

## CT SIM Aligns with National Movement Towards Alternative Payment Models

National public and private efforts are underway to accelerate the movement towards Alternative Payment Models (APMs) that emphasize the quality of care over the quantity of care, such as the value based payment strategy being promoted by Connecticut's State Innovation Model (SIM).

The Department of Health and Human Services (HHS) is working in concert with stakeholders in the private, public, and non-profit sectors to transform the nation's health care payment system to achieve the goals of healthier people, improved care, and smarter spending. To support these efforts, HHS launched the **Health Care Payment Learning and Action Network** (HCPLAN) to advance the work being done across sectors to increase the adoption of value-based payments and APMs.

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***LAN Goal: 30% of U.S. health care payments  
(including Medicaid, Medicare, and commercial)  
in APMs or population-based payment by 2016, and 50% by 2018***

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HHS and the learning network believe it is essential to substantially reform the U.S. payment structure to improve quality and safety of care, and the overall performance and sustainability of our health care system. This will make possible a health system focused on "patient-centered care," resting on three pillars:

1. **Quality:** Patients receive appropriate and timely care consistent with evidence-based guidelines and patient goals, and that result in positive patient outcomes.
2. **Cost effectiveness:** Actual costs of care should not exceed what would be expected when a set of services is provided to a particular population.
3. **Patient engagement:** Encompasses the disparate, non-clinical aspects of care that improve patient experience, shared decision-making, and ensure patient goals are met.

In October, 2015, the LAN convened health systems, health plans, consumer groups, employers, government, experts and others who are designing or have implemented alternative payment models, including State Innovation Model representatives, to learn about the APM framework and their work.

The LAN's draft [White Paper](#) defines APMs and provides case studies and frameworks.

### CMS Payment Framework



The LAN framework groups APMs into four categories. Category 1 is the traditional fee-for-service model. Categories 2-4 represent APMs, with Category 4 being the most mature APM. The LAN will track progress and status of APM adoption using this framework.

The Center for Medicare & Medicaid Services (CMS) set ambitious goals for Medicare to move towards Category 4. →

### Medicare Fee-for-Service

In alignment with the goals of CMS (Goal 1 on the right) and HHS, the LAN aims to have **30% of U.S. health care payments (including Medicaid, Medicare, and commercial) in APMs or population-based payment by 2016, and 50% by 2018.**

