



EXECUTIVE SUMMARY

How to Create an Alternative Payment Model

*Designing Value-Based Payments That Support
Affordable, High-Quality Healthcare Services*

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WHAT IS AN ALTERNATIVE PAYMENT MODEL?

There is broad consensus that fee-for-service payment is a major reason why healthcare spending has grown faster than inflation without any corresponding improvement in the quality of care for patients. To address this, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) authorized the creation of “Alternative Payment Models” in Medicare. In general, an APM must either:

- improve the quality of care without increasing spending;
- reduce spending without reducing the quality of care; or
- improve the quality of care and reduce spending.

As of 2018, the majority of healthcare providers in the country were not participating in an Alternative Payment Model, and most providers had not even had an opportunity to do so because of the small number and narrow focus of the APMs that had been created. Moreover, the APMs that do exist have generally failed to achieve any significant savings.

Although many people believe the poor performance of current APMs is because they do not create enough “financial risk” for the participating providers, there is no evidence that simply increasing financial risk would result in greater savings. On the other hand, transferring financial risk to providers can have undesirable results, including loss of access to services for higher-need patients, higher prices due to consolidation of providers, and lower quality of care.

A more plausible explanation for the failure of current APMs is that the APMs have not actually solved the problems with fee-for-service payment. For example, most APMs do not actually change the underlying fee-for-service system, but simply provide bonuses to healthcare providers when spending is reduced.

Fortunately, there are different and better ways to design Alternative Payment Models that can directly address the problems in the fee-for-service system without placing healthcare providers at significant financial risk or causing patients to worry about whether needed care is being withheld for financial reasons.

HOW TO CREATE A SUCCESSFUL ALTERNATIVE PAYMENT MODEL

Creating a successful APM requires a six-step process:

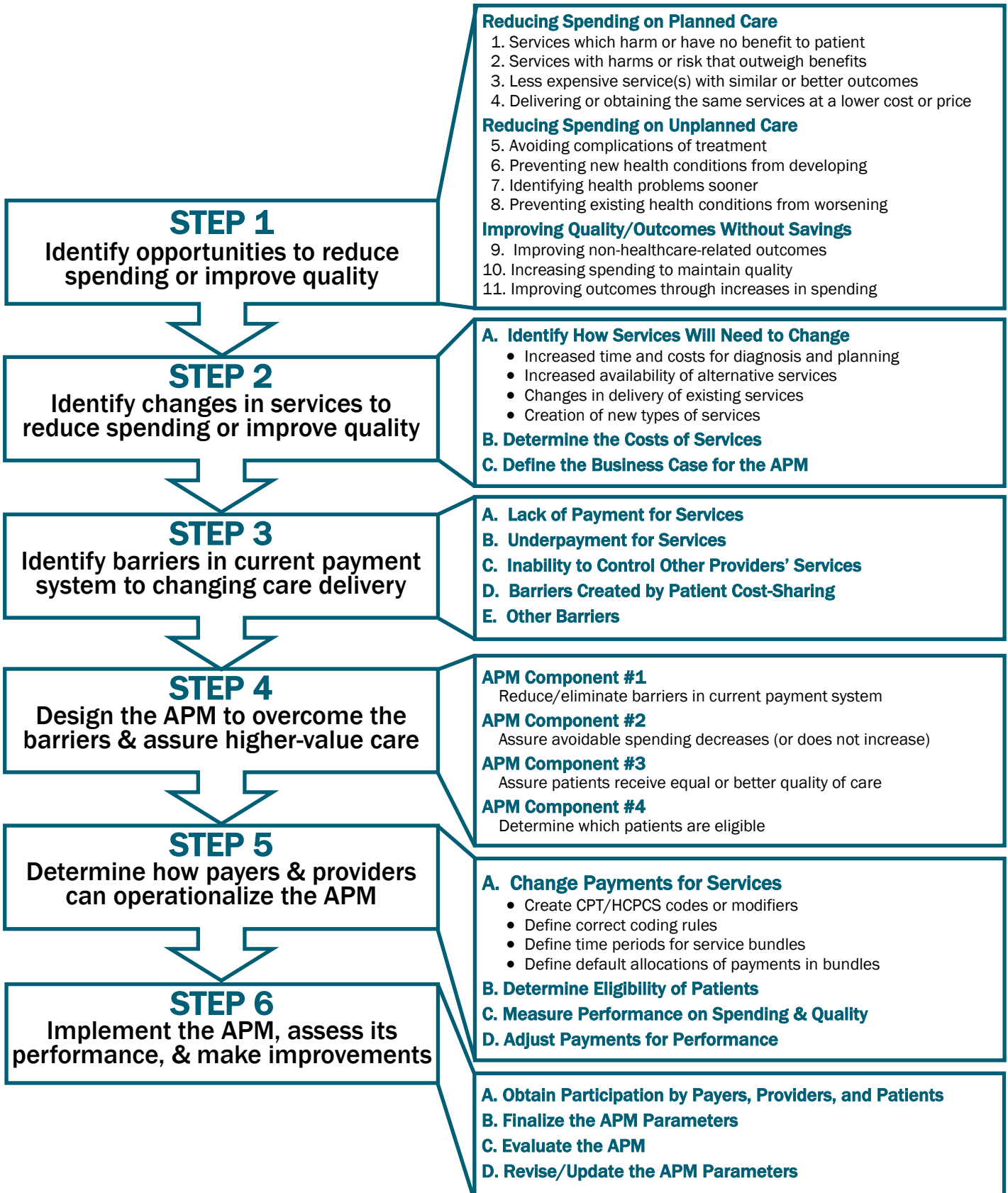
- Step 1:** Identify one or more opportunities for reducing spending and/or improving the quality of care;
- Step 2:** Identify changes in care delivery that will reduce spending or improve quality in those opportunity areas;
- Step 3:** Identify the barriers in the current payment system that prevent or impede implementing the improved approach to care delivery;
- Step 4:** Design the Alternative Payment Model so that it will overcome the barriers in the current payment system and assure the delivery of higher-value care;
- Step 5:** Determine how payers and providers can operationalize the APM as easily and quickly as possible; and
- Step 6:** Implement the APM, assess its performance, and make improvements as needed.

