HCP LAN
Health Care Payment Learning & Action Network

ALTERNATIVE PAYMENT MODEL (APM) FRAMEWORK

Draft White Paper

Written by:

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

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In an effort to maximize transparency and seek input at an early stage, the Work Group has taken the unusual step of releasing a draft version of the White Paper to a large audience. Information and positions taken in this document should be considered preliminary until the Work Group receives input from the LAN and releases a final version of the White Paper. For instructions on how to submit comments go to the LAN website (http://www.hcp-lan.org). Future iterations of the White Paper will include an Executive Summary and a conclusion that summarizes the Work Group's key findings and implementation goals.

Overview

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 the participation of the entire health care community. The Health Care Payment Learning and 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 ecosystem. By making a commitment to changing payment models, by establishing a common framework and aligned 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 adoption of alternative payment models (APMs).

A LAN Guiding Committee (GC) was established in May 2015 as the collaborative body charged with advancing alignment of payment approaches across and within the private and public sectors. This alignment will accelerate the adoption and dissemination of meaningful financial incentives to reward providers who implement patient-centered care and patient responsive delivery systems. 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 payment by 2016, and 50% by 2018.

The GC convened the Alternative Payment Models Framework and Progress Tracking (APM FPT) Work Group and charged it with creating a Framework for categorizing APMs and establishing a standardized and nationally accepted method to measure progress in the adoption of APMs across the U.S. health care system (the "APM Framework"). The Work Group brought together public and private stakeholders to assess APMs in use across the nation and 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.) The aim of the Work Group is to create a clear and understandable APM Framework, provide a deeper understanding of payment models and how those models can enhance health and health care, and provide examples of how public and private payment models are organized within the APM Framework.

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 our health system. The Work Group, along with many other stakeholders, envision a health care

system that provides "patient-centered care." Recognizing that the Work Group was not charged with developing a comprehensive definition of the term nor its constituent components, and that these terms may encompass additional characteristics that are not captured below, the Work Group understands patient-centered care to mean *high-quality care that is delivered in an efficient manner, where the patient's or consumer's informed choices, values, priorities, and individual circumstances are paramount*. The Work Group believes that patient-centered care, so defined, rests upon three pillars:

- Quality: This term indicates that patients receive appropriate and timely care that is consistent with evidence-based guidelines and patient goals, and that results in positive patient outcomes. Ideally, quality should be evaluated using a harmonized set of process and outcome measures that provide an accurate and comprehensive assessment of clinical care, and that generate results that can be meaningfully communicated to patients and consumers.
- Cost Effectiveness: This term indicates that the actual costs of care should not exceed what would be expected when a set of services are provided to a particular patient population. Care that is less expensive than expected, but that results in poor clinical outcomes, is not considered cost effective. Affordability of health care services is vital to ensuring that our nation can support investments in education, housing and other social determinants that support better health.
- Patient Engagement: This term encompasses the disparate, non-clinical aspects of care that improve patient experience, enhance shared decision-making, and ensure that patients and consumers achieve their health goals. Engaged patients and consumers are informed of their health improvement and share in their own care; they are able easily to access appointments and clinical opinions; 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; and they can move seamlessly between providers who are engaged in different aspects of their care.

As evidenced by the creation of the LAN, there is an emerging consensus among providers, payers, patients and consumers, employers, and other stakeholders in the health care system that efforts to deliver patient-centered care have been stymied, in large part, by a payment system that is oriented towards volume, as opposed to value. These stakeholders and the Work Group share in the belief that by reconfiguring payments to incentivize value, providers will be able to invest in care-delivery systems that are optimized for the provision of care that is focused on patient needs and that is less constrained by today's current models. In other words, changes in payment are necessary (though insufficient on their own) to drive delivery system transformations that are capable of changing provider behavior, ensuring that patients and consumers receive high-value, patient-centered care, and ensuring that health care costs reflect appropriate and necessary spending for individuals, government, employers, and other payers.

The Work Group strongly maintains that shifting from traditional fee-for-service (FFS) reimbursements to population-based payments (in which all or much of a person's care is contained within a single payment) will be essential to sustain delivery systems that value quality, cost effectiveness, and patient engagement. This position is predicated on the assumption that population-based payments give providers more flexibility to coordinate and manage care

for individuals and populations, and that this flexibility will facilitate positive innovations in care delivery, particularly for individuals with chronic, complex, and costly illnesses.

