballero**

Program Director, Catalyst for Payment Reform

**Roz Murray**

Project and Research Assistant, Catalyst for Payment Reform

# ADDENDUM

## Addendum to the Alternative Payment Model (APM) Framework White Paper

**APM Framework and Progress Tracking (FPT) Work Group**

**Health Care Payment Learning & Action Network**

**CMS Alliance to Modernize Healthcare**

**January 12, 2016**

*This Addendum presents the case studies submitted to the APM FPT Work Group in response to the draft APM Framework White Paper released October 2015.*

## Table of Contents



HCP LAN Health Care Payment Learning & Action Network .....	i
Table of Contents .....	1
Category 2: Fee for Service Linked to Quality and Value .....	2
<i>Anthem – Quality Cancer Care</i> .....	2
<i>Anthem – Quality In Sights Hospital Incentive Program</i> .....	3
<i>AmeriHealth Caritas– PerformPlus© Program</i> .....	4
<i>Cigna Collaborative Care Hospitals</i> .....	5
Category 3: APMs Built on Fee for Service Architecture .....	6
<i>Cigna Collaborative Care – large physician groups</i> .....	6
<i>CMS Comprehensive Primary Care (CPC) Initiatives</i> .....	7
<i>Anthem – Enhanced Personal Healthcare Model</i> .....	9
<i>FUHN – Safety Net Medicaid ACO</i> .....	10
<i>Integrated Healthcare Association (IHA) – Value Based Pay for Performance Program (VBP4P)</i> .....	12
<i>UnitedHealthcare – Episode Payment Program for Cancer Therapy</i> .....	13
<i>Arkansas Healthcare Payment Improvement Initiative (AHCPII)</i> .....	14
<i>CMS – Medicare Shared Savings Program (MSSP)</i> .....	16
<i>Minnesota Integrated Health Partnership</i> .....	18
<i>MD-Value In Prevention (VIP) - Personalized Preventive Primary Care</i> .....	20
Reference: <a href="http://www.ajmc.com/journals/issue/2014/2014-vol20-n8/personalized-preventive-care-reduces-healthcare-expenditures-among-medicare-advantage-beneficiaries/P-3">http://www.ajmc.com/journals/issue/2014/2014-vol20-n8/personalized-preventive-care-reduces-healthcare-expenditures-among-medicare-advantage-beneficiaries/P-3</a> .....	21
<i>CMS Bundled Payments for Care Improvement</i> .....	21
<i>Capital District Physicians’ Health Plan (CDPHP®) -Enhanced Primary Care (EPC) Program</i> .....	23
<i>Presbyterian Health Plan, Albuquerque, New Mexico</i> .....	25
Category 4: Population Based Payments.....	26
<i>Tufts Health Plan, Watertown, Massachusetts</i> .....	26

*Please note that the examples cataloged in this Addendum are intended to illustrate the likely ways in which real world APMs will be categorized in the APM Framework. These case studies have been voluntarily submitted by the LAN community. The Work Group will continue to collect and redistribute additional case studies after the release of the Final White Paper, with the goal of identifying examples for each of the subcategories. Categorizations of particular case studies may subsequently change based on additional information.*

## Category 2: Fee for Service Linked to Quality and Value

### **Anthem – Quality Cancer Care**

#### **Overview**

---

The Cancer Care Quality Program identifies certain cancer treatment pathways based on current medical evidence, peer reviewed published literature, consensus guidelines, and Anthem’s clinical policies, to support oncologists in identifying cancer treatment therapies that are proven effective and provide greater value. The program allows in network oncologists to receive treatment planning fees for choosing cancer treatment regimens most likely to produce better outcomes, fewer side effects and cost effective care.

#### **Underlying payment approach**

---

2(C) – FFS with rewards for quality.

#### **Approaches to cost assessment**

---

N/A

#### **Approaches to quality assessment**

---

Pay for performance with quality gates.

#### **Method and magnitude of payment adjustment**

---

Participating practices receive a \$350 one-time fee at the onset of treatment planning and care coordination for each member. The practice will also receive \$350 per month per member (PMPM) while the member is active in therapy and on pathway.

Providers will continue to be reimbursed for visits and cancer drugs according to the terms of the member’s health plan regardless of whether a treatment is on pathway, however, only pathway regimens are eligible for greater reimbursement for health plan in network providers.

#### **Additional infrastructure and operational investments**

---

N/A

#### **Results**

---

Data for Anthem states (GA, IN, KY, MO, OH, & WI) from 7/1/2014 to 12/31/2014 showed:

- 616 practices participating in the Program
- 5538 patients were registered in the Program
- Pathway adherence\* for the top three cancers
  - Breast = 63%
  - Colon = 72%
  - Non small cell lung cancer = 63%

\* pathway adherence goal for year 1 of Program is 55%.

## ***Anthem – Quality In Sights Hospital Incentive Program***

### **Overview**

---

Anthem’s Quality In Sights Hospital Incentive Program (Q HIP) ties increases in hospital reimbursement to performance on a scorecard consisting of nationally recognized measures of quality, outcomes and patient experience. The mission of Q HIP is to improve patient outcomes in the hospital setting and promote health care value by financially rewarding hospitals for practicing evidence based medicine and implementing best practices.

### **Underlying payment approach**

---

2(C) – FFS with rewards for quality

### **Approaches to cost assessment**

---

N/A

### **Approaches to quality assessment**

---

Pay for performance with quality gates, such that higher performance yields higher rewards

### **Method and magnitude of payment adjustment**

---

Q HIP has shifted annual hospital rate increases to an at-risk model where increases are only earned based on demonstrated performance on key value metrics. Hospitals “earn” their increases in payment rates based standards such as post discharge planning, adherence to a safety checklist and patient satisfaction.

Q HIP utilizes one of two payment methodologies dependent on market needs and hospital specific scenarios. The first Q HIP payment model establishes a static tiered payment scale where hospital performance determines the amount of annual rate increase earned (ex: score of 80 earns a 0.5% increase, a score of 85 earns a 1.0% increase, a score of 90 earns a 1.5% increase and a score of 95 earns a 2% increase). Payment scales are customizable at the market level and specific amounts at risk are specific to individual hospital contracts. Alternatively, a dynamic performance model is available which measures hospital performance against peer facilities within a given state or region. This model utilizes percentile and quartile measurements within the peer group to determine a given facility's earned increase based on their performance against those percentile/quartile thresholds.

### **Additional infrastructure and operational investments**

---

Q HIP offers numerous tools aimed at assisting facilities in meeting the scorecard goals, including best practice sharing webinars and compliance examples from SME hospitals for specific areas of care and/or metrics. Anthem staff are also available year round to discuss quality improvement activities and opportunities related to Q HIP metrics and connect facilities in need of assistance with “mentor” hospitals within the Q HIP community

---

## Results

Q HIP has driven impressive improvements across a spectrum of patient safety and quality metrics since inception, including:

- A 49% reduction in Early Elective Deliveries between years 2013 and 2014, resulting in fewer avoidable elective deliveries of infants prior to 39 weeks gestation. Ensuring these elective deliveries are prevented reduces both harm and mortality to the mother and child.
- A 13% decrease in likely inappropriate PCIs for patients without acute coronary syndrome between years 2013 and 2014, resulting in avoided angioplasty procedures for patients who didn’t need them according to American College of Cardiology Appropriate Use Criteria (AUC).
- A 14% increase in WHO Surgical Safety Checklist adoption by Q HIP hospitals between years 2012 and 2014, resulting in a safer surgery processes that have been shown to lead to lower complications and mortality for patients.