Most current APMs have not been designed to focus on specific opportunities for reducing avoidable spending. Defining the goal of the APM as “reducing the total cost of care” may seem ideal from the perspective of a payer, but it can be highly problematic for both healthcare providers and patients because:

- There are many ways total spending might be reduced that would be harmful for patients. An APM that targets specific opportunities to reduce spending by improving the quality of care will be much safer for patients than an APM that rewards providers for *any* reduction in healthcare spending.
- Providing adequate payments requires knowing what high-value services will need to be delivered to reduce spending or improve quality.
- No individual physician, hospital, or other provider delivers all of the services any individual patient receives or all of the factors affecting the total cost of care for their patients. Accountability needs to be focused on the specific aspects of spending and quality that providers can control.

Consequently, the starting point in creating an APM is to identify specific opportunities for improving outcomes and/or reducing potentially avoidable spending. The APM can then be designed to pay adequately for the necessary services and to hold providers accountable for achieving the expected results.

STEPS TO CREATE AN ALTERNATIVE PAYMENT MODEL



STEP 1: IDENTIFY OPPORTUNITIES FOR SAVINGS & QUALITY IMPROVEMENT

A successful Alternative Payment Model will achieve reductions in healthcare spending in ways that maintain, and ideally improve, the quality of care for patients. Opportunities for doing this can be divided into the following eight categories:

Reducing Spending on Planned Care:

1. Avoiding the use of services that harm or have no benefit for the patient;
2. Avoiding the use of services with harms or risks that outweigh the benefits;
3. Using a different service or combination of services that is less expensive but achieves similar or better outcomes; and
4. Delivering or obtaining the same services at a lower cost or price.

Reducing Spending on Unplanned Care:

5. Avoiding complications of treatment;
6. Preventing new health conditions from developing;
7. Identifying treatable conditions before they worsen; and
8. Preventing existing health conditions from worsening.

“Reducing spending” includes avoiding increases in spending that would otherwise have occurred if utilization of avoidable services is expected to increase in the absence of the APM.

There may also be opportunities to improve the quality of care or outcomes for patients that do not result in any healthcare savings. If there is no change in spending, but quality or outcomes improve, that could still qualify as an APM. If an opportunity for improving quality would require an increase in spending, it would need to be combined with an opportunity for reducing spending in order to be part of an APM.