At present, FFS reimbursements are ill-suited for initiating investments and sustaining innovations in population health management, such as information technology and clinical decision support tools, patient engagement and care coordination functions, and additional opportunities to increase access to care (e.g., telehealth, home visits, and additional office hours). This is because FFS incentivizes providers to optimize volume, and may, at times, encourage the perspective that patients are collections of symptoms and services, instead of people who require individualized and highly coordinated care. Population-based payments enable providers to develop more innovative approaches to patient-centered health care delivery, because they reward providers who 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 on the altar of cost effectiveness, and that the care delivered is state-of-the-art and takes advantage of valued advances in science and technology, these innovative approaches to health care delivery stand to benefit patients and society alike. In the first instance, patients may come to expect a more coordinated, more accessible, and more effective health care system; the country as a whole, and taxpayers in particular, would welcome reductions in national health care expenditures, and a healthier, more productive workforce. For these reasons, the Work Group believes that population-based payment provides the foundation upon which a truly patient-centered health care system can be built.

The Work Group recognizes that new payment models require providers to make fundamental changes in the way they provide care. Nevertheless, it also believes that this transition can be smoothed and accelerated if a critical mass of public and private payers adopts aligned approaches, and sends a clear and consistent message that payers are committed to a population-based health system that delivers the best health and health care possible. If providers were able to implement APMs in a consistent manner 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 will increase the likelihood of success for innovative patient-centered 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 who are eager to take a more holistic approach to medical practice.

The Work Group believes that a shift to population-based payments will, in concert with other reforms, result in an expansion of patient-centered 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 the potential to limit costly but proven medical services. Because the ultimate objective is to achieve patient-centered care, the Work Group believes that it is 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 population-based payment as a course-correcting feedback loop between innovation, implementation, and

evaluation. It is excited that its work will be the first in a series of LAN publications that can be used to align stakeholders in the public and private sectors, and to help implement patient-centered payment systems wisely.

Purpose of the White Paper

In order to accelerate the transformations described above, the LAN GC charged the Work Group with creating an APM Framework through which progress can be described and measured.[1] In addition to providing a roadmap to measure progress, the APM Framework helps establish a common nomenclature and a common set of conventions, which can facilitate discussions between 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 delineates and describes 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 the boundaries between them lie. In order to further clarify the classification of individual APMs, Appendix B includes a catalog of real-world APMs and their categorizations, in order to exemplify each of the categories and subcategories in the APM Framework. The White Paper concludes with a summation of the Work Group's key findings and recommendations, and its implementation goals for APMs.

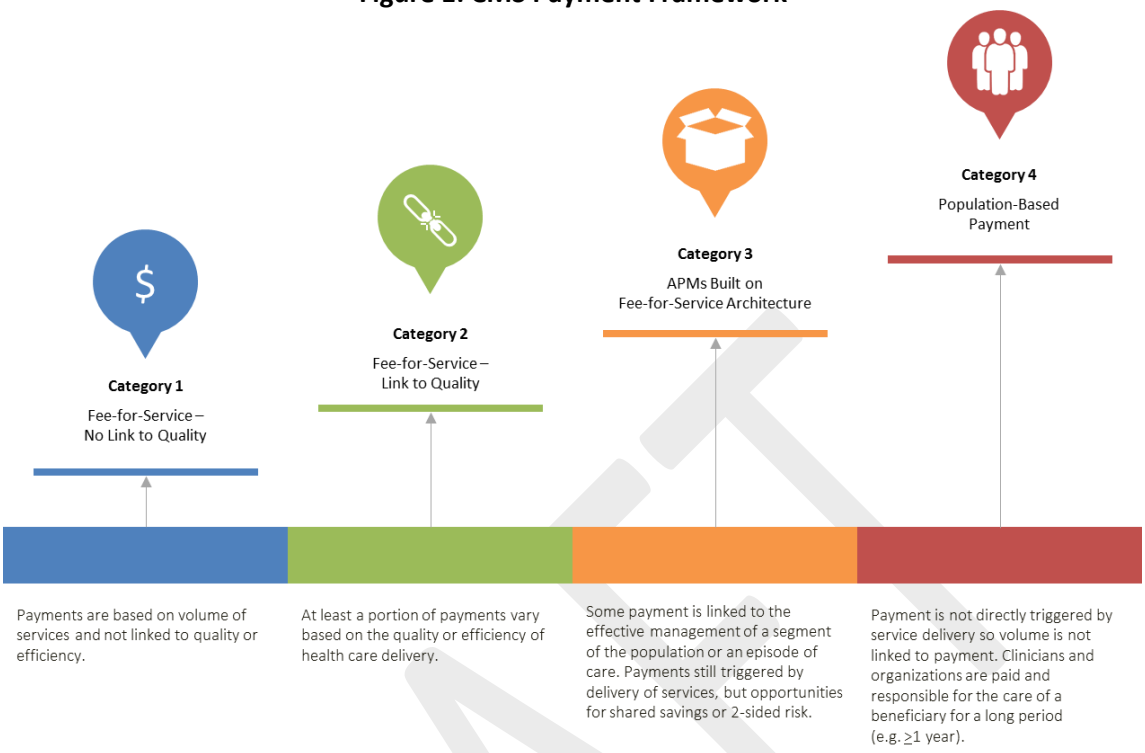
At this stage, the Work Group is requesting feedback on the White Paper and the APM Framework in order to obtain broad agreement on the approach to categorizing APMs among health plans, providers, employers, patients, consumer groups, states, federal agencies, and other partners within the health care community who are tasked with implementing APMs. In particular, the Work Group is seeking information on APMs that exemplify categories and subcategories within the Framework.

