ACA Implementation—Monitoring and Tracking

Refining the Framework for Payment Reform

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

EXECUTIVE SUMMARY

Broad consensus holds that to further the Triple Aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care, payment methods for physicians, other health professionals, and institutional providers must evolve from rewarding volume to promoting value.

In the past year, policy-makers have taken concrete steps to put flesh on the bones of value-based payment. Last February, the Secretary of the Department of Health and Human Services (HHS) began this process by announcing the intent to move Medicare along a continuum of payment methods: Category 1, fee-for-service with no link of payment to quality; Category 2, fee-for-service with a link of payment to quality; Category 3, alternative payment methods built on fee-for-service architecture; and Category 4, population-based payment.

Congress, in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), ratified HHS's approach in Medicare by consolidating an array of pay-for-performance mechanisms into a single merit-based incentive payment system (MIPS; Category 2) and creating strong incentives for provider participation in alternative payment models (APMs) (Categories 3 and 4). To support its work in implementing MACRA, CMS has established the Health Care Payment Learning and Action Network (LAN), consisting of public and private sector stakeholders, to encourage the development of and accelerate the transition to APMs.

The LAN, in turn, convened the Alternative Payment Model Framework and Progress Tracking Work Group to establish a consistent method for measuring progress in APM adoption across the health care system. In January, 2016, the work group produced an APM framework expanding on the HHS categorization, detailing 28 payment methods arrayed within HHS's four main categories. The LAN Framework provides a useful start for establishing a common language along with a helpful categorization to discuss payment reform. In this paper, we attempt to advance the discussion further by raising practical considerations, suggesting that added value for beneficiaries and the Medicare program does not necessarily follow a continuum as the framework's classification suggests.

Findings

We agree that the two most important goals for payment reform are to incent provider organizations to provide high-quality care efficiently and to hold them accountable for the total cost and quality of care. Yet, not all health professionals and other providers can, or necessarily should, participate in organizations capable of assuming financial risk for total health care spending across the spectrum of services contemplated under what the framework labels "comprehensive, population-based payment" (Category 4). That is why we appreciate that the framework provides a range of payment methods, and that even Category 1 fee-for-service payment methods, deserve value-enhancing attention. Indeed, we believe that Category 1 payment done well—that is, much better than today—can produce as much or more value than Category 4 implemented poorly.

We strongly endorse the framework's recognition of the need to align public and private payment methods. Without aligned payment methods, health professionals and hospitals will continue to face conflicting incentives, inconsistent reporting requirements, and disjointed administrative demands. We agree that incentives, financial or otherwise, significantly matter to both—those who deliver care, as well as the organizations involved in the delivery of care. The strength of the organization's management structure, its culture, and the effectiveness with which incentives are transmitted from the organization to the individual provider help determine the success or failure of any payment method.

Additional Considerations

The HHS categorization and the LAN framework correctly acknowledge that many—indeed most—commonly discussed potential APMs are meant to be layered on top of legacy payment methods, referred to as fee-for-service architecture. Yet, despite the central role of this long-standing architecture (and its criticisms), these approaches can be improved substantially to produce higher value. For example, in commenting on the flaws of fee-for-service, the framework paper correctly points out that certain services are "systematically undervalued" and "currently undervalued." But these services do not *have to be* undervalued. We should work to correct the flaws in legacy payment methods, both to improve those current payment methods as long as they remain in use and to ensure that the new APMs do not carry forward the same flaws when new methods are layered on top.

The framework paper accepts HHS's view that quality can only be improved by measuring and rewarding performance. This position is consistent with the MACRA approach. Among ourselves we have differing views on the potential of public reporting and pay-for-performance, such as MACRA's merit-based incentive payment system (MIPS), to improve quality and value; nevertheless, we all agree more attention should be paid to modifying Category 1 payment design to improve quality, often, but not necessarily, with complementary performance measurement.

For example, an alternative Category 1 payment approach, sometimes called a warranty, has been implemented in Germany and in the past in Maryland's all-payer hospital payment system. Under the German design, readmissions within a designated time period that vary with diagnosis would not be separately paid if the readmission were for the same condition or resulted from complications of the initial hospitalization. This approach increases incentives to improve discharge planning and transition care for all hospitals, not just below-average performers as under the current Hospital Readmissions Reduction Program in Medicare, and mitigates some of the formidable measurement challenges. Of course, improvement of any Category 1 legacy payment method raises its own significant design challenges. Our point is not that fixing Category 1 payments is easy, but rather that improvements in Category 1 payment also can improve quality and value.