## *AmeriHealth Caritas– PerformPlus© Program*

---

### Overview

PerformPlus© represents ACFC’s suite of value based incentive programs available to participating physicians (primary care and specialists), hospitals, and integrated delivery systems. PerformPlus© is designed to reward providers for timely, appropriate care and positive patient outcomes. The programs advance delivery and payment reform and are aligned with efforts in the Medicare and Commercial markets. The quality measures that provide the foundation for each program are designed to incentivize necessary and preventive care and discourage preventable resource utilization. In certain markets, AmeriHealth Caritas’ PerformPlus© program includes category 3(A) shared savings arrangements with integrated delivery systems. Approximately 40% of AmeriHealth Caritas’ membership is touched in some way by a value-based PerformPlus© program.

---

### Underlying payment approach

2(C) –FFS with rewards for quality and cost efficiency.

3(A) – APM built on FFS architecture

---

### Approaches to cost assessment

Baselined to historical benchmarks and risk adjusted peer targets.

---

### Approaches to quality assessment

Pay for performance with quality gates.

---

## Method and magnitude of payment adjustment

---

PCP models include semi-annual capitation adjustments, upside only, based upon peer based percentile performance guardrails built upon quality and total cost of care results. IDS shared savings models include trend and peer based measurement based upon quality scorecard and efficiency measures such as preventable admissions, readmissions and emergency room usage. Annual settlement parameters with interim payment stream.

---

## Additional infrastructure and operational investments

---

Partners participating in the PerformPlus® model can access a secure, web based dashboard to track their progress for each metric, and produce self-service reports with drill down data mining capabilities. The dashboard also allows the identification of frequent emergency department utilizers, readmissions, HEDIS results, care gaps, clinical risk, and other member centric data to foster collaboration and meaningful member outreach. Data reports are updated monthly. Dashboards have been deployed to approximately 300 PCP groups, including FQHC and large IDS partnerships.

---

## Results

---

The majority of PerformPlus® partnerships have demonstrated positive quality and efficiency results. Quality improvement has been noted in prenatal care, post-partum care, chlamydia screening, beta blocker therapy, cholesterol testing and antiplatelet therapy HEDIS metric performance. Cost efficiency improvements include preventable readmissions, preventable admissions, reduced low acuity emergency room visits and improved NICU LOS management.

### *Cigna Collaborative Care Hospitals*

---

## Overview

---

Cigna's hospital collaborative initiative includes arrangements with over 330 hospitals and is a pay for performance model, which links the hospital's reimbursement to achievement of quality standards. Hospitals are measured on various quality based metrics including patient safety, patient experience, outcomes and efficiency. The program has two options for reimbursement: one where the at risk portion is paid as an increase in rate schedule based on a hospital's quality results and one where there is a bonus amount paid immediately after the measurement period.

---

## Underlying payment approach

---

2(D) – Rate escalator methodology: Portion of hospital's annual rate escalator is at risk based on its performance on quality metrics. The amount earned increases some of the FFS payments in future periods.

2(D) – Bonus methodology: Portion of hospital's annual rate escalator is removed and translated into an annual bonus amount which is at risk based on performance on quality metrics. The amount earned is paid after the measurement period.

---

## Approaches to cost assessment

---

For most measures, achievement is defined as a significant improvement compared to the hospital's baseline, or the hospital being in the top quartile of all hospitals reporting nationally.



---

**Approaches to quality assessment**

---

Hospital performance is based on 14 quality metrics focusing on outcomes, efficiency, patient experience, and process of care measures. Most metrics are CMS/Hospital Compare or all payer measures. Limited Cigna based metrics are also used.

---

**Method and magnitude of payment adjustment**

---

Each measure has a certain weighting attached; failure on any measure lowers the incentive payment by that weighted amount. To earn 100% of the incentive, a hospital must achieve top performance on each metric. The typical weighting is:

- CMS process of care measures 10%
- Outcome measures 45%
- Patient experience measures 20%
- Efficiency measures 25%

---

**Additional infrastructure and operational investments**

---

N/A

---

**Results**

---

Measures should correlate to lowered total medical costs and higher quality outcomes.

### Category 3: APMs Built on Fee for Service Architecture

#### *Cigna Collaborative Care – large physician groups*

---

**Overview**

---

Cigna has 142 collaborative care initiatives with large physician groups. Similar to CMS MSSP, Cigna provides financial incentives to improve the total medical cost and quality of care for an aligned population of patients. These groups provide care to over 1.6 million Cigna customers and comprise more than 65,000 physicians, over 32,000 of which are primary care physicians. More than two thirds of groups with at least two years of experience are meeting Cigna's total medical cost goals, over two thirds are meeting its quality goals and more than half are meeting both goals.

---

**Underlying payment approach**

---

3(A) –APM built on FFS architecture.

---

**Approaches to cost assessment**

---

Baselined to regional benchmarks.

Total medical cost is evaluated based on the physician group trend compared to market trend. The maximum potential reward is 50% of the difference.

---

**Approaches to quality assessment**

---

Pay for performance with quality gates.

Rewards are based on performance on 17 quality metrics relevant to a commercial population and available through claims data. Quality must be maintained or improved to be eligible for any financial incentive.

---

### **Method and magnitude of payment adjustment**

---

The incentive is paid in the following year as a care coordination payment on a PPPM basis. The care coordination payment amount is adjusted annually after reviewing the cost and quality performance of the physician group. When evaluating a group's performance Cigna first determines if the group's total medical costs are lowered compared to market trend to establish the maximum incentive award. The final step is to review the group's quality performance to determine the proportion of the maximum incentive award that the group receives.

- If quality deteriorates, there is no financial incentive.
- If quality is maintained but does not improve, the group gets 50% of the maximum possible incentive.
- If quality improves by four percent or reaches market or national benchmarks, the group can earn up to the entire maximum possible incentive.

---

### **Additional infrastructure and operational investments**

---

Cigna provides groups with a comprehensive set of total medical cost and quality performance reports. Information is provided that allows the groups to identify the opportunities for improvement for their patient population and track progress. These reports are also designed to allow the group to engage individual physicians to help drive improvement.

Cigna requires the groups to establish an "embedded care coordinator," typically a nurse employed by the group, who proactively engages with patients in need of greater care coordination, such as patients being discharged from the hospital, patients with multiple care providers, or patients with multiple gaps in care. Cigna provides predictive models to identify patients most in need of care coordination and trains the embedded care coordinators in their use. The embedded care coordinators are linked with Cigna medical case managers, behavioral case managers, pharmacists and chronic disease coaches who can provide additional services to at risk patients.

Finally, Cigna hosts quarterly national learning collaborative meetings designed to be a forum for sharing of best practices among the participating physician groups.

---

### **Results**

---

More than two thirds of groups with at least two years of experience are meeting Cigna's total medical cost goals, over two thirds are meeting its quality goals, and more than half are meeting both goals. The average impact on trend was a reduction of more than one percent.

### ***CMS Comprehensive Primary Care (CPC) Initiatives***

---

#### **Overview**

---

The Comprehensive Primary Care (CPC) initiative is a four year multipayer CMS model test designed to strengthen primary care. Since CPC's launch in October 2012, CMS has collaborated with commercial and State health insurance plans in seven U.S. regions to offer population based care management fees and shared savings opportunities to participating primary care practices to support the provision of a core set of five "Comprehensive" primary care functions for Medicare FFS beneficiaries. These five functions are: (1) Risk stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; (5) Coordination of Care across the Medical Neighborhood. The initiative is testing whether provision of these functions at each practice site (supported by multi payer payment reform, the continuous use of data to guide improvement, and meaningful use of health information technology) can achieve improved care, better health for populations, and lower costs, and can inform future Medicare and Medicaid policy.

---

### **Underlying payment approach**

---

3(A) – APM built on FFS architecture with upside risk only.

---

### **Approaches to cost assessment**

---

Baselined to regional benchmarks.