There are also situations in which spending may need to increase simply to sustain current levels of quality and outcomes, such as addressing the problems of underpayment for services faced by many rural hospitals and physician practices. Since these changes would not qualify as an APM, they would need to be pursued through other types of payment reform.

STEP 2: IDENTIFY CHANGES IN SERVICES NEEDED TO IMPROVE CARE

The existence of an opportunity for reducing a particular aspect of spending while maintaining or improving quality does not automatically mean that savings in that area can be reliably achieved; there must be a systematic way of delivering care differently that can successfully address that opportunity, and any additional spending involved must be less than the savings that are achievable. To determine whether an Alternative Payment Model is feasible, three separate steps are needed:

- **Identify one or more changes to care delivery that are expected to achieve the desired savings or improvement in quality.** An APM is unlikely to be successful unless it is clear there is at least one way to deliver healthcare services differently that can achieve the desired results in terms of savings and quality. The specific ways in which services will need to change must be identified in order to ensure that the APM design adequately supports an improved approach to care delivery.
- **Determine the costs of delivering services under the revised approach to care.** The cost of delivering a service may be very different from what Medicare or other payers currently pay for the service (if they pay for it at all). Even when the goal of the APM is to avoid unnecessary or harmful services, providers may need to spend more time or incur more costs in order to make the decisions to change services or to deliver alternative services. If current payment amounts are less than the costs of delivering desirable services, it may be impossible to sustain those services under

the APM; if payment amounts are higher than costs, reducing payments could provide an additional way to generate savings.

Cost-to-charge ratios cannot be used to accurately determine the true costs of individual services. Moreover, if the volume of services changes under the APM, the cost of delivering services will also likely change. Because a significant proportion of most healthcare providers' costs are fixed, the *average* cost per service will *increase* when fewer services are provided. Consequently, it is not enough to have a cost accounting system that reports what it currently costs to deliver a service; a *cost model* is needed that identifies the fixed costs, semi-variable costs, and variable costs associated with the service and estimates how those costs will change when there are changes in the number or types of services delivered.

- **Determine whether there is a business case for pursuing development of an APM.** If the estimated increase in cost associated with the change in service delivery is less than the savings expected to result from reducing the avoidable spending, the APM can be successful. If not, a different approach to service delivery will be needed that has a lower cost or a larger impact on avoidable spending, or a payment reform other than an APM may be more appropriate.

OPPORTUNITIES TO REDUCE SPENDING AND/OR IMPROVE QUALITY

Opportunity	Examples
Reducing Spending on Planned Care	
1. Avoiding services which harm or have no benefit for the patient	Use of antibiotics for viral illnesses Repeated tests and imaging studies Pre-operative testing prior to outpatient surgery Imaging for acute low back pain Misdiagnosis
2. Avoiding services with harms or risks that outweigh benefits	Coronary angiography in low-risk patients
3. Using services that are less expensive with similar/better outcomes	Physical therapy instead of spinal surgery Low-risk childbirth in a birth center instead of a hospital Home care rather than inpatient admission
4. Delivering/ordering the same service from a provider with a lower cost or price	Diagnostic tests and procedures in physician offices instead of hospitals
Reducing Spending on Unplanned Care	
5. Avoiding complications of treatment	Reducing/eliminating central line-associated bloodstream infections Reducing adverse events during hospital and SNF admissions
6. Preventing new health conditions from developing	Losing weight to prevent diabetes
7. Identifying health problems sooner	Screening for high blood pressure Early identification and treatment of COPD exacerbations Early identification and treatment of chemotherapy complications
8. Preventing health conditions from worsening	Slowing the progression of Chronic Kidney Disease
Improving Quality/Outcomes Without Savings	
9. Improving non-healthcare related outcomes with no increase in spending	Returning patients to work sooner
10. Increasing spending to maintain quality	Increasing payments to sustain primary care physicians Increasing payments to keep small rural hospitals from closing
11. Improving healthcare related outcomes through increases in spending	Expensive new drugs or medical devices that extend life