The importance of APM design

The effects of specific payment methods on provider and consumer behavior—and thus on quality and costs—depends crucially on the specific design features payers adopt. Because of this reality, a fixed classification along a continuum can mislead policy-makers about strengths and weaknesses of proposed APMs. For example, the framework paper correctly observes that diagnosis related groups (DRGs) reward increased inpatient volume. Yet, the white paper does not mention that a potential Category 3 APM, "bundled episodes around a hospital procedure," similarly could produce an increase in the number of episodes. This possibility remains to be investigated empirically.

Conversely, in the heyday of managed care in the early 1990s, it was often argued that physicians were being put under excessive financial pressure that led to a tendency to stint on care, although that effect was not demonstrated. Indeed, an analysis of the relationship between the strength of payment incentives and the effects on physician behavior concluded that, in practice, the incentives provided by various payment methods vary in strength along at least seven dimensions, each with multiple components: (1) the type of service covered, (2) the practice setting, (3) the base payment method, (4) the relative generosity of the base payment, (5) the size of the incentive, (6) the incentive's immediacy, and (7) the presence of various counterbalancing monitoring mechanisms. Payment methods can be expected to elicit different results across the United States, depending on the configuration of health care providers, the population served, the culture of the particular delivery system, and other local market characteristics.

Operational Challenges

Not considered in the LAN framework's continuum are the operational challenges associated with implementing what might appear to be more potent incentives to improve quality and reduce costs. For example, condition-based payment as a form of population-based payment has strong appeal. Yet, even when one uses episode groupers, the vagaries of diagnosis coding, as evidenced by large regional variations, raise practical concerns about the reliability of diagnosis and the possibility of "gaming" to find or exaggerate conditions for payment purposes. Proponents of payment for conditions are aware of this and other

operational challenges and are trying to address them in testing the approach. Our point is that the placement in the highest category of the LAN Framework may give the misleading impression that this approach has been proven effective. The elegance of incentives is not sufficient to justify placing them in a preferred category, given their major operational challenges. Only testing in a variety of settings, with design variations, can lead to the conclusions about which payment methods deserve broad adoption.

Conclusion

The LAN Framework paper's typology of payment methods represents a useful continuum for *describing* a range of payment models. However, this continuum works less well for actually *judging* which payment methods deserve priority emphasis for the following reasons:

- Because all payment models have strengths and weaknesses, the impact of any particular one depends crucially on the specific payment design adopted—including not only the structure of the payment method but also the relative and absolute levels of payment provided.
- Operational issues related to coding accuracy, availability of reliable and relevant quality measures, and other practical requirements for proper payment need to be addressed.
- Broad-based testing will be needed in a variety of provider settings to assess the actual impact of new payment methods before they can be adopted nationally in the Medicare program.
- The highest value might be delivered in hybrid payment models that combine the strengths of various payment methods while mitigating their weaknesses, rather than by relying on the pure payment methods that make up the LAN continuum.