**GOAL 1:** **30%**

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

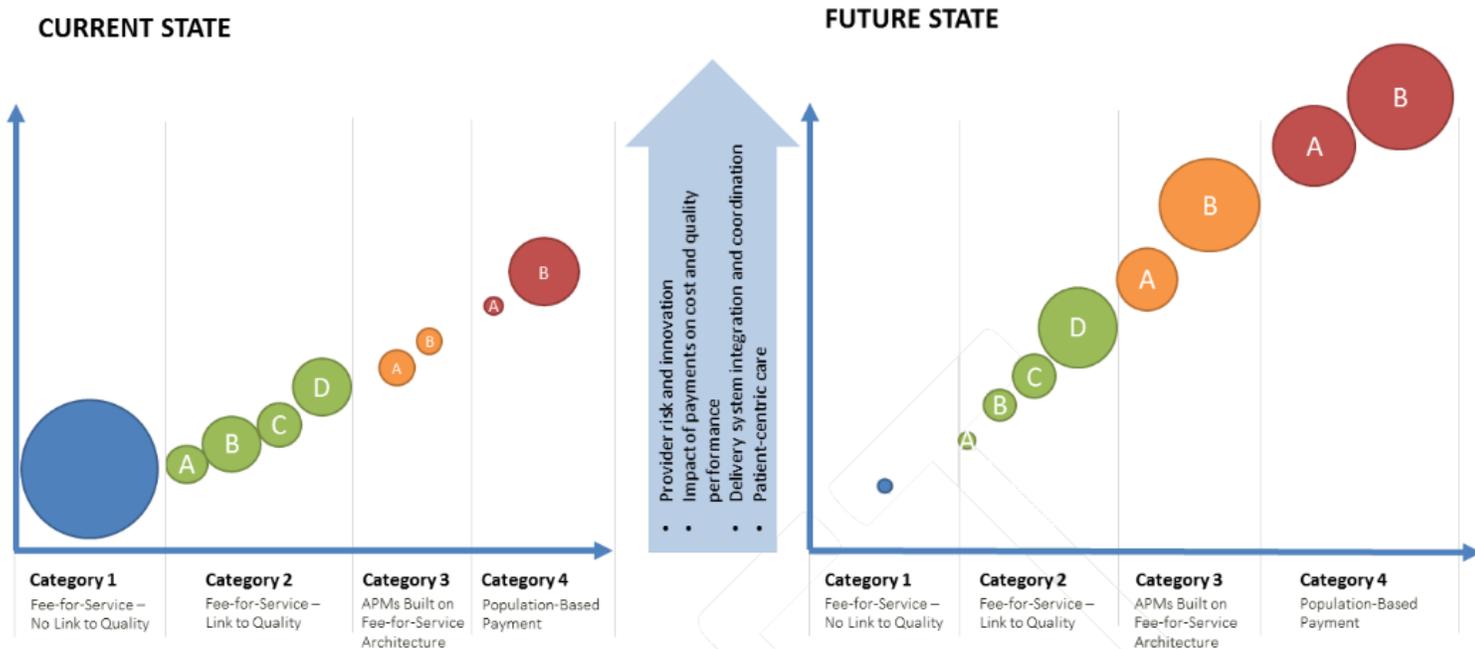
**GOAL 2:** **85%**

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

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

fee-for-service payment. The LAN recommends that, over time, public and private health plans should move concertedly towards **APMs in Categories 3 and 4**, to achieve the goals of healthier people, improved care, and reduced cost.

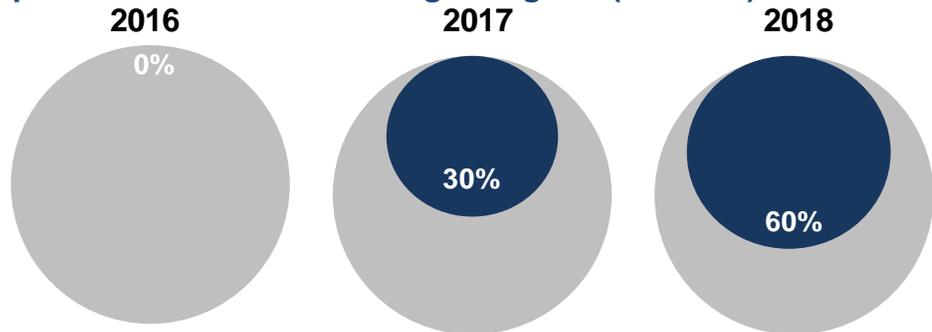
### The Work Group’s Goals for Health Care Reform



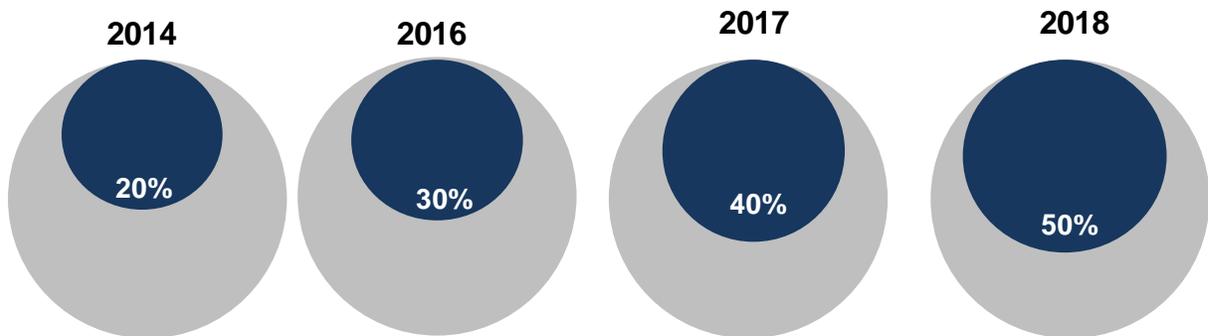
The above graphic shows the current state of national adoption of APMs, with most of today’s payment methods in “Category 1: fee for service.” The right hand side of the graphic shows the LAN’s goals for a future state, where a very small amount of payments are in traditional fee for service. Their goal is for the majority of payments to be in “Category 3” or “Category 4.”

The Connecticut State Innovation Model (SIM) aims to have 64% of the Connecticut population benefit from an APM by 2018. SIM is funding the launch of a new Medicaid Quality Improvement & Shared Savings Program (MQISSP), which falls into “**Category 3A: ACOs with upside risk only.**” The goals and timeline for MQISSP align with LAN goals and national Medicare goals.

Target percent of **Medicaid** in alternative payment model (category 3-4)  
Medicaid Quality Improvement & Shared Savings Program (MQISSP):



Target percent of **Medicare** in alternative payment model (category 3-4)



It was emphasized that changing the financial reward for providers is only way to drive sustainable and innovative approaches. Empowering consumers and advancing health care delivery capabilities are needed simultaneously. The SIM grant is a unique opportunity for states like Connecticut to fund multiple initiatives that reinforce each other in the areas of payment reform, care delivery support, quality measure alignment, consumer engagement, and workforce development.

[Draft White Paper outlining the APM Framework](#): Also contains APM definitions, examples, and results

[Agenda and PowerPoints from LAN Summit](#)

There are currently 4,500 participants in LAN. To be part of the network, receive notices, webinar information etc [Register to be part of LAN](#)