---

### **Approaches to quality assessment**

---

Pay for performance based on quality scores derived from EHR clinical quality measures, claims, and patient surveys.

---

### **Method and magnitude of payment adjustment**

---

Participating practices receive a monthly care management fee for each Medicare fee for service (FFS) beneficiary and, in cases where the state Medicaid agency is participating, for each Medicaid FFS beneficiary. The monthly payment from Medicare averages \$20 per beneficiary per month during the years one and two of the initiative (years 2013 14), and decreases to an average of \$15 per beneficiary per month during the third and fourth years (2015 16). Practices also receive monthly fees from other participating CPC payers and are expected to combine CPC revenues across payers to develop a whole practice transformation strategy.

Additionally, CMS is offering each CPC practice the opportunity to share net savings generated from improved care to Medicare beneficiaries attributable to the practice. Annually in years 2014 16, savings to the Medicare program will be calculated at a regional level and distributed to practices according to their performance on quality metrics. Practices have similar shared savings opportunities with other CPC payers in their region.

---

### **Additional infrastructure and operational investments**

---

CPC provides learning support and other resources to help practices work with patients in the five comprehensive primary care functions: (1) Risk stratified Care Management; (2) Access and Continuity; (3) Planned Care for Chronic Conditions and Preventive Care; (4) Patient and Caregiver Engagement; and (5) Coordination of Care across the Medical Neighborhood.

---

### **Results**

---

In year 2014, CPC practices showed positive quality results, with hospital readmissions lower than national benchmarks and high performance on patient experience measures, particularly on provider communication with patients and timely access to care. CPC practices that demonstrated high quality care and reduced spending above a threshold shared in savings generated for Medicare.

During this first shared savings performance year, the initiative decreased Medicare Part A and Part B spending compared to spending targets while achieving high quality outcomes. The CPC initiative generated a total of \$24 million in gross savings overall (excluding the CPC care management fees). These results reflect the work of 483 practices that served approximately 377,000 people with Medicare and more than 2.7 million patients overall. Four of the CPC initiative's seven regions (Arkansas, Colorado, Cincinnati Dayton region of Ohio, and Oregon) generated gross savings. The Greater Tulsa region decreased costs in excess of the CPC care management fees, generating net savings of \$10.8 million and earning more than \$500,000 in shared savings payments.

## ***Anthem – Enhanced Personal Healthcare Model***

### **Overview**

---

Enhanced Personal Health Care (EPHC) is Anthem's value based payment initiative that rewards high quality care, improved health outcomes and cost efficiency, rather than volume of care delivered.

### **Underlying payment approach**

---

3(A) – APMs built on FFS architecture with upside risk only.

### **Approaches to cost assessment**

---

Primary care providers held accountable for the total cost of care for their attributed members, including professional, facility and post-acute care.

### **Approaches to quality assessment**

---

Performance on a scorecard of 27 nationally recognized quality and efficiency measures determines whether providers receive shared savings, and calibrates the amount of shared savings for which providers are eligible.

### **Method and magnitude of payment adjustment**

---

Each year, our actuaries set a Medical Cost Target (MCT) for each participating provider group, based on the expected cost of health care services for attributed members. Risk adjusted costs incurred during the year are compared with the medical cost target. If the actual costs are less than the medical cost target and the provider meets a quality threshold, then the provider becomes eligible to receive a portion of the savings. If a provider does not meet the quality threshold, the provider is NOT entitled to any bonus payment, regardless of the savings generated. The amount of the shared savings bonus is calibrated based on the Provider's quality scores, subject to a maximum payment amount. On average, providers are eligible for up to 35% of the shared savings they generate; providers who assume downside risk as well as upside are eligible for up to 50% of shared savings.

### **Additional infrastructure and operational investments**

---

The EPHC model supports participating providers through investment in expanded access, population health management and care coordination.

- PMPM Clinical coordination payments are targeted to support important clinical interventions that occur outside of a patient visit. This can include investments in population health management (like creating a disease registry or disease management outreach program), investments in population management infrastructure (such as acquiring electronic health records), or hiring care additional clinical staff to help coordinate patient care.
- EPHC fortifies value based payment with a robust suite of tools, support, and resources that providers need to thrive in a value based payment environment.
- Provider Care Management Solutions (PCMS) is a web based population health management application, designed to provide a full picture of patient health history, and identify interventions to manage chronic conditions and exercise preventative care. Through alerts, dashboards, and reports, PCMS gives practices the tools to risk stratify their membership to identify the most vulnerable patients in need of intervention.

Anthem's Care Delivery Transformation team provides transformation support to helps providers assume accountability for the health of patient populations.

---

## Results

Data from Anthem's first year of program experience point to Cost of Care savings of \$9.51 per attributed member per month. EPHC generated cost savings through reductions in acute patient stays, emergency room visits, and reduced outpatient surgery costs. EPHC providers outperformed peers on several clinical quality measures, and patients rated many aspects of their care experience better than comparison patients.

## *FUHN – Safety Net Medicaid ACO*

---

### Overview

The Federally Qualified Health Center Urban Healthcare Network (FUHN) is one of sixteen Medical Assistance Integrated Health Partnerships (IHPs) authorized by Minnesota's Department of Human Services (DHS). IHPs were created by the 2010 Minnesota Legislature that authorized DHS to establish a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations (ACO) that provide services to a specified patient population for an agreed upon total cost of care or risk/gain sharing payment arrangement." (Minnesota Statutes, 256B.0755, 2010, 1<sup>st</sup> Special Session, Chapter 1, Article 16, Section 19)

In response to this initiative, FUHN formed a "virtual" ACO as it consists solely of FQHCs and is not affiliated with any hospitals or health systems. FUHN consists of 10 FQHCs with 40 delivery sites, all located within the Twin Cities of Minneapolis and Saint Paul. Almost 28,000 Medical Assistance (MA) patients are attributed to FUHN. FUHN is currently the third-largest IHP in Minnesota and is one of the first six IHPs launched in year 2012. FUHN demonstration's approach relies heavily on the primary care relationship, enhanced care coordination efforts supported by robust data analytic capabilities, and patient activation strategies.

Nationally, FUHN is the first FQHC-only Medical Assistance accountable care organization.

---

## **Underlying payment approach**

---

3(A) – APM built on FFS architecture

## **Approaches to cost assessment**

---

DHS sets a “benchmark” cost for FUHN’s attributable Medicaid population each year. FUHN is then accountable for the total cost of care for a defined set of Medicaid services. However, some services are excluded from the cost assessment such as ambulatory dental, transportation, long term care, and residential mental health services.

## **Approaches to quality assessment**

---

IHPs must meet the reporting requirements outlined under the state’s Statewide Quality Reporting and Measurement System (SQRMS). FUHN and DHS’ IHP contract requires relative improvement in FUHN’s SQRMS measures compared to the previous year. Relative improvement and comparison to FUHN only previously reported SQRMS quality outcomes was necessary as SQRMS does not currently consider the social determinants of health (SDH) such as homelessness, poverty, race/ethnicity, language and country of origin to risk-adjust provider quality measures. The lack of such risk-adjustment is especially important given SQRMS reporting reflects an aggregate reported population at the provider organizational. This aggregation fails to control not only for SDH differences that disproportionately affects safety net populations, like FUHN FQHCs, but also fails to control for differences in payer mix among disparate provider organizations.

## **Method and magnitude of payment adjustment**

---

Achieved total cost of care (TCOC) savings are shared equally (50/50) between FUHN and DHS only when a threshold of 2% of savings is achieved. In addition, FUHN’s ability to realize its 50% of achieved TCOC savings is subject to meeting the SQRMS measures as discussed above, with up to 50% of FUHN’s TCOC savings currently at risk if quality expectations are not met. As a “virtual” IHP model, there is no “down-side risk.”