INTRODUCTION

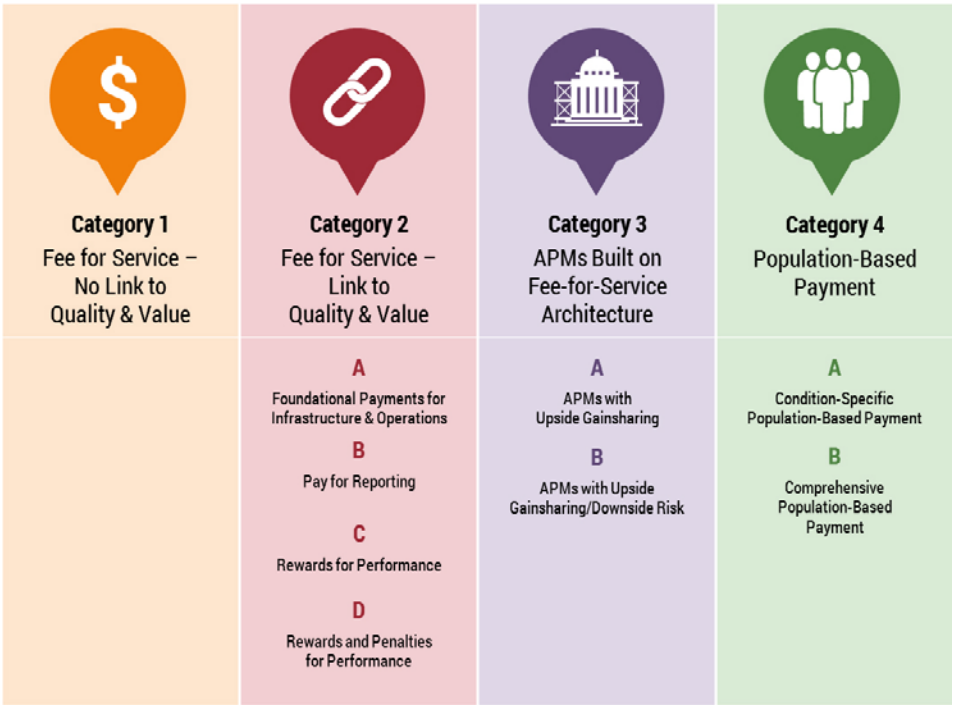
Broad consensus holds that to further the Triple Aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care, payment methods for physicians, other health professionals, and institutional providers must evolve from rewarding *volume* to promoting *value*, defined as the efficient use of health care resources to produce better outcomes.

In the past year, policy-makers have taken concrete steps to put flesh on the bones of value-based payment. Last February, the Secretary of the Department of Health and Human Services (HHS) began this process by announcing the intent to move Medicare along a continuum of payment methods: Category 1, fee-for-service with no link of payment to quality; Category 2, fee-for-service with a link of payment to quality; Category 3, alternative payment methods built on fee-for-service architecture; and Category 4, population-based payment.[1]

In the Centers for Medicare & Medicaid Services's (CMS's) lexicon, *fee-for-service* refers to the variety of current Medicare payment methods. These might more accurately be labeled *volume-based payments*, because regardless of the payment unit used, recipients receive more revenues when they produce more units of service. In fact, few of traditional Medicare's payment methods are actually fee-for-service in the sense that individual services are the unit of payment. Indeed, payment by diagnosis related group for a hospital discharge specifically does not pay for each service a hospital provides but does pay for each additional discharge—so it is volume-based. Although technically any payment method that attaches payment to the provision of specific services (or bundles of services) could be called fee-for-service, this broad usage may conceal the substantial progress Medicare has made in reforming payment in the past 35 years. Medicare has adopted a variety of payment approaches, including episode-based ones, but has also ignored opportunities to improve those legacy payment systems in ways that enhance the value of modified approaches that rely on their continued use.[2]

Over the past decade, Medicare has begun to move away from Category 1 toward Category 2 by adopting so-called value-based purchasing, under which providers are paid incrementally more or less based on their performance on a set of quality measures, along with publicly reporting that performance. Category 3 payment extends the use of quality metrics and introduces financial incentives, which can include limited downside financial risk, layered on top of payment that remains based on service volume. Population-based payment—Category 4—features payment of a fixed amount based on the characteristics of the population cared for, with no additional payment based on service volume, and continues the requirement for quality metrics.

Figure 1. The Alternate Payment Model Framework for Medicare put forth by Centers for Medicare & Medicaid Services and modified by the Health Care Payment Learning and Action Network



Source: Alternative Payment Model Framework and Progress-Tracking Work Group. Alternative Payment Model (APM) Framework. Bedford, MA: Health Care Payment Learning and Action Network. hcp-lan.org/workproducts/apm-whitepaper.pdf (accessed April 15, 2016).

APM = alternative payment model

Congress, in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), ratified HHS's approach in Medicare by consolidating an array of pay-for-performance mechanisms into a single merit-based incentive payment system (MIPS; Category 2) and creating strong incentives for provider participation in alternative payment models (APMs) (Categories 3 and 4).