Approach

When developing the APM Framework, the Work Group began with the four-category framework that the Centers for Medicare & Medicaid Services (CMS) recently advanced,[2] and expanded it by introducing refinements that are described in more detail below. As illustrated in Figure 1, the CMS framework assigns payments to delivery systems 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 reimbursement for specific services).

[1] In a subsequent White Paper, the Work Group will put forth a methodological approach for measuring progress within the Framework.
[2] Rajkumar R, Conway PH, Tavenner M. CMS: Engaging multiple payers in payment reform. JAMA. 2014 May 21: 311(19):1967-8.

Figure 1: CMS Payment Framework



The Work Group added to and refined the CMS model by 1) explicating key principles that were needed to understand what the APM Framework did and did not mean to convey; 2) introducing four new categories to account for payment models that are not considered progress towards payment reform; 3) introducing seven 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 APM Framework is predicated on several key assumptions. To provide context for understanding the APM Framework and the Work Group's recommendations, these principles are delineated and explained below.

***Principle 1**: The Work Group recognizes that changing the financial reward to providers is only one way to stimulate and sustain innovative approaches to the delivery of patient-centered care. In the future, the Work Group believes it will be important to monitor progress in initiatives that empower patients (via meaningful performance metrics, financial incentives, and other means) to seek care from high-value providers and become active participants in clinical and shared decision-making.*

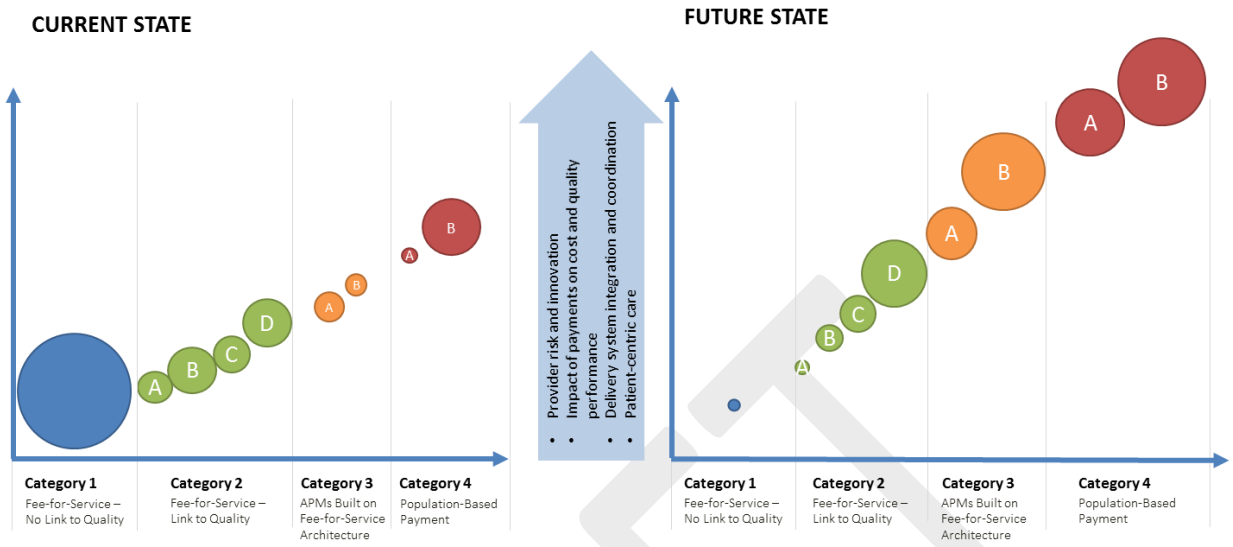
Although it was necessary to focus on financial incentives for providers as a critical first step, the Work Group recognizes that additional efforts to engage patients and consumers will be needed to achieve a patient-centered, coordinated health care system. As more providers begin to participate in payment models that are further 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 communicate provider performance on clinical and patient experience measures in a meaningful way, financial incentives to select high-value providers (e.g., differential cost sharing for particular services or providers), and efforts to enlist patients and consumers as informed participants in the setting of health goals and the development of treatment plans.