CARE CHANGES NEEDED TO REDUCE SPENDING AND/OR IMPROVE QUALITY

Opportunity	Care Changes Needed	Examples
<ol style="list-style-type: none"> 1. Avoiding services which harm or have no benefit for patients 2. Avoiding services with harms or risks that outweigh benefits 	Additional time or costs of doing less	<p>Additional time needed during patient visits for shared decision-making about treatment</p> <p>Additional time outside of patient visits to determine which treatment pathway is most appropriate</p>
<ol style="list-style-type: none"> 3. Using services that are less expensive with similar/better outcomes 4. Delivering/ordering the same services from a provider with a lower cost or price 	Ensuring availability of alternative services	<p>Creation or expansion of birth centers</p> <p>Expansion of home health and hospice services to rural communities</p>
<ol style="list-style-type: none"> 5. Avoiding complications of treatment 6. Preventing new health conditions from developing 7. Identifying health problems sooner 	Changes in the way existing services are delivered	<p>Following checklists to prevent infections</p> <p>Remote monitoring of patients for early identification of problems</p>
<ol style="list-style-type: none"> 8. Preventing health conditions from worsening 	Ensuring availability of services	Ensuring adequate home health services in rural communities
<ol style="list-style-type: none"> 9. Improving non-healthcare related outcomes 10. Increasing spending to maintain quality 11. Improving healthcare related outcomes through increases in spending 	Creation of entirely new services	Delivery of "hospital at home" services who need intensive home care for acute illness

STEP 3: IDENTIFY THE BARRIERS IN THE CURRENT PAYMENT SYSTEM

The current fee-for-service payment system may create barriers to the delivery of the new or modified services needed to achieve savings and/or improve quality. If the APM does not identify and remove these barriers, it will be unlikely to achieve the desired results. Common barriers to implementing changes in care delivery include:

- **No payment for one or more of the services providers would need to deliver.** The current fee-for-service payment system defines specific payment amounts for over 15,000 different services. Despite this, many payers do not pay at all for a variety of high-value services, such as communications between physicians and patients, communications between primary care physicians and specialists, palliative care services for patients with advanced illnesses who do not qualify for hospice care, and many others. In some cases, payments may only be available for the service in certain circumstances that do not include the patients or providers targeted by the APM.
- **Current payments for the services to be delivered are less than needed to cover the costs of delivering the services.** For example:
 - ◆ **Underpayment for specific phases of care.** The amount of payment may be too low for a service when it is delivered during certain phases of the care process.
 - ◆ **Underpayment for specific kinds of patients.** If there is only one payment amount for delivery of a service, but the amount of time, staffing, or materials required to deliver the service varies significantly from patient to patient, then the provider will be financially penalized for treating the higher-cost patients.
 - ◆ **Underpayment related to volume.** The payment amount may be too low for providers who deliver the service less frequently than others. Because a significant portion of the costs of many healthcare services is fixed, a healthcare provider that reduces the volume of services delivered can experience losses when paid an amount that would be ade-

quate for higher-volume providers. Providers in rural areas will often have higher costs to deliver a service than providers in more densely-populated areas simply because of the lower number of eligible patients.

- ◆ **Underpayment for new services.** There will often be significant startup costs associated with a new service, or a period of time in which costs have to be incurred before revenue can be generated. A payment amount that is adequate to cover ongoing costs may not be enough to enable recovery of startup costs.
- **Healthcare providers are unable to control the types or costs of services delivered by the other providers they rely on for a portion of their patients' care.** Under current fee-for-service payment systems, each provider is paid separately for the services they deliver, and so a provider participating in the APM may be unable to control whether other providers deliver an undesirable service, fail to deliver a service that patients need, or use an unnecessarily expensive method of delivering a needed service.
- **Patients are unable to afford to pay for the services or to pay their share of the cost of services under their insurance plan.** If the patient feels the cost-sharing amount is unaffordable or is not commensurate with the benefit of the service to them, the patient may not seek out or accept a service, even if doing so would enable the insurer to achieve savings on its share of the payments or enable the provider to achieve better outcomes for the patient.

There may also be barriers to delivering the desired services or reducing the avoidable services that have nothing to do with the payment system, such as fear of being sued if a test or service was not delivered, inability to deliver a particular service because of the scope of practice laws in the state, or restrictions in federal and state fraud and abuse statutes. These barriers cannot be addressed by changes in the payment system alone.