Of note, FUHN’s participant 10 FQHCs individually maintain their right to the federally-mandated Medical Assistance payment methodology known as the Prospective Payment System (PPS). FQHCs payments received under PPS are included in determining FUHN’s attributable population’s TCOC. Authorized in federal law in 1999, the PPS provides FQHCs with a per encounter reimbursement that recognizes not only the unique patient base of FQHCs – 80% uninsured or enrolled in public programs such as Medical Assistance – and the “enabling” services provided at FQHCs to serve a diverse (70% non-white, 30% served in a language other than English) population.

It is also important to note that the state of Minnesota did not provide any “start-up” or operational funding to the IHPs including FUHN. Instead, FUHN, through a competitive process, secured an administrative services partner to support the needed technical, personnel, and data analytic infrastructure required to stand up FUHN’s IHP. These services aided FUHN and its participant FQHC’s in identifying opportunities for enhanced primary care-patient engagement and informed the strategic initiatives that FUHN has undertaken as an ACO.

## **Additional infrastructure and operational investments**

---

N/A

---

## Results

To date, FUHN:

- Reduced the total cost of care in Year 1 (2013) by 3.1%.
- Achieved a projected 4.5% reduction in the total cost of care for Year 2 (2014) with \$4.8 million in anticipated
- Achieved a total savings of \$9.4 million - \$3.6 million in 2013 and \$4.8 million in 2014.
- Reduced emergency room use by 18%.

## *Integrated Healthcare Association (IHA) – Value Based Pay for Performance Program (VBP4P)*

---

### Overview

The Integrated Healthcare Association’s (IHA’s) California Value Based Pay for Performance program, a shared savings model, holds physician organizations accountable for cost, cost trend, and resources used for all care provided to their commercial health maintenance organization (HMO)/point of service (POS) members, as well as the quality of this care. Physician organizations must meet minimum quality and cost trend standards to be eligible for shared savings payments. Along with the incentive design, the program features use of a common set of measures (with benchmarks), public reporting, and physician organization performance recognition awards. Launched in 2001, participation in this statewide program now includes 10 health plans and 200 physician organizations caring for 9 million Californians.

---

### Underlying payment approach

3(A) –APM with FFS Architecture.

---

### Approaches to cost assessment

Cost performance is assessed using a Total Cost of Care measure with adjustments to account for differences in risk and geographic input costs. The percent change in Total Cost of Care between years is compared against a gate of CPI + three percent to determine physician organization eligibility for shared savings incentive payments.

Estimated cost savings are derived from improvements in resource use measures using physician organization specific unit costs applied to resource units saved.

---

### Approaches to quality assessment

A composite definition of quality is used in two ways: (1) minimum standard for eligibility for incentives and (2) adjustment to the share of savings earned. The quality composite combines three domains: clinical care measures (e.g., administratively derived HEDIS and PQA measures) weighted at 50%, patient experience (using CG CAHPS) weighted at 20%, and meaningful use of health IT (based on the CMS meaningful use standards) weighted at 30%. Physician organization performance is assessed on both attainment and improvement (similar to CMS Hospital Value Based Purchasing model).

---

### Method and magnitude of payment adjustment

The Value Based P4P incentive design is based on shared savings; adjusted for quality results. Shared savings are calculated based on performance on resource use measures, including: inpatient utilization



and readmissions, emergency department visits, outpatient procedures utilization, and generic prescribing. Cost savings are estimated for each of the five resource use measures. The number of units of utilization below the target (which is generally the physician organization's previous year performance) is multiplied by the unit cost; 50% of the resulting amount is the physician organization's base incentive amount for that resource use measure. Base incentive amounts may be positive or negative depending on whether performance improved or worsened, and are then summed across resource use measures to generate net shared savings. The net shared savings amount is then adjusted based on the physician organization's quality performance.

---

### **Additional infrastructure and operational investments**

From a physician organization perspective, participants voluntarily participate in the collection of patient experience results (clinician and group CAHPS survey) and may invest in systems to support improved data collection, patient monitoring, and self-reporting of audited performance results.

From a program administration perspective, IHA provides a Web reporting portal with downloadable data, benchmarks, and visualizations of performance compared to peers. For resource use measures, patient level files that support measurement results are available. IHA is currently developing interim reports with benchmarks and patient level detail to support performance improvement efforts. We also annually convene a stakeholders' conference highlighting overall program performance and focusing on learnings and best practices in various areas.

---

### **Results**

The first participating health plan made payments using the design in year 2014, two additional health plans implemented in year 2015, and two more have adopted the design. Together these five health plans – Aetna, Anthem Blue Cross, Blue Shield of California, and UnitedHealthcare. For the first year, 39% of physician organizations (52) earned a shared savings payment by meeting the minimum standards for quality and cost trend and generating net adjusted shared savings across five resource use measures. The total shared savings payments for the one health plan were \$8.05M and averaged \$1.90 PMPM.

Summary information on health plans' year 2015 payments are still being collected. However, based on the program measure results, it appears that almost half of POs are on track to meet the minimum quality and cost trend standards and generate adjusted shared savings.

### ***UnitedHealthcare – Episode Payment Program for Cancer Therapy***

---

#### **Overview**

UnitedHealthcare's pilot program included five medical oncology groups from Atlanta, Fort Worth, Miami, Dayton, and Memphis.

---

#### **Underlying payment approach**

3(A) –APM with FFS Architecture.

The program was designed as a risk sharing arrangement without downside risk. The medical oncologists chose their specific chemotherapy regimen for 19 different clinical scenarios in breast, colon and lung cancer. The medical group was paid the calculated drug profits from those regimens on the first day of

treatment (episode payment). All other services were paid fee for service. Chemotherapy drugs were paid at cost.

The medical groups were free to change the chemotherapy regimens at any time, but the episode payment was frozen until the pilot was completed. The episode could only be increased if the groups demonstrated a reduction of total cost of care or an improved survival compared to patients treated in standard fee for service.

---

### **Approaches to cost assessment**

The pilot group was compared using total cost of care to a matched cohort of cancer patients treated in a contemporary fee for service design. No costs were excluded from the analysis.

---

### **Approaches to quality assessment**

There were 64 measures of quality. Representative measures include mortality, hospitalization, and emergency room usage, median days from last chemotherapy to death and use of erythropoietin in adjuvant therapy.

---

### **Method and magnitude of payment adjustment**

The pilot sample of 810 patients was measured using a difference of differences between the fee for service control group using a pre test and post test measurement. Regression models for the type of cancer, stage and previous performance were examined.

---

### **Additional infrastructure and operational investments**

Most of the medical groups added additional clinic hours including weekend coverage. The business office required a dedicated individual to adjust the claims and receipts with this model.

---

### **Results**

The pilot group delivered their cancer care for \$33,361,272 less than the comparable fee for service patients. This represented a 34% reduction in the cost of care. Survivals were the same for both groups. The pilot group had far fewer hospitalizations for complications of the cancer and the therapy.

---

## ***Arkansas Healthcare Payment Improvement Initiative (AHCPII)***

---

### **Overview**

The Arkansas Healthcare Payment Improvement Initiative (AHCPII) is a collaborative effort across public and private payers focused on designing and supporting implementation of a new payment system in Arkansas tailored to the unique needs of patients and providers. The model employs two primary components: 1) Patient centered medical homes (PCMH) and 2) Retrospective episodes for medical care.

---

### **Underlying payment approach**

PCMH 3(A) –APM with FFS Architecture.

Episodes of care model – 3(B) – APM with FFS Architecture.

---

### **Approaches to cost assessment**

For PCMH, providers risk adjusted average cost are assessed and compared to historical Arkansas based benchmark trend. Providers may receive shared savings for achieving cost growth that is lower than their own historical benchmark trend or a statewide benchmark trend.

