

ACA Implementation – Monitoring and Tracking

Executive Summary: 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.

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.

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