In implementing the MACRA requirements, CMS has established the Health Care Payment Learning and Action Network (LAN), consisting of public and private sector stakeholders, to encourage the development of and accelerate the transition to APMs. The LAN, in turn, convened the Alternative Payment Model Framework and Progress Tracking Work Group (the work group) to establish a consistent method for measuring progress in APM adoption across the health care system. In January, the work group, under expert leadership from the public and private sectors,[3] produced an APM framework expanding on the HHS categorization and representing a milestone in the effort to align payment incentives with goals for the U.S. health care system[4] (figure 1). CMS recently promulgated proposed MACRA regulations consistent with the LAN Framework approach.[5]

The framework accepts and elaborates HHS's payment categories by detailing 28 payment methods arrayed within HHS's four main categories. The methods range along a continuum from fee-for-service to shared risk and population-based payment, with categories 2–4 also including use of quality metrics. Moving from Category 1 to Category 4 thus involves two shifts: (1) increasing accountability for both quality and total cost of care, and (2) a greater focus on payment for population health management as opposed to specific services.

The LAN Framework provides a useful start for establishing a common language in which to discuss payment reform, as well as a useful categorization to discuss payment reform along a continuum in order to move away from fee-for-service. In this paper, we attempt to advance the discussion further by raising some practical considerations, suggesting that added value for beneficiaries and the Medicare program does not necessarily follow the same continuum as the framework's classification implies. We believe that Category 1 payment done well—that is, much better than today—can produce as much or more value than Category 4 implemented poorly.

Moreover, the framework does not address the complexity of payment methods. All payment methods have strengths and weaknesses, some related to practical, operational issues. Further, the various payment methods interact, sometimes in unanticipated ways. In fact, a single payment method rarely operates in isolation; hybrids of various methods are the norm, in order to balance individual methods' strengths and weaknesses. In the end, the relative merits of different combinations of payment methods should be determined by extensive testing with a variety of delivery organizations and payers.

THE FRAMEWORK'S CONTRIBUTION

The framework white paper proposes principles and insights to guide payment reform. Perhaps the two most important goals for payment reform, we agree, are to incent provider organizations to provide high-quality care efficiently and to hold them accountable for the total cost and quality of care. The payment methods in categories 3 and 4 perhaps pursue these goals most visibly. Yet, LAN Category 3A includes several upside-only gainsharing approaches that do not meet MACRA's requirement. In particular, for APMs to qualify for additional payment, providers have to bear more than "nominal" financial risk. Not all health professionals and other providers can, or necessarily should, participate in organizations capable of assuming financial risk across the spectrum of services contemplated under what the framework labels "comprehensive, population-based payment" (Category 4). That is why we appreciate that the framework provides a range of payment methods, and why even Category 1, fee-for-service payment methods, deserves value-enhancing attention, as we discuss below.

We strongly endorse the framework's recognition of the need to align public and private payment methods. Without aligned payment methods, health professionals and hospitals will continue to face conflicting incentives, inconsistent reporting requirements, and disjointed administrative demands.[6] Further, payment approaches that work well for a large public payer may have perverse effects on private payers if they do not (or are not able to) incorporate consistent incentives: accountable care organizations (ACOs), for example, might work well for Medicare, which sets payment rates, but ACOs may then be able to use the Medicare imprimatur as a consolidated provider system to gain market power and obtain high prices from private insurers without necessarily delivering higher-quality care.[7]

We agree that incentives, financial or otherwise, significantly matter to both—those who deliver care, as well as the organizations involved in the delivery of care. The strength of the organization's management structure and the effectiveness with which incentives are transmitted from the organization to the individual provider help determine the success or failure of any payment method. For example, maintaining Category 1 fee schedules and diagnosis related groups for health professionals and hospitals, respectively, while providing their affiliated ACOs small shared savings incentives, may have limited potential to change front-line providers' behavior because the fee-for-service incentives may dominate those from shared savings. This may occur both because the sheer size of the base payments dwarfs the incremental incentives to reduce spending and because the organizational incentives are not effectively transmitted to the provider at the point of service. Conversely, for organizations in which clinicians practice, weak incremental incentives may exert more influence than direct fee-for-service incentives, if the clinicians are tightly connected to the organization and if the organization is well managed.

In fact, some Category 3 models that rely on fee-for-service but place providers at financial risk for excessive health care spending may be just as effective as Category 4 models if the organizations are strong enough to implement managerial and incentive programs to offset the underlying fee-for-service incentives; these Category 3 models may be much more practical, at least in the short term. Moreover, even in Category 4 models, providers may face incentives, with productivity bonuses, that mimic fee-for-service. As a result, in all cases, organizations' managerial structures and processes matter, as discussed further below.