For the episodes of care model, providers average episode cost are assessed based on episode specific algorithms, and compared on an annual basis to statewide historical benchmarks. Acceptable costs are characterized as approximately the middle 50 percentile range, commendable costs are approximately the lower 25 percentile range, and unacceptable cost are approximately the upper 25th percentile range.

---

### **Approaches to quality assessment**

---

For both the PCMH and episodes model, providers must meet predetermined quality targets in order to be eligible for any gain share payments (for episodes) or shared savings payments (PCMH). Detailed descriptions for episodic and PCMH quality targets can be found at the [Health Care Payment Improvement Initiative website](#).

---

### **Method and magnitude of payment adjustment**

---

For the PCMH model, providers are eligible for up to 50 percent of the savings generated as a result of achieving cost growth below either the historical statewide or provider specific benchmark trend.

For episodes providers may receive fifty percent of average costs below the commendable threshold, or conversely may be subject to 50 percent of average costs that fall above the unacceptable threshold.

---

### **Additional infrastructure and operational investments**

---

PCMH participants receive per member per month care coordination payments if they successfully achieve practice transformation milestones and quality metrics. Providers receive quarterly reports that are accessed on an online provider portal. These reports offer providers detailed information about key quality and utilization metrics for their performance.

---

### **Results**

---

#### PCMH

In year 2014, Medicaid realized \$34.3 million in direct cost avoidance through trend reduction. Of the \$34.3 million in savings, \$12.1 million went to care coordination payments to providers. The remaining 22.2 million in net cost avoidance was shared between the state and those providers who met both quality and cost requirements.

In year 2014, enrolled practices received a cost decrease of 1.2 percent, beating both the 2.6% benchmark trend increase and the 0.6% cost growth of non-enrolled practices

In year 2014, the vast majority of practices met transformation milestones, and approximately 78% of quality measures either improved or maintained prior year levels.

#### Episodes of care

Medicaid has achieved quality improvements and cost avoidance

- Perinatal: C section rate reduced from 36% to 34%, with an estimated 2.4% savings to date
- URI: 17% reduction in antibiotic prescriptions; episode costs remained flat despite a 10% increase in drug prices
- ADHD: average episode cost fell by 22%, with 400 providers contacted regarding stimulant prescribing
- Total Joint Replacement: number of episodes down from 141 to 101; 30 day all cause readmission rate reduced from 3.9% to zero; estimated 5% to 10% direct savings to date

For 2014, Arkansas BCBS reported reductions in cost across several implemented episodes, either beating projected trend or demonstrating actual cost reductions

- Heart Failure: lowered actual costs 10.3%
- Perinatal: lowered actual cost 1.3%
- Colonoscopy: lowered actual cost 1.5%
- Total Hip Knee Replacement: 2.9% below projected costs, costs increased 0.8%

### ***CMS – Medicare Shared Savings Program (MSSP)***

#### **Overview**

---

The Medicare Shared Savings Program (Shared Savings Program) was established by Section 3022 of the Affordable Care Act to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee For Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). These ACOs create incentives for health care providers to work together to treat an individual patient across care settings – including doctor’s offices, hospitals, and long term care facilities. The Medicare Shared Savings Program (Shared Savings Program) will reward ACOs that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first. Provider participation in an ACO is purely voluntary.

Under the program regulations, the ACO providers and suppliers continue to be paid for services rendered to Fee for Service Medicare beneficiaries in the same manner as they would otherwise. In addition, the ACO that meets the program’s quality performance standards may receive a share of the savings if its assigned beneficiary expenditures are below its own specific updated expenditure benchmark. The regulations would also hold certain ACOs accountable for sharing losses by requiring ACOs to repay Medicare for a portion of losses (expenditures above its updated benchmark). To provide an entry point for organizations with varied levels of experience with and willingness to share losses, the regulations allow an ACO to choose one of two program tracks.

Track 1: Allows an ACO to operate on a shared savings only arrangement for the duration of their first agreement.

Track 2: Allows ACOs to share in savings and losses for the duration of the agreement, in return for a higher share of any savings it generates.

#### **Underlying payment approach**

---

Track 1: 3(A) – APMs built on FFS architecture with upside risk only.

Track 2: 3(B) – APMs built on FFS architecture with upside and downside risk.

---

### **Approaches to cost assessment**

---

#### Baselined to provider’s past performance

Section 1899(d)(1)(B)(ii) of the Act requires the Secretary to establish the “benchmark for each agreement period for each ACO using the most recent available 3 years of per beneficiary expenditures for Parts A and B services for Medicare Fee For Service beneficiaries assigned to the ACO.” This section also requires the benchmark to “be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for Parts A and B services under the original Medicare Fee For Service Program, as estimated by the Secretary.” A new benchmark is to be established, consistent with these requirements, at the beginning of each agreement period.

---

### **Approaches to quality assessment**

---

#### Pay for performance based on quality performance standards

Thirty three individual measures of quality performance are used to determine if an ACO qualifies for shared savings. These 33 measures span four quality domains: Patient Experience of Care, Care Coordination/Patient Safety, Preventive Health, and At Risk Population. The ACO quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Programs.

Pay for performance will be phased in over the ACO’s first agreement period as follows:

- Year 1: Pay for reporting applies to all 33 measures.
- Year 2: Pay for performance applies to 25 measures. Pay for reporting applies to eight measures.
- Year 3: Pay for performance applies to 32 measures. Pay for reporting applies to one measure that is a survey measure of functional status. CMS will keep the measure in pay for reporting status for the entire agreement period. This will allow ACOs to gain experience with the measure and will provide important information to them on improving the outcomes of their patient populations.

---

### **Method and magnitude of payment adjustment**

---

**Track 1** – The ACO may earn a sharing rate of up to 50 percent based on quality performance. Under the one sided model, the performance payment limit is 10 percent of the applicable year’s Part A and Part B updated benchmark.

**Track 2** – The ACO may earn a sharing rate of up to 60 percent based on quality performance. Under the two sided model, the performance payment limit is 15 percent of the applicable year’s Part A and Part B updated benchmark.

---

### **Additional infrastructure and operational investments**

---

N/A

---

### **Results**

---

Ninety-two Shared Savings Program ACOs held spending \$806 million below their targets and earned performance payments of more than \$341 million as their share of program savings. No Track 2 ACOs owed CMS losses. Total net savings to the Medicare Trust Funds was \$465 million. These numbers represent an increase from year 2013, when 58 ACOs held spending \$705 million below their targets and earned performance payments of more than \$315 million. Total net savings to the Medicare Trust Funds was \$383 million.

- An additional 89 ACOs reduced health care costs compared to their benchmark, but did not qualify for shared savings, as they did not meet the minimum savings threshold.
- ACOs with more experience in the program were more likely to generate shared savings. Among ACOs that entered the program in year 2012, 37 % generated shared savings, compared to 27 % of those that entered in year 2013, and 19 % of those that entered in year 2014.
- Shared Savings Program ACOs that reported in both year 2013 and year 2014 improved 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.
- Shared Savings Program ACOs achieved higher average performance rates on 18 of the 22 Group Practice Reporting Option Web Interface measures reported by other Medicare FFS providers reporting through this system.
- Eligible professionals participating in ACOs also qualify for their Physician Quality Reporting System (PQRS) incentive payments for reporting their quality of care through the ACO. These providers will also avoid the PQRS payment adjustment in year 2016 because their ACO satisfactorily reported quality measures on their behalf for the 2014 reporting year.
- The Shared Savings Program continues to receive strong interest from both new applicants seeking to join the program as well as from existing ACOs seeking to continue in the program for a second agreement period starting in year 2016. New and renewing ACOs will be announced around the end of year 2015.