STEP 4: DESIGN THE ALTERNATIVE PAYMENT MODEL

An Alternative Payment Model needs four distinct, but interrelated components:

APM Component #1:

A mechanism for reducing or eliminating the barriers in the current payment system that impede delivering the services that would reduce specific types of avoidable spending;

APM Component #2:

A mechanism for assuring patients and payers that the avoidable spending targeted by the APM will decrease (if the goal of the APM is to achieve savings), or that spending will not increase (if the goal of the APM is to improve quality);

APM Component #3:

A mechanism for assuring that patients will receive equal or better quality of care and outcomes as they would with the kind of care delivery they receive under the current payment system; and

APM Component #4:

A mechanism for determining which patients will be eligible for the services supported by the APM.

There are multiple ways to implement each of these components.

APM Component #1: Removing the Barriers in the Current Payment System

If the current payment system creates barriers to delivering the services needed to achieve reductions in avoidable spending, the APM needs to remove those barriers or at least reduce them. The mechanism used to do that depends on the nature of the barriers and on the ways care may be delivered once the barriers are removed. There are at least fourteen options for doing this. These options are not mutually exclusive, and two or more options may need to be combined, either to address multiple barriers in the current payment system or to avoid creating a new type of barrier by using an overly narrowly defined payment change.

Paying for Unpaid Services

Option 1: Pay a Fee When the Service is Delivered. If the barrier to delivering a high-value service is that there is no payment for that service, the most straightforward solution is to simply create a fee for the service. If there are only specific circumstances in which delivery of the service is desirable, those circumstances can be defined as conditions required in order for the fee to be paid. Concerns about potential overuse of the service can be addressed through Component #2 of the APM.

Option 2: Pay for the Service Through a Bundled Fee for a Group of Services. An alternative to paying a separate fee for an individual service is to include the service as a part of a group of services and pay a single “bundled” fee for the group. This can be desirable if the service should always or almost always be delivered together with the other services in the group, if the service is intended as an alternative to one or more of the other services in the group, or if there are different ways of delivering the service itself to achieve the same results. However, bundled payments are not always better, particularly when different patients will need more or fewer of the services in the bundle.

Aligning Payments With the Costs of Services

Option 3: Increase the Payment to Cover Costs. If the payment amount for a service is lower than the cost of delivering that service in most or all circumstances, an obvious solution is to increase the amount of payment to match the cost of delivering the service. If the payment is too low in specific circumstances, then it may be preferable to define a different payment for the service in those circumstances, using Option 1.

Option 4: Stratify Payments by Phase of Care. If there are situations in which the “same” service or group of services is costlier to deliver in one phase of care than another, e.g., when a chronic condition is first diagnosed and treated, payments can be “stratified” by phase, i.e., the amount of payment is determined by both the type of service and the phase of care in which it is delivered.

Option 5: Stratify Payments by Patient Characteristics. If it takes longer to deliver a service to patients with specific characteristics, or if the costs for materials or devices are higher for certain types of patients, higher payments can be defined for the service when it is delivered to pa-

tients with those characteristics. Stratification is usually preferable to “risk-adjusting” payment amounts because of weaknesses in the methodologies used for risk adjustment.

Option 6: Condition-Based Payments. If the cost of delivering a service depends more on the number and types of patients being treated than on the number of times the service is delivered, a “condition-based payment” – paying based on the number of patients treated for a particular condition – will be preferable to paying fees for each individual service. A “condition” could include multiple diseases that require coordinated treatment, and condition-based payments can also be stratified and/or bundled. There will need to be an objective way of defining and documenting the presence of the condition that will trigger the payment.

Option 7: Standby Capacity Payments. There are a number of important healthcare services, such as hospital emergency departments, which must be available in a community regardless of how many patients are treated or whether any patients are treated at all. Fee for service payment is not an appropriate way to pay for these “standby” services, because the services provide a benefit not just to patients who actually use them, but also to the individuals who could have potentially needed them. Standby capacity payments represent a way to ask “potential patients” to pay for the fixed costs of this standby capacity.

Option 8: Volume-Based Adjustments. An alternative approach when services have significant fixed costs is to pay on a per-service basis, but explicitly adjust the payment amount based on the total volume of the services delivered by the provider.

Option 9: Outlier Payments. If there are *individual* patients who have unique characteristics that make the cost of delivering services dramatically higher than average, a provider could receive an outlier payment to cover all or part of the extra costs involved in delivering services to those patients.

Option 10: Cost-Based Payments. A cost-based payment explicitly ties the payment amount to the *actual* cost a provider incurs for delivering a service or combination of services to the specific patients who received the services.