We also concur with the framework white paper's observation that multiple innovative delivery models, including centers of excellence, patient-centered medical homes, and ACOs, are available to achieve system goals. The white paper suggests that a particular payment model may use several APMs concurrently, especially as the model is evolving. We agree but would observe that combinations of base payment methods could be desirable for the long term as well, to achieve higher value than any single payment method can produce by itself.

Finally, we strongly endorse the framework's call for clarity in the use of often-misunderstood terms

as policy-makers, providers, insurers, and other stakeholders, acting as reformers, sort through and test various payment methods to achieve higher value for patients and consumers. In particular, we agree with the white paper's explanation that delivery-system reforms such as patient-centered medical homes are delivery-system innovations and not payment methods—a range of payment methods can be used with this model of delivery—even if CMS rules and MACRA's statutory language sometimes conflate the two terms.

ADDITIONAL CONSIDERATIONS

Although the LAN white paper presents a useful framework for categorizing payment methods as well as principles to guide testing various methods, other considerations not addressed by the LAN also will determine whether payment reform models will be successful.

Improvement of Legacy Payment Methods

The HHS categorization and the LAN framework correctly acknowledge that many—indeed most—commonly discussed potential APMs are meant to be layered on top of legacy payment methods, referred to as fee-for-service architecture. Yet, despite the central role of this long-standing architecture (and its criticisms), its underlying payment approaches can be improved substantially to produce higher value. For example, in commenting on the flaws of fee-for-service, the framework paper correctly points out that certain services are "systematically undervalued" and "currently undervalued," but these services do not *have to be* undervalued. We should work to correct the flaws in current base-payment methods, both to improve those current payment methods as long as they remain in use and to ensure that the new APMs do not carry forward the same flaws when new methods are layered on top.

The clearest example is the Medicare Physician Fee Schedule (MPFS). By correcting the egregious misvaluations of fees in the MPFS, CMS could produce a different mix of services provided to beneficiaries. This would reduce often unneeded tests and procedures and increase the time physicians and other health professionals spend with patients, both during face-to-face visits and in other forms of communication, including phone, e-mail, and telehealth.[8] ACOs functioning under the incentives of shared savings and shared risk understand that misvaluations within the current MPFS interfere with ACOs' interest in improving care coordination and in other initiatives to generate cost savings.[9]

In short, upgrading fee-for-service payment architecture should be considered an integral part of the movement to value-based payment. To its credit, CMS has been attempting to improve legacy payment methods, but it faces determined opposition from negatively affected stakeholders that wish to preserve the status quo. Considering all four HHS payment categories as inherent parts of the movement to APMs could change the political dynamics that produce the opposition to CMS's fee-schedule reform efforts.

Another major challenge in improving the current Medicare payment approach is that having different prices for the same service in different care settings is distorting provider incentives. Further, it may be causing divergence between payment incentives and patients' best interests.[10] For example, hospital outpatient departments (HOPDs) receive almost twice as much on average for services than independent physicians' offices do, giving physicians an incentive to perform these procedures in HOPDs and, more recently, giving hospitals a business reason to acquire physician practices and start billing for these services as outpatient services. This is problematic in the context of Category 1 payment itself, but it also undermines the incentives in Category 3 and 4 payment methods for physicians and hospitals to collaborate to reduce total cost of care.

In the Bipartisan Budget Act of 2015, Congress moved to modify site-of-service differentials, but with significant differences from the recommendations of the Medicare Payment Advisory Commission (MedPAC).[10] On one hand, Congress equalized payments in all services commonly provided by HOPDs and physician offices rather than adopt MedPAC's distinctions among services, which recognize hospitals' unique characteristics. On the other hand, Congress grandfathered existing physician employment relationships, only applying the across-the-board reductions going forward, and also exempted on-campus HOPDs from the new payment policy. These presumably politically-driven provisions create new distortions in provider behavior that make it more difficult to succeed with APMs. As part of APM review and development, we suggest revisiting these site-of-service provisions in closer accord with MedPAC's recommendations.

The Interaction of Payment and Quality Measurement

The framework white paper accepts HHS's view that quality can only be improved by measuring and rewarding performance. It indicates that payment models that do not take measured quality into account cannot be considered value based or eligible to be designated as an APM; this position is consistent with the MACRA approach. Among

ourselves we have differing views on the potential of public reporting and pay-for-performance, such as the merit-based incentive payment system (MIPS), to improve quality and value; nevertheless, we all agree more attention should be paid to modifying Category 1 payment design to improve quality, often with complementary performance measurement.