## ***Minnesota Integrated Health Partnership***

### **Overview**

---

Minnesota's Integrated Health Partnership (IHP) program allows Medicaid providers to form ACO like entities that meet state criteria including offering a full scope of primary care; coordinating, locating and monitoring of health care services across the care system; partnering with community based organizations and public health agencies; having data systems that are able to receive data electronically from the state, stratify beneficiaries by need; and that participate in required quality measurement and improvement activities for Medicaid beneficiaries.

There are two types of IHP delivery models: "virtual" model entities, which include FQHCs and entities with smaller numbers of attributed beneficiaries and "integrated" model entities, which include larger numbers of attributed beneficiaries and providers such as hospital systems. IHP entities that meet pre-established quality targets and which lower the total cost of care of their beneficiaries relative to projected costs are eligible to receive "shared savings" payments from the state. IHP entities which are not able to lower beneficiary costs below established thresholds are at risk of financial penalties. In addition, quality targets must be met to receive the total, potential shared savings payment amount.

---

## Underlying payment approach

---

Years 1 & 2: 3(A) – APMs built on FFS architecture with upside risk only

Year 3: 3(B) – APMs built on FFS architecture with upside and downside risk

The Medicaid state plan authorizes shared savings payments through 1905(t) authority to IHPs that demonstrate quality care and reduce the TCOC of their attributed beneficiaries. IHPs that are classified as “integrated” providers are subject to downside risk (financial penalties) if TCOC measured in the “participation year” exceeds the target TCOC. IHPs with fewer than 2,000 attributed beneficiaries and IHPs that include FQHCs are classified as “virtual” providers and are not subject to downside risk, i.e., these providers are not required to pay back costs that exceed target costs.

---

## Approaches to cost assessment

---

Cost is measured per IHP based on Medicaid beneficiaries attributed during the performance period. Beneficiary attribution is determined retrospectively by the state Medicaid agency. The total cost of care per beneficiary includes fee for service (FFS) cost and managed care cost in the total cost pool, but providers are only rewarded in the state plan for FFS TCOC reductions. The TCOC includes services mandated by the state Medicaid agency and any additional services agreed upon by an IHP and the state Medicaid agency. Cost projections are adjusted for risk based on attributed beneficiaries’ diagnoses and trended based on state calculated Medicaid cost trends. Individual claims in excess of \$50,000 are excluded from the TCOC and certain populations are excluded from attribution.

---

## Approaches to quality assessment

---

Pay for performance with quality gates.

The amount of shared savings payments is subject to meeting quality performance targets established by Minnesota Community Measurement and are updated yearly\*. Quality measures impact the payments differentially per contract year. In year one, 25% of the shared savings payment is at risk if providers do not report quality measure results. In year two, 25% of the shared savings payment is at risk if providers do not achieve the quality measure targets, and in year three the percent at risk increases to 50%.

The [IHP quality & patient experience measures](#), using year 2014 data, are found online.

---

## Method and magnitude of payment adjustment

---

The IHP program is based on 3 year contract periods per provider. Shared savings payments are made to Integrated and Virtual IHPs from the first dollar saved (no minimum savings rate). The magnitude of the amount of savings shared between the state and the IHP provider is negotiated between the state and the provider, but in year 3, the amount of gain sharing (for Integrated IHPs) must be the same amount as the risk sharing. For example, if the gain sharing amount is 70% IHP provider / 30% state Medicaid agency in year three, losses must be shared at 70% IHP provider / 30% state Medicaid agency as well.

---

## Additional infrastructure and operational investments

---

N/A

---

## Results

---



Nine providers and 165,000 Minnesota medical assistance enrollees participated in the program in year 2014. As of June 2015, the IHP demonstration expanded to include 16 providers, covering over 200,000 enrollees, which equates to about one in five people served by Minnesota's public health care programs.

Minnesota has reported that the program saved \$14.8 million in the first year of operations and \$61.5 million in the second year, while decreasing hospitalizations and emergency room visits.

[\(Minnesota press release\)](#)

## ***MD-Value In Prevention (VIP) - Personalized Preventive Primary Care***

### **Overview**

---

MDVIP, consists of a network of affiliated primary care physicians, uses a model based on an augmented physician-patient relationship and focused on preventive medicine. A five-year, prospective study, completed in 2010, was conducted to investigate the impact of this model on hospital admissions in primary care practices in five states: New York, Florida, Virginia, Arizona, and Nevada. The study population included 2360 Medicare Advantage and commercial participants with case-matched controls.

### **Underlying payment approach**

---

3(B) – APMs with Upside Gainsharing/Downside Risk.

Primary care capitation (population-based), at 10-14% of the global cost of healthcare. Uncontrolled FFS payment for all other services (hospital, other specialties)

### **Approaches to cost assessment**

---

Baselined to regional benchmarks, case-control comparisons. Utilization metrics included annual rates of emergency department visits, inpatient expenditures, and readmissions, as well as length (in days) of hospital stay and average inpatient expenditures comparing participants with matched non-participants. Intellimed database and Medicare database used to compare admissions and cost.

### **Approaches to quality assessment**

---

Direct feedback to practices, admission rates for ambulatory care sensitive conditions, readmission rates for acute MI, Pneumonia, and CHF.

### **Method and magnitude of payment adjustment**

---

Providers were paid only primary care capitation.

### **Additional infrastructure and operational investments**

---

Providers were advised of recommended screening and access requirements.

### **Results**

---

Study resulted in:

- Reduction in annual hospital admissions of 42%, 47%, 54%, 58% and 62% for all participants.



- Reduction in annual hospital admission rates for Medicare participants of 70%, increasing to 79% over the study.
- Reduction in elective, non-elective, emergent, urgent, avoidable and unavoidable admissions.
- Reduction in avoidable admissions of 23%, 31%, 38%, 47%, and 49% annually.
- Reduction in supposedly unavoidable admissions of 45%, 49%, 56%, 59%, and 63% annually.
- Reduction in hospital readmissions for Medicare participants, including a 97% reduction for acute MI, 95% reduction for CHF, and a 91% reduction for pneumonia when compared to the control population.
- Savings of \$2551 per Medicare participant per year (\$212.58 pmpm).

**Reference:** <http://www.ajmc.com/journals/issue/2014/2014-vol20-n8/personalized-preventive-care-reduces-healthcare-expenditures-among-medicare-advantage-beneficiaries/P-3>

## **CMS Bundled Payments for Care Improvement**

### **Overview**

---

The Bundled Payments for Care Improvement (BPCI) initiative is comprised of four broadly defined models of care, which link payments for the multiple services beneficiaries receive during an episode of care. CMS defines an episode of care as the set of services provided to treat a clinical condition or procedure, such as a heart bypass surgery or a hip replacement. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care.

Three BPCI models of care (Models 2, 3, and 4) provide upside risk. Models 2 and Model 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care.

In Model 2, the episode includes the inpatient stay in an acute care hospital plus the post-acute care and all related services up to 90 days after hospital discharge. In Model 3, the episode of care is triggered by an acute care hospital stay but begins at initiation of post-acute care services with a skilled nursing facility, inpatient rehabilitation facility, long term care hospital or home health agency.

In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which lasts the entire inpatient stay. Physicians and other practitioners submit “no pay” claims to Medicare and are paid by the hospital out of the bundled payment. The first cohorts of Awardees in Models 2, 3, and 4 began in October 2013.

### **Underlying payment approach**

---

3(B) APMs built on FFS architecture with upside and downside risk.

### **Approaches to cost assessment**

---

At risk if costs for the bundle are higher than a historical benchmark.

### **Approaches to quality assessment**

---

CMS is committed to ensuring that beneficiaries receiving care from providers participating in BPCI receive high quality care. To that end, CMS is analyzing information available from Awardees’ claims and quality reporting, as well as surveys and patient assessment tools to assess care experience and health outcomes. CMS’ monitoring effort aims to identify quality improvements, including process improvements, changes in outcomes, and reductions in expenditures, and to detect inappropriate practices such as care stinting, patient selection to maximize financial gain, and cost shifting. Participants are required to comply with and participate in evaluation and monitoring activities and data collection efforts. Participants must also continue to meet current quality standards required by the Medicare program.