***Principle 2**: As delivery systems evolve, the goal is to drive a shift towards shared-risk and population-based payment models, in order to incentivize delivery system reforms that improve the quality and efficiency of patient-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, public and private health plans should move concertedly towards APMs in Categories 3 and 4. The Work Group recognizes that market forces have led to different levels of delivery system organization and integration, and to differing capabilities with regard to the necessary investments in infrastructure and management to advance to more robust population health payments. Therefore, APMs in Categories 3 and 4 will not be readily achievable in every market and for every patient population, and the Work Group anticipates that some regional markets may be slower to make the transition to Categories 3 and 4.

A more detailed depiction of the Work Group's goals for the health care system appears in Figure 2.

Figure 2: 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 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 and persistent impact of Medicare's Merit-Based Incentive Payment System (MIPS). 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 2, the size of the various circles represents allocations (either in terms of members/beneficiaries, providers, or dollars) in various types of APMs. As Figure 2 illustrates, payments 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 provider risk and innovation, make a greater impact on quality and cost performance, increase integration and coordination in delivery systems, and, ultimately, result in more patient-centered care. Figure 2 also implies that overall spending will diminish over time. For example, compared with present Category 3B APMs, future Category 3B APMs will employ larger risk corridors and more extensive sets of quality measures; they will offer further opportunities for providers to develop innovative delivery models; and, they will provide additional support for coordinating care across multiple providers. For the reasons discussed above, the Work Group believes that these advancements will also result in more patient-centered care.

***Principle 3**: To the greatest extent possible, value-based incentives should reach providers who directly deliver care.*

Based on the experience of members of the Work Group, incentives for quality improvement and cost reduction are most effective when they directly impact payments for providers who 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 patient-centered, well-coordinated, and high-value care that ultimately leads to better outcomes. For

example, physicians within a two-sided risk model accountable care organization (ACO) that holds physicians and hospitals accountable for quality and financial performance, has appropriately aligned the incentives from the organizational ACO level to the individual physician and facility level. The Work Group recognizes that it may not always be possible to accurately measure 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 providing population-based payment to a provider organization that pays providers through FFS contracts will not fully benefit from the importance of translating APMs directly to the providers who are responsible for delivering care.

***Principle 4**: Payment models that do not take quality and value into account will be classified in 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 3, the Framework is a continuum of payment approaches divided into four categories. Category 1 represents FFS payment not linked to quality incentives. Categories 2 through 4 in the Framework are organized according to the degree to which they advance beyond traditional FFS payment, such that APMs in Category 4 constitute more progress toward value-based care than payments in Category 2 At the same time, the Work Group believes strongly that there is limited merit in moving toward population-based payments if the resulting payment models do not include quality incentives to deliver high-value health care that is based on current clinical knowledge. When classifying current payment models, payments that represent some movement away from traditional FFS, but do not take quality and value into account, will be placed adjacent to the appropriate category and marked with an "N," to indicate "No Quality" considerations (e.g., population-based payments not linked to value will fall under Category "4N"). Accordingly, they will not be considered progress toward true patient-centered payment reform, and the Work Group will not track them for the purposes of measuring achievement of the LAN's goals.