Option 11: Using Multi-Component Payment Structures. Options 1-9 are each designed to align payment with one aspect of costs – either fixed costs, semi-variable costs, or variable costs – but not with all three. Since most services involve a combination of fixed costs, semi-variable costs, and truly variable costs, none of the options is ideal for matching payment to costs at different volumes of services. To address this, a payment model can be created that explicitly includes separate components using two or more options from Options 1-9.

Enabling Control of Services Delivered by Other Providers

Option 12: Multi-Provider Bundled Payment. In a multi-provider bundled payment, a single payment supports all of the individual services delivered by all of the providers who need to work as a team, so all of the included providers can hold each other accountable for what they are doing and how they are paid. Such bundles work best when the providers have agreed to work together as a team and the patient has agreed to use the members of that team for the services included in the bundle.

Modifying Cost-Sharing

Option 13: Modify standard cost-sharing rules. In most insurance plans, the amount that a patient is expected to pay for a healthcare service is determined using some combination of copayments, co-insurance, and deductibles. Special cost-sharing requirements could be created for services delivered under the APM to ensure that they do not discourage the use of desirable services or encourage the use of undesirable services.

Option 14: Create or change last-dollar cost-sharing amounts. Typical cost-sharing requirements are “first dollar,” i.e., the amount that the patient pays is determined first, and then the payer pays the rest. An alternative is to require the patient to pay the “last dollar” of the cost, i.e., if there are two different choices of services or providers, the patient’s cost sharing would be based on the difference in the cost.

METHODS OF REMOVING THE BARRIERS IN THE CURRENT PAYMENT SYSTEM		
Payment Option	Payment Barrier(s) Addressed	Challenges/Weaknesses
1. Pay a fee for the service	No payment for a high-value service	Can encourage unnecessary use
2. Bundled payment for a group of services	No payment for a service that complements or substitutes for other services	Can limit flexibility if patients need different combinations of services
3. Higher payment for the service	Payment is usually below cost	Can encourage unnecessary use
4. Payment stratified by phase of care	Payment too low in some phases	Requires clear definition of phases
5. Payment stratified by patient characteristics	Higher cost of delivering service to certain types of patients	Requires objective way of assessing presence of characteristics
6. Condition-based payment	Cost depends more on number and type of patients than # of services	Can encourage over-diagnosis of condition
7. Standby capacity payment	Service needs to be available even if no patients need or use it	Requires determining minimum capacity needed for service
8. Volume-based payment adjustment	Higher cost for low-volume providers	Can encourage delivery of low volumes of service
9. Outlier payment	Higher cost for specific patients	Can reward inefficiency
10. Cost-based payment	Costs differ for different providers	Can encourage inefficiency
11. Multi-component payment	Cost of services depends on multiple factors	Increases the complexity of payment
12. Multi-provider bundled payment	Multiple providers need to deliver services in a coordinated way	Requires designating a payment recipient and allocation method
13. Modified first dollar cost-sharing	Co-pays, co-insurance, deductibles discourage use of high-value service	Lower cost-sharing can encourage unnecessary use
14. Last-dollar cost-sharing	Different providers/services have similar benefits but different costs	Can discourage use of higher-cost services that have better outcomes

APM Component #2: Creating Accountability for Spending

If the changes in payment included in Component #1 eliminate or adequately mitigate the payment barriers identified in Step 3, then it should be feasible for patients to receive the kinds of services defined in Step 2. However, in order to make these changes in payment, a payer or patient will also want assurance that the expected savings will actually materialize. An accountability component for spending has four distinct elements:

1. One or more *measures of spending or utilization* that the participants in the APM will be accountable for reducing or controlling;
2. A *Target* for each of these measures, i.e., the level that must be achieved or maintained or the change

that must occur in order for the APM to be deemed successful in achieving its goal;

3. A *performance assessment methodology*, i.e., the calculations that will be made to determine whether a specific entity participating in the APM has achieved or maintained the targets.
4. A *mechanism for adjusting payments based on performance*, i.e., what changes will be made in payments if the targets are not achieved.

It is often desirable to have multiple accountability components for different aspects of spending.

1. Defining the Accountability Measures

The APM needs to define the specific aspects of utilization or spending for which the participant in the APM will be accountable and how they will be measured.