---

### **Method and magnitude of payment adjustment**

Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Under these payment models, Medicare continues to make fee for service (FFS) payments to providers and suppliers furnishing services to beneficiaries. At the time of reconciliation, the total expenditures for all related services during a beneficiary’s episode are compared against a bundled payment amount (the target price) determined by the Centers for Medicare & Medicaid Services (CMS). If the total expenditures are below the bundled payment amount, then CMS shares those savings with the Awardee; if the total expenditures are above the bundled payment amount, then the Awardee pays a recoupment amount to CMS.

In Model 4, CMS makes a single, prospectively determined bundled payment to the hospital that encompasses all services furnished by the hospital, physicians, and other practitioners during the episode of care, which includes the entire inpatient stay and any related readmissions. In general, physicians and other practitioners are paid by the hospital out of the prospective bundled payment amount.

---

### **Additional infrastructure and operational investments**

Implementation of Models 2, 3 and 4 was divided into two phases. During Phase 1, also referred to as “the preparation period,” CMS shared data and engaged in education and shared learning activities with participants as they prepared for assumption of financial risk under Phase 2, the performance, or “risk bearing implementation,” period.

---

### **Results**

It is still too early to report results. See the context below:

Implementation of Models 2, 3 and 4 was divided into two phases. During Phase 1, also referred to as “the preparation period,” CMS shared data and engaged in education and shared learning activities with participants as they prepared for assumption of financial risk under Phase 2, the performance, or “risk bearing implementation,” period. CMS announced the first set of BPCI Phase 1 participants on January 31, 2013. By October 1, 2013, some BPCI participants entered into Awardee Agreements with CMS, at which point they became Awardees and began bearing financial risk with CMS for some or all of their episodes. CMS required all participants to transition at least one episode into Phase 2 by July 1, 2015 in order to continue participation in the initiative.

As of July 1, 2015, BPCI has 2115 participants in Phase 2. The 2115 participants are composed of 360 Awardees and 1755 Episode Initiators actively involved in care redesign. The breakdown of participants by provider type is as follows:

- Acute Care Hospitals (423)
- Physician Group Practices (441)
- Home Health Agencies (101)
- Inpatient Rehabilitation Facilities (9)
- Long Term Care Hospitals (1)
- Skilled Nursing Facilities (1071)

***Capital District Physicians’ Health Plan (CDPHP®) -Enhanced Primary Care (EPC) Program***

**Overview**

---

The CDPHP Enhanced Primary Care (EPC) program moves primary care doctors from a historic fee for service (FFS) payment model, to a risk adjusted global payment with the addition of a quality bonus. These two payment structures combine to give physicians the opportunity to increase their earning potential by an average of 40%. Now in its seventh year, EPC includes 193 network practices, 836 network clinicians, and more than 250,000 CDPHP members (more than 50% of total enrollment.)

**Underlying payment approach**

---

3(B) – APMs with Upside Gainsharing/Downside Risk. The replacement of the FFS model with a risk adjusted global payment for primary care services currently pays an average of 40% more than FFS equivalent claims, with the opportunity for an average 20% bonus based on success in the goals of the Triple Aim.

**Approaches to cost assessment**

---

Cost or efficiency is assessed using a risk adjusted relative utilization of health care resources in six categories: inpatient hospital, emergency room, medical imaging, pharmacy, laboratory, and specialists. CDPHP uses a risk adjusted total cost of care assessment (Optum Impact Intelligence) that creates an index of the practice’s performance compared to the network. The practice is then assigned a percentile rank of efficiency performance, which creates an efficiency score.

**Approaches to quality assessment**

---

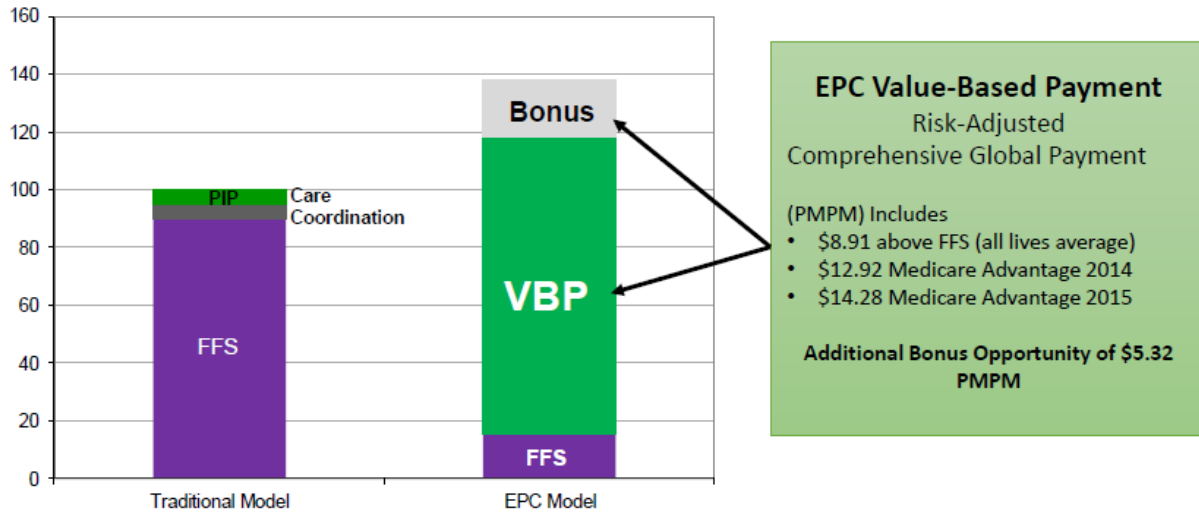
Quality is assessed using HEDIS metrics or composites in four categories: population health and prevention, management of chronic conditions, use of antibiotics in adults and children, and behavioral health, as well as experience of care composite of ten CG CAHPS questions. CDPHP creates an aggregate quality score by creating a ratio of the sum of the numerators to the sum of the denominators in these measures. This aggregate quality score is then assigned a percentile rank which creates an effectiveness score.

**Method and magnitude of payment adjustment**

---

The risk adjusted global payment for primary care services is more than 80 % of payments that primary care practices receive, and accounts for the vast majority of codes for which CDPHP reimburses. CDPHP uses a unique risk adjustment factor created by Verisk, Inc., which predicts payments to primary care physicians based on member diagnoses received from all sites of care (hospital, specialist, etc.). This risk adjustment factor drives specific risk adjusted global payment rates for commercial HMO, commercial non HMO, Medicaid, and Medicare patients. The payment is made monthly with adjustments for the prior month’s patient responsibility for actual visits received. The plan continues to use FFS reimbursement for a small set of services that are outside of the capitation code list, such as immunizations and skin biopsies.

CDPHP also offers primary care practices the opportunity to earn an additional 20% bonus payment based on performance in the goals of the Triple Aim. Each CDPHP practice has a specific potential bonus, which is determined by the number of CDPHP members in the practice and the risk of those members. This potential bonus is then multiplied by the effectiveness and efficiency scores to determine the amount that the practice has earned. For example, if a provider is at the 50th percentile for quality and cost, those two amounts are multiplied, and the provider receives 25% of the potential total bonus. This approach ensures that practices are appropriately incentivized for high quality, efficient care, only. The chart below compares a traditional FFS model against the current EPC model, demonstrating how PCPs engaged in the program can earn up to 40% more.