***Principle 5**: In order to reach our goals for health care reform, the intensity of value-based incentives should be high enough to influence provider behaviors and it should increase over time. However, this intensity should not be a determining factor for classifying APMs in the Framework. Intensity will be included when reporting progress toward goals.*

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 population-based payment systems will require substantial investments on the part of providers. Accordingly, it is critical that value-based

incentives are large enough to motivate providers to invest in and adopt new approaches to care delivery. In order to accelerate and sustain progress throughout the entire health care system, it is equally important for these incentives to expand over time. For example, the Work Group believes that a two-sided incentive of plus/minus 5% would promote change to a greater extent than a plus/minus 2% incentive. The Work Group also believes that this shared savings and risk payment incentive should grow over time, as providers have greater success 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 5% financial risk/reward is classified the same as an episode-based payment with a 2% financial risk/reward. In addition, the Work Group believes that more experience will be needed to determine what the 'right' risk/reward level is to promote progress towards improved patient-centered care and population health and it may be different for hospitals and health systems than for physician organizations and health professionals. Most important, from the perspective of the Work Group, is that cost and quality incentives should (in conjunction with other aspects of plan designs) be tailored to optimally support and align innovative approaches to delivering patient-centered care.

***Principle 6**: When health plans adopt hybrid payment reforms that incorporate multiple APMs, the payment reform as a whole will be classified according to the more dominant APM. This will avoid double-counting payments through APMs.*

The Work Group recognizes that in certain cases a particular payment model may make use of several types of APMs, often as the model is evolving. For example, an ACO may utilize a shared-savings model in years one and two 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.

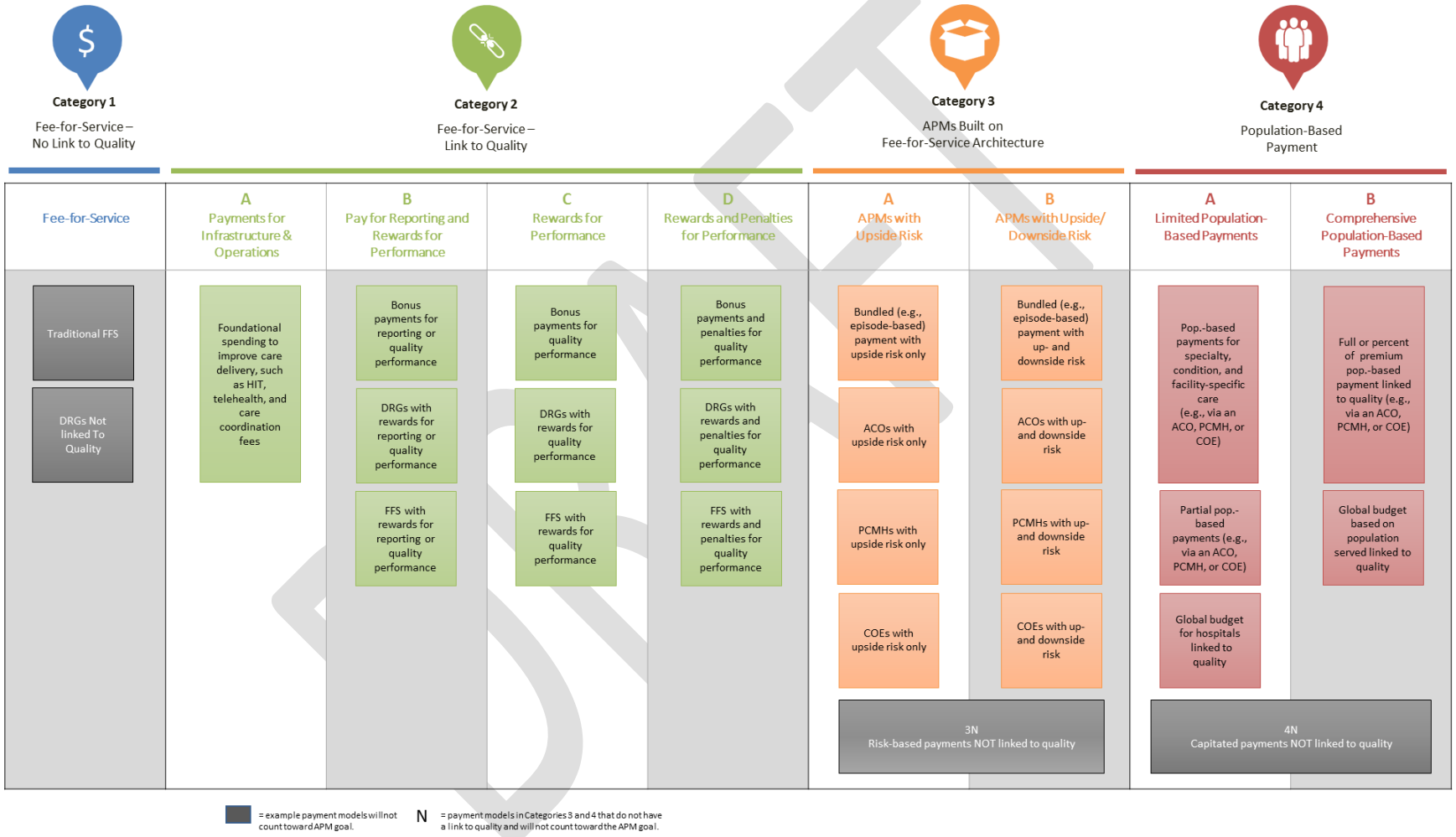
***Principle 7**: Centers of excellence, patient-centered medical homes, and accountable care organizations are delivery models, not payment models. These delivery system models enable APMs and, in many instances, have achieved successes in advancing quality, but they should not be viewed as synonymous with a specific APM. Accordingly, they appear in multiple locations in the 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. 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 APMs are represented today and, likely, in the future.