Consider, for example, policy approaches to alleviate preventable hospital readmissions, a problem that affects both cost and quality. The issue has received priority attention in the Affordable Care Act, leading to Medicare's Hospital Readmissions Reduction Program, which measures every hospital's readmission rate for specified conditions and then penalizes hospitals that have above-average rates. Although the program appears to have contributed to a reduction in readmission rates,[11] the Category 2 approach of measuring readmission rates and penalizing hospitals with a higher rate than average has generated significant controversy. Concern has been raised about the appropriateness of the readmission rate measure itself (since a hospital that successfully reduces both readmissions and initial admissions may still be penalized because the calculated readmission rate does not reflect its success[12]), as well as the vexing problem that hospitals in disadvantaged communities tend to have higher-than-average readmission rates because of patient and community factors outside their control.[13]

An alternative Category 1 approach, sometimes called a warranty, has been implemented in Germany. Before the current demonstration of global budgets for hospitals, a warranty was featured in Maryland's all-payer rate-setting program as well. Under the German design, readmissions within a designated time period that varies with diagnosis would not be separately paid if the readmission were for the same condition or resulted from complications of the initial hospitalization.[14] This approach increases incentives to improve discharge planning and transition care for all hospitals, not just below-average performers as under the Hospital Readmissions Reduction Program, and mitigates some measurement challenges.[15] Public reporting of hospital readmission rates—with the challenges described above—can be carried out but is not essential in this payment design approach.

Of course, improvement of any Category 1 legacy payment method raises its own significant design challenges. Some would argue that nonpayment for a readmission would be too strong an incentive and possibly lead to inappropriate denial of hospitalization. In the past, Maryland hospitals were paid a reduced amount (but still more than the hospital's variable cost) when admission volume increased above a baseline level.[16] Our point is not that fixing Category 1 payments is easy, but rather that improvements in Category 1 payment also can improve quality and value. In addition, Category 1 improvements are often necessary to facilitate the development and application of Category 2–4 methods.

The Importance of APM Design

The effects of specific payment methods on provider and consumer behavior—and thus on quality and costs—depends crucially on the specific design features payers adopt. Because of this reality, a fixed classification along a continuum can mislead policy-makers about strengths and weaknesses of proposed APMs. For example, the framework white paper correctly criticizes diagnosis related groups because the approach provides a reward for increased inpatient volume. Yet, the white paper does not mention that a potential Category 3 APM, "bundled episodes around a hospital procedure," similarly rewards an increase in the number of episodes. Indeed, putting physicians and hospitals, in effect, into a "joint venture" to receive bundled-episode payments could actually increase inappropriate procedures, whether or not they are produced more efficiently. This possibility remains to be investigated empirically.

As discussed earlier, even a prototypical fee-for-service payment method—the MPFS—which has inherent incentives to increase volume of services, can be modified in numerous ways to mitigate those incentives. Examples include adoption of care management and telehealth codes and correction of misvalued fees, which can serve as a part of—or at least a platform for—improved APMs.

Another example of the influence of design features on behavior can be found in primary care capitation. This payment approach was used widely in association with "gatekeeper" physicians in health maintenance organizations (HMOs) in the 1980s and 1990s and is now being reconsidered as a payment reform option.[17] Yet, some primary care capitation designs might encourage physicians to refer patients to other clinicians paid outside of the primary care capitation arrangement. Unnecessary referrals, in addition to increasing overall costs, could lead to fragmented, impersonal care—the consequence capitation is supposed to reduce.

A strategy that was often adopted to counter this perverse result established what, in essence, were early forms of shared-risk payments, with physicians receiving lower payment if they exceeded their "risk pool" spending (a total cost of care allotment for their assigned patients).[18] This design approach counteracts the incentive for unnecessary referrals.[19] In short, different designs can produce very different effects on physician behavior from ostensibly the same payment model.