### Additional infrastructure and operational investments

CDPHP provides primary care practices with a year long transformation program, which begins with leadership and cultural assessments. Four learning collaboratives are used to facilitate the sharing of best practices among provider groups and also provide additional education. Practices undergoing transformation are each given a \$20,000 stipend to support their time away from their practice. At the end of the transformation program, the practice becomes eligible for the enhanced payment model described above.

CDPHP also provides significant financial investments to support practices needing to acquire electronic health records, establish connections to the local health information exchange, and achieve meaningful use designation.

As a result, new resources were added, including a performance management department, to support the success of practices in the program. This support includes:

- Engagement and training to achieve cultural shift across organizational boundaries, to create a more collaborative, patient centered approach;
- Coaching and support of primary care practices to achieve NCQA Level 3 PCMH recognition;
- Engagement with practices to provide actionable information, identify and promote opportunities, assist in the clinical integration of care management, and other available services in the community of from the health plan; and
- Assistance to primary care practitioners with the transition toward value based payments (VBP), and away from traditional FFS models.

CDPHP also continues to make significant investments in claims payment systems and analytics to support the automated member attribution methodology, risk adjustment methodology, system generated global payments, solutions to address changing member panels and network providers, as well as requirements to address the challenges of member responsibility in high deductible and other copayment arrangements.

**Results**

CDPHP has seen a \$17.11 PMPM reduction in the total cost of care, resulting in a 2.9% overall cost reduction, and \$20.7 million annual total savings for the organization in year 2014. Under this global model of payment, the actual rate of visits for healthy members decreased as physicians found alternate ways of providing necessary care. At the same time, the rate of visits increased for those with the greatest need – Medicaid, Medicare, and the sickest 10% of the population. These savings were accomplished despite paying the primary care community \$10 million in additional reimbursements. Savings came largely from drug utilization management, outpatient services, and the sickest members having a greater level of engagement with primary care. The table below demonstrates cost savings by line of business and severity of condition.

PMPM	All	Healthiest 50%	Sickest 50% 10%	Sickest 10%
All	\$ 17.11	\$ 3.81	\$ 26.37	\$ 49.34
Commercial	\$ 15.81	\$ 1.92	\$ 33.07	\$ 15.35
Medicaid	\$ 22.30	\$ 4.41	\$ 15.79	\$ 104.65
Medicare	\$ 24.03	\$ 10.64	\$ 28.81	\$ 146.30

*Note: Total estimated as the product of the year 2014 average PMPM difference in TCOC, and the sum of the total member months in each cohort in year 2014. Meaningful estimates have at least 60% of the weight sum corresponding to significant cohort estimates and are highlighted in orange.*

**Presbyterian Health Plan, Albuquerque, New Mexico**

**Overview**

Presbyterian Health Plan instituted a Medicaid multispecialty sub capitation model for primary care and multispecialty groups that have invested in care management infrastructure and demonstrate the ability to improve performance. The model allows both upside and downside risk and has an actuarially determined capitated medical budget.

**Underlying payment approach**

Years 1–5: 3(B) – APMs built on FFS architecture with upside/downside risk  
 Year 5+: 4(B) – Full or percent of premium population based payment linked to quality; global budget based on population served linked to quality.

**Approaches to cost assessment**

The annual capitated budget is calculated off prior year FFS claims data and then adjusted downward to guarantee savings to the plan. The primary performance measures examine outpatient pharmacy costs, emergency department visits and emergency department costs.

**Approaches to quality assessment**

Performance measures ensuring that the payment model does not deteriorate quality and access include: encounter value of services for members, timely submission of encounters, penetration rates, hospitalization rates, complaint and grievance data and emergency department visits by persons with significant behavioral health needs.

---

**Method and magnitude of payment adjustment**

---

Presbyterian Medical Services receives a monthly capitated payment for Medicaid members. Using years 2013 and 2014 Medicaid membership and claims data, Presbyterian Health Plan developed models to measure medical costs for fee for service claims. This information is used to define covered services that will be included in the capitated payment and the projected PMPM costs for those services.

The two main avenues of savings to the plan are pharmacy spend and emergency department diversion. To ensure savings for both the plan and providers, pharmacy costs are designated as a component of medical costs. Presbyterian Health Plan then reduced the capitated payment for outpatient pharmacy costs by 30% and allowed providers to retain the difference between the set pharmacy budget and the actual year end drug costs inclusive of the discounts under the 340B Drug Pricing program.

Emergency department diversion savings are calculated against the prior year's usage and split equally between the plan and providers.

During a provider's first year in the model, the plan institutes risk corridors so that losses or gains are within 2% of what would have been earned under FFS. This allows the practice to adjust to value based care. The level of risk grows over a five year process and culminates in 100% global risk.

---

**Additional infrastructure and operational investments**

---

In some cases, grants from external sources or the plan itself have been used to encourage physician groups to participate in APMs. Grants serve as incentive to participate and also increase requisite core competencies including health information technology, care managers, data analytics support and more.

---

**Results**

---

The structure of the model helps the plan achieve a 30% reduction in pharmacy costs for providers that participate, as well as shared savings from reduced unnecessary emergency department utilization.

## Category 4: Population Based Payments

### *Tufts Health Plan, Watertown, Massachusetts*

---

**Overview**

---

Tufts Health Plan's risk model functions as a fee for service (FFS) payment that is reconciled with an annual global budget. The plan has 86% of its Massachusetts Commercial HMO membership engaged with a primary care physician participating in an APM, and 29% of members have a primary care physician in full risk capitation in which providers adopt 100% risk above and below a negotiated PMPM budget amount. This case study pertains to the 29% of providers that receive 100% risk.

---

**Underlying payment approach**

---

4(B) A full or percent of premium population based payment linked to quality; global budget based on population served linked to quality.

---

**Approaches to cost assessment**

---

Tufts Health Plan works with providers to set an annual budget target based on prior claims, which is adjusted for severity and other factors as appropriate. The plan examines the three primary pieces of unit cost, case mix and utilization rates.

---

### **Approaches to quality assessment**

The measures that Tufts Health Plan uses include, but are not limited to: cost and utilization, referral patterns, practice patterns, quality and total medical expenses.

---

### **Method and magnitude of payment adjustment**

In the standard risk agreement, Tufts Health Plan works with providers to set an annual budget target based on prior claims experience, which is adjusted for severity and other factors as appropriate. If the total cost is less than the budget target (surplus), the provider will receive a percentage of the surplus. If the total cost is more than the budget target (deficit), the provider will pay Tufts Health Plan a percentage of the deficit.

Tufts Health Plan in the commercial space typically has a direct relationship with a delivery network that includes primary care physicians and specialists. In negotiations with the delivery network, the group includes hospitals, specialists and PCPs in aggregate. It is up to the delivery group to decide how to allocate risk amongst itself, though Tufts Health Plan provides some guidelines.

---

### **Additional infrastructure and operational investments**

Tufts Health Plan identifies specific measures in which each provider group is struggling and uses resources to help drive improvement on those measures. The plan aims to pay for improvement, not just continued performance. It writes contracts so that more money is put into improving operations rather than simply protecting against regression.

---

### **Results**

Early results indicate a more favorable total medical expense trend for global payment providers than for fee for service.

Under these contract arrangements, providers are more engaged in reporting and analytics related to managing overall cost and quality of care.

Tufts Health Plan has seen positive change in provider referral patterns for contracts with APMs.

Providers under APM contracts have made progress to retain care within systems and have moved care to lower cost settings. Providers have been able to move care that must go to an ambulatory medical center to more efficient care partners.

The graphic below shows how Tufts Health Plan has been able to move provider groups along the risk spectrum from FFS to accepting full risk, and what percentage of contracted practices participate in each type of APM. With respect to the Framework, this corresponds to a movement from Category 1 through Category 3B, with an aim to end up in Category 4. Currently, 29% of practices are in a full risk arrangement.