The APM Framework

The Work Group's APM Framework is depicted in Figure 3. 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 that are placed into each category.

Figure 3: DRAFT APM Framework



❶ Fee-for-Service with No Link to Quality and Value (Category 1):

Payment models classified in Category 1 utilize traditional FFS payments (i.e., payments are made for units of service) that are neither adjusted to account for provider quality data reporting nor for their 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 throughout a hospital, and that hospitals typically bill DRGs in much the same way that physicians bill services that are reimbursed on a fee schedule: in both instances, the provider's incentive may be to bill for additional services because they are paid on the basis of volume.

Payments in Category 1 are distinguished from those in Category 2 in that the latter 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 reports quality data, or how well a provider performs on quality metrics.

❷ Fee-for-Service Linked to Quality and 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 whether providers report quality data or how well they perform on cost and quality metrics.

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

- Payments placed in **Category 2A** involve payment for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on cost and 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 in **Category 2B** provide positive or negative incentives to report quality data to the health plan and (ideally) to the public. Providers may have initial difficulties reporting clinical data accurately. Participation in a pay-for-reporting program gives providers an opportunity to familiarize themselves with the performance metrics, their internal resources to collect data, and 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.
- Payments are placed in **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 produce value, such as a reduction in emergency-room visits for individuals with chronic illnesses or a reduction in a hospital-acquired infection. The Work Group envisions that participation in Category 2C payment models will likely evolve into Category 3.

- Payments placed in **Category 2D** reward providers that perform well on quality metrics and penalize providers that do not perform well, thus providing a significant linkage between payment and quality.

As indicated in the discussion above, the Work Group considers payments in Categories 2A through 2C to be an "on-ramp" that providers can use to participate in alternative payment models. The Work Group expects that under most circumstances, providers and provider groups will transition 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 pay-for-performance programs in the same clinical 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 financial risk associated with APMs in Categories 3 and 4. This notion of Categories 2A through 2C as an "on-ramp" for subsequent Categories will be assessed as we measure and track 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 take on financial risk and/or have an opportunity to participate in shared savings, based on established cost targets. Second, FFS-based payments in Category 3 reflect to a greater degree care that is provided longitudinally, such that they encourage more care coordination and patient-centered care than the FFS payments in Category 2.

❸ 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 population or an episode of care, based on cost and quality performance against a target. For APMs in Category 3, providers that meet their targets are eligible for shared savings, and those that do not may be held financially accountable. Additionally, payments in Category 3 are structured in a way 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.

The Work Group decided to refine Category 3 into subcategories A and B as outlined below:

- **Category 3A** gives providers an opportunity to share in the savings they generate. In other words, if the provider does not meet or exceed the quality or cost targets, APMs in Category 3A do not hold the provider financially responsible for not meeting cost targets.

- Payments in **Category 3B** involve both upside risk (i.e., positive payment adjustments) and downside risk (i.e., negative payment adjustments).

Episode-based payments, other types of bundled payment systems, and most ACO arrangements today can be placed in either Category 3A or Category 3B, depending on whether the underlying risk arrangement includes only upside or both upside and downside risk for providers. The Work Group considers 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.