If the APM is explicitly intended to reduce or control spending on certain types of services, then the APM needs specific measures for each of those services or the aspects of spending that are to be reduced. This could include:

- Planned reductions in utilization or spending on services delivered by the APM participants.
- Planned reductions in utilization or spending on services ordered from other providers.
- Reductions in utilization or spending on unplanned services that the APM is intended to achieve.
- Spending on complications of treatment related to the new or expanded services under the APM.
- Spending on complications of undertreatment when fewer or different services are being delivered under the APM.
- Spending on substitutions of other services for the services reduced by the APM.
- Spending from increased utilization of a lower-priced service.

Using a “total cost of care” measure may seem simpler and more reliable than defining and measuring spending for specific types of services, but such a measure can be problematic because individual providers generally cannot control all aspects of utilization and spending. Using measures of total spending can also be problematic for the patients who are receiving services supported by the APM because it creates financial incentives for providers to inappropriately delay or withhold needed services. Moreover, the random variation in utilization and spending in a total cost of care measure can hide meaningful reductions in spending that are achieved in specific types of services. These problems can be reduced by using a more narrowly-defined composite measure that includes only services related to the specific condition for which the patient is being treated or to a specific procedure the patient has received (e.g., an “episode

spending” measure). However, use of any kind of composite measure makes it more difficult for providers, payers, and patients to determine whether the APM is achieving savings in desirable or undesirable ways.

In most cases, the best approach will be to use a combination of both service-specific measures and composite measures based on the types of impacts on spending the APM could have. Two or three separate groups of measures or composites could be defined as follows:

- a. **Potentially Avoidable Spending**, i.e., one or more service-specific measures for aspects of spending where the APM is intended to achieve savings. For each of these measures, specific goals for savings would be defined.
- b. **Related Spending**, i.e., service-specific measures, or a single composite measure, focused on specific types of services and spending where increases caused by the APM are possible but undesirable. Here, the goal would be no increase in utilization or spending on these measures of related spending (or an increase smaller than the savings on targeted spending).
- c. **Unrelated Spending**. If there is concern that utilization or spending could increase in other, unidentified areas, an additional broad composite measure of spending could be defined by taking an episode spending measure or total cost of care measure and subtracting the aspects of utilization or spending defined in the first two groups, and monitoring this measure for significant changes.

Instead of measuring spending, it may be preferable to measure *utilization* or *resource use* in order to separate the effects of individual providers’ decisions about which services to use from decisions made by pharmaceutical companies, device manufacturers, and large health systems about the prices they charge for services. Moreover, it will generally be desirable to *stratify* or *risk-adjust* measures of utilization and spending for differences in patient needs. In addition to defining the types of services for which utilization, spending, resource use, or appropriateness will be measured, a decision must also be made about the *timeframe* in which those services must occur in order to be included in the measure.

ALTERNATIVE WAYS OF MEASURING UTILIZATION AND SPENDING

Measure	Strengths	Weaknesses	Examples
Spending for a Specific Service the APM is Intended to Reduce	Focuses on exact services APM is intended to reduce	Service may be delivered to patients not included in the APM; provider may be able to control utilization but not price of service; spending may be higher if provider has a higher-than-average number of patients with characteristics requiring delivery of the service	Spending per patient on ED visits
Spending for a Service in Specific Circumstances	Focuses on circumstances in which APM is intended to reduce spending	Requires ability to define and identify existence of circumstances	Spending per patient on ED visits related to the chronic diseases targeted by the APM
Spending for a Group of Services APM is Intended to Reduce	Adjusts for offsetting changes across all services APM is intended to reduce	Use of other services may change in unexpected ways	Spending per patient on ED visits and hospitalizations related to the chronic diseases targeted by the APM
Spending for All Services the Patient Receives During a Period of Time	Captures all changes in services	Net change may be due to unrelated factors the provider cannot control; random variation in unrelated services may mask targeted changes	"Total cost of care" per patient "Episode spending" per patient
Multiple Measures of Spending	Allows different Targets to be used for each measure	Requires clear definitions for what types of services are included in each measure	Measures of three subsets of spending: - Avoidable Spending - Related Spending - Unrelated Spending
Utilization of a Specific Service	Focuses on change in use of service, not changes in price	Does not encourage use of alternative services that have lower prices	Number of ED visits per patient that are related to the chronic diseases targeted by APM
Resources Used for a Group of Services	Focuses on extent to which higher-cost or lower-cost services are used but not on differences in price relative to cost	Does not encourage use of lower-cost providers	# of ED visits multiplied by a standardized cost per ED visit + # of hospital admissions times standardized cost per admission) divided by # of patients
Risk-Stratified Spending on a Service	Controls for patient characteristics that require more services or more expensive services	Reliable data on important patient characteristics may not be available	Spending per patient on ED visits for (1) high-risk patients, (2) medium-risk patients, and (3) low-risk patients
Utilization/Spending on Services Not Meeting Appropriateness Criteria	Focuses on the services that can be eliminated without harming patients	Reliable data on patient characteristics needed to assess appropriateness may not be available	Spending per patient on ED visits for (1) low-mortality, non-urgent symptoms and (2) urgent/high-risk symptoms
Spending During Different Timeframes	Separates short term and long-term spending and savings	If boundaries of time periods are arbitrary, spending could shift between time periods	Spending per patient on ED visits during (1) the first 30 days and (2) the next 60 days