In the heyday of managed care in the early 1990s, it was often argued that physicians were being put under excessive financial pressure that led to a tendency to stint on care, although that effect has not been demonstrated. An analysis of the relationship between the strength of payment incentives and the effects on physician behavior concluded that, in practice, the incentives provided by various payment methods vary in strength along at least seven dimensions, each with multiple components: (1) the type of service covered, (2) the practice setting, (3) the base payment method, (4) the relative generosity of the base payment, (5) the size of the incentive, (6) the incentive's immediacy, and (7) the presence of various counterbalancing monitoring mechanisms.[20]

Some believe, for example, that generous primary care capitation payments might reduce the incentive to refer patients unnecessarily and encourage care continuity. In short, without taking into account the proposed APMs' specific design features (including payment generosity), it would be challenging to predict their impact. Empirical testing using design variations will be necessary to assess the impact of the full array of APMs.

The Context for Adoption

Different payment methods can be expected to elicit different results across the United States, depending on the configuration of health care providers, the population served, and other local market characteristics. The culture of the individual delivery system matters crucially as well. Salary as a method for compensating health professionals has been adopted successfully by some multispecialty group practices as a way to neutralize financial incentives that produce too much or too little care and to support a collaborative group-practice culture. Yet, in the 1990s, many hospitals employed previously independent physicians and found that when the newly employed physicians were compensated by a fixed salary based on work hours, their work effort flagged.[21] As a result, in the most recent move toward hospital employment of physicians, hospitals, rather than relying on salary, compensate their newly employed physicians based on fee-schedule-based productivity—typically, the relative value units physicians have generated in their delivery of care.[22]

Similarly, differences in organizational culture might produce higher-quality and more efficiently produced bundled episodes in places that emphasize a certain procedure; in other places, the focus might be more on branding and marketing a lucrative new service line. The result would be a concomitant increase in the volume of services provided, albeit at a lower cost per episode. In short, both design features and delivery-system culture play roles in determining how payment methods influence behavior, and, ultimately, value.

Operational Challenges

As noted earlier, the LAN Framework presents a continuum of payment methods that relies first on adoption of provider-specific quality measures and second on assumption of financial risk, ultimately for the care of populations. Not considered in the continuum are the operational challenges associated with implementing what might appear to be more potent incentives to improve quality and reduce costs. Certainly, concerns about operational feasibility animate skeptics of the broad use of performance measurement and pay-for-performance adopted in MACRA as the MIPS. The ability to measure quality reliably at the individual-physician level is currently limited by concerns about gaps in what aspects of care are amenable to accurate measurement and the statistical validity of measurement with small numbers.[23] Many of these problems do not have easy fixes, so a completely satisfactory solution is likely years off.

Another example in which operational concerns are relevant is the placement of "episode-based payments for procedures" in Category 3B and "episode-based payment for clinical conditions" in Category 4A. Condition-based payment as a form of population-based payment has strong appeal. This approach addresses the concern that procedure-based episodes can generate inappropriate episodes involving unneeded, risky procedural interventions. Yet, a major concern about this payment method also relates to its operational feasibility—in addition to the concern that paying for condition-based episodes is a nonholistic approach, especially for Medicare patients who often have multiple chronic conditions that would then have to be paid for separately. Even when one uses state-of-the-art episode groupers, the vagaries of diagnosis coding, as evidenced by large regional variations, raise practical concerns about the reliability of condition identification and the possibility of "gaming" to find or exaggerate spurious conditions for payment purposes.[24] A recent draft proposal from the LAN Clinical Episode Work Group for a coronary artery disease episode payment acknowledges the challenge of requiring accurate and consistent diagnoses to trigger payment, but does not provide a ready solution.[25]

Proponents of payment for episode-based conditions are quite aware of these and other operational challenges and are trying to address them in testing the approach. Our point is that the placement in the highest category of the LAN Framework may give the misleading impression that this approach has been proven effective. The elegance of incentives is not sufficient to justify prioritizing them, given their major operational challenges. In fact, APMs specified

in MACRA that both qualify participating health professionals for the 5 percent APM bonus and exempt them from MIPS penalties and bonuses are mostly being conducted under Section 1115A demonstration authority. This means that even the few designated advanced APMs will not be broadly available to any provider who wishes to participate but only to those selected to participate in a particular APM-qualifying demonstration. Because of the various considerations discussed above—payment design, organizational culture, and operational challenges—empirical testing in a variety of settings is needed to determine whether an appealing payment method can pass the Affordable Care Act tests for broad national implementation.