Payments that fall under Category 3 are distinguished from those that fall under Category 4 in that payments in the latter are population-based and include a strong incentive to promote health and wellness, including lifestyle modification and preventive services, while payments in the former are still triggered by the delivery of services (even if the current FFS systems serves as the basis for setting population-based payment rates).

❹ Population-Based Payment (Category 4):

Payment models classified in Category 4 involve population-based payments, structured in a manner that encourages providers to deliver person-centered and coordinated care within a global budget, and providers are held accountable for meeting quality and, increasingly, patient-centered goals for a population of patients or members. Payments within Category 4 are intended to cover a wide range of preventative health, health maintenance, and health improvement services, and these payments will likely require care-delivery systems to establish and maintain teams of providers, who are able to coordinate and improve access to care.

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

- **Category 4A** payments are population-based, but they are limited to certain sets of condition-, specialty-, or facility-specific services (e.g., asthma, oncology, or hospital care for a given population). The Work Group recognizes that certain types of conditions, specialties, and facilities may be well suited for payments in Category 4A, and that there are legitimate reasons why small provider organizations (in particular) may never be able to provide 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 condition, organ group, or facility setting. For highly integrated delivery systems, with a primary care foundation, specialists and community resources, we envision that 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. Highly integrated arrangements 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 also typically have a higher percentage of salaried physicians. The Work Group believes that these highly integrated arrangements yield key benefits and efficiencies, because they have a greater impact on organizational responses to

quality and value incentives in APMs. Additionally, and in contrast to capitated arrangements in Category 4N, providers participating in Category 4B APMs are held accountable for delivering high quality, and clinically necessary care, and for meeting cost targets.

The Work Group believes 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 delivery systems of care.

Conclusion

[This section will summarize the WG's main findings and recommendations, make a statement about how the Framework should be used to drive payment reform, and possibly establish implementation goals for the LAN as a whole.]

Appendix A: Work Group Members and Staff

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Appendix B: Draft Case Studies

Please note that the examples cataloged in Draft Appendix B are intended to illustrate the likely ways in which real-world APMs will be categorized in the APM Framework.

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 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

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 are 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 (EED) between 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 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 2012 and 2014, resulting in a safer surgery processes that have been shown to lead to lower complications and mortality for patients.

Cigna – Collaborative Accountable Care

Overview

Cigna has 134 collaborative accountable care (CAC) initiatives encompassing more than 1.3 million customers and more than 59,000 doctors, including more than 28,000 primary care physicians and more than 31,000 specialists.

Underlying payment approach

2(C) –FFS with rewards for quality

Approaches to cost assessment

Baselined to regional benchmarks

Approaches to quality assessment

Pay for performance with quality gates

Method and magnitude of payment adjustment

Care coordination fee is increased annually based on the extent to which medical costs are lowered compared to market trend, and the proportion that the group receives depends on their performance on the quality metrics. E.g. if quality decreases, they receive no increase in care coordination fee. If quality increases to meet benchmark goals, they receive up to 50% of the TMC savings in an increase to the care coordination fee.

Additional infrastructure and operational investments

Includes a care coordinator - typically a nurse practitioner who works with individuals, especially people with chronic conditions. Additional support is provided via learning collaboratives, ECC training and ongoing education, collaboration with Cigna Case management and disease management staff as well as sharing of performance and patient actionable informatics.

Results

The majority of CACs demonstrated positive quality results, with fewer emergency room visits and higher performance on management of chronic disease measures compared to market.

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

CMS - Comprehensive Primary Care (CPC) Initiatives

Overview

The Comprehensive Primary Care (CPC) initiative is a four-year multi-payer 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 years 1-2 of the initiative (2013-14), and decreases to an average of $15 per beneficiary per month during years 3-4 (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 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 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.

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

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 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 2012, 37 percent generated shared savings, compared to 27 percent of those that entered in 2013, and 19 percent of those that entered in 2014.
- Shared Savings Program ACOs that reported in both 2013 and 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 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 2016. New and renewing ACOs will be announced around the end of 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 total cost of care (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 1, 25% of the shared savings payment is at risk if providers do not report quality measure results. In year 2, 25% of the shared savings payment is at risk if providers do not achieve the quality measure targets, and in year 3 the percent at risk increases to 50%.

* 2015 quality measures can be found here: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_181535

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

Results

Nine providers and 165,000 Minnesota medical assistance enrollees participated in the program in 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. (Link to Minnesota press release: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_196131)

Categories 2, 3 and 4

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's 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), and
- Skilled Nursing Facilities (1071).