DISCUSSION

All payment methods, not only those that HHS and the LAN label fee-for-service, have strengths and weaknesses. Their impacts on provider behavior—and the resulting costs and quality—depend crucially on the specific designs that are adopted and the context in which each method is applied. Although the LAN Framework is quite useful as a starting point, the continuum from "fee-for-service" to "population-based" may not reflect the effectiveness of different payment methods in practice or their operational feasibility in Medicare—or, in fact, the evolutionary path that necessarily will, or ultimately should, be taken.

Only testing in a variety of settings, with design variations, can lead to the successful adoption of higher-value payment methods. The operational limitations of some models may unfortunately restrict their application, even if they are conceptually appealing, producing results that differ from their intended effects.

Similarly, we think the framework white paper's recommendation for "progress tracking" based on rates of adoption of different payment methods is useful. But without measuring the specific methods' effect on cost and quality outcomes, progress tracking could produce misleading claims of success and divert attention from adequate impact assessment.

Practically, as the framework implicitly acknowledges, most of the likely best APMs are actually hybrid payment models, layering on top of standard legacy payment methods often modest financial incentives for improving on specific quality measures and spending more prudently. LAN Framework 1.0 presents 28 payment options as separate choices, when in reality they will be combined in various configurations as mixed payment models. LAN Framework 2.0 might present payment reform as packages of complementary methods, perhaps also with benefit designs best able to support the payment-package objectives.[26]

CONCLUSION

The LAN Framework white paper's typology of payment methods represents a useful continuum for *describing* a range of payment models. However, this continuum works less well for actually *judging which* payment methods deserve to be tested for broad adoption, for the following reasons:

- Because all payment models have strengths and weaknesses, the impact of any particular one depends crucially on the specific payment design adopted—including not only the structure of the payment method but also both the relative and absolute levels of payment provided.
- Operational issues related to coding accuracy, availability of reliable and relevant quality measures, and other practical requirements for proper payment must be addressed and solved.
- Broad-based testing will be needed in a variety of provider settings to assess the actual impact of new payment methods before they can be adopted nationally in the Medicare program.
- The highest value might be delivered in hybrid payment models that combine the strengths of various payment methods while mitigating their weaknesses, rather than by relying on the pure payment methods that make up the LAN continuum.

ENDNOTES

1. Centers for Medicare & Medicaid Services, "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume," press release, January 26, 2015, www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html (accessed April 15, 2016).

2. Before 1983, Medicare paid hospitals for their reasonable costs; moving hospitals to prospective payment per stay represented a major departure from the previous payment approach. Medicare payment for services provided by home health agencies, rehabilitation hospitals, and skilled nursing facilities similarly departs significantly from the original fee-for-service framework (Blumenthal D, Davis K and Guterman S. "Medicare at 50—Origins and Evolution." *New England Journal of Medicine*, 372(5): 479–486, January 29, 2015). Payment for services provided by physicians and other health professionals has largely remained classic fee-for-service, using a fee schedule for individual items and services, even though the method of calculating the fees has changed. Although we do not think fee-for-service is the best term to describe these volume-based payment methods, because HHS and the LAN Framework have adopted its use, we use it in the rest of the document.

3. The Alternative Payment Model Framework and Progress Tracking Work Group, which represents a range of experts and stakeholders, is chaired by Samuel Nussbaum, M.D., former chief medical officer of Anthem Inc. The framework white paper was endorsed by Patrick Conway, M.D., CMS deputy administrator for innovation & quality and chief medical officer, and LAN co-chairs Mark McClellan, M.D., director of the Robert J. Margolis Center for Health Policy at Duke University and former CMS administrator, and Mark Smith, M.D., visiting professor, University of California at Berkeley; clinical professor of medicine, University of California at San Francisco; and former president of the California Healthcare Foundation.

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19. The experience with primary care capitation suggests that even the concept of financial risk can be an elusive one. In the lead author's practice experience, a private insurer initially provided about a $12.50 per member per month primary care capitation with a 20 percent "withhold." This withhold would be completely or partially returned based on the insurer's comparison of the total cost of care for the physician's patients against the risk pool allocation. In response to physicians' resistance to such a large withhold, the insurer eliminated the withhold altogether, providing an upside-only model by reducing the monthly capitation rate to $10 per member. The two approaches were financially equivalent, but one likely would be labeled as having two-sided risk while the other would be considered upside-only and therefore of low priority as a qualified APM.

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