2. Setting the Performance Targets for Utilization and Spending

Alternative Ways of Setting Targets

A Target for each of the measures is needed that defines the level of spending or utilization that must be achieved to assure that the business case for the APM is being fulfilled. Two different types of Targets can be defined based on the types of savings that are expected:

- a. **Patient-Level Targets.** Ideally, an APM will define the Target for a measure in terms of the level of service utilization or spending that is appropriate for *each individual patient*, based on that patient's needs. This is easiest to accomplish for an APM that makes changes in *planned* services that are expected to achieve net savings for *every* participating patient with particular characteristics (e.g., use of a less expensive but equally effective service). When different types or amounts of services are appropriate for different patients, the Target could be defined as adherence to evidence-based clinical guidelines or "pathways."
- b. **Population-Level Targets.** An alternative is to define Targets in terms of the level of utilization or spending to be achieved for a *group of patients*. This is most appropriate in APMs that are designed to reduce *unplanned* services, since any individual patient might or might not have experienced an unplanned service (e.g., a complication of surgery) even without the APM. There are three different ways to set Population-Based Targets:
 - i. **Benchmark-Based Target.** Because spending under an APM is required to be equal to or lower than it would have been in the absence of the APM, most Population-Level Targets, at least initially, will likely be defined as a Benchmark-Based Target using two separate components:
 - a *Benchmark* that defines what level of spending/utilization for the group of patients receiving services supported by the APM is viewed as reflecting "no impact of the APM"; and
 - a *Target Change*, i.e., the minimum or maximum amount by which actual spending or utilization under the APM should differ from the Benchmark.
 - ii. **Evidence-Based Target.** If there is evidence indicating that a specific level of utilization or spending can be achieved that is lower than the level currently being achieved by most providers, then that level of utilization and spending could be set as an Evidence-Based Target, thereby avoiding the need to define Benchmarks and Target Changes.
 - iii. **Competitive Target.** In situations in which there are multiple providers offering services under an APM, the Target could be set through a competitive process.

Alternative Ways of Defining Population-Level Benchmarks

If a Benchmark-Based Target is going to be utilized, three basic methods can be used to define the Benchmark:

- **Prior Performance Benchmark.** This is based on the actual level of spending or utilization during a previous period of time, either for the same patients or for the patients the same provider has treated or managed in the past.
- **Comparison Group Benchmark.** This is based on the actual level of spending for a group of patients who are not participating in the APM but who are similar to those who are in the APM.
- **Counterfactual Benchmark.** This is based on an estimate of what the spending or utilization in the current year would be for the specific patients who are receiving services supported by the APM.

Alternative Ways of Defining Target Changes

Since the Benchmark for a measure is intended to represent the level of spending/utilization that reflects "no impact" of the APM, the Target Change must define the magnitude of the desired impact of the APM. There are four different approaches that could be used to define the Target Change:

- **Minimum/Maximum Change Needed for Success.** If the APM is intended to reduce utilization or spending, the Target Change could be set at a level that achieves sufficient savings to offset any expected increases in spending on desirable services. If the goal is to avoid an increase in spending, the Target Change could be defined as either zero or an increase that would be less than the net savings expected for other services under the APM.
- **Change Achieved by a Comparison Group.** Since there is frequently uncertainty regarding whether unplanned care will occur and the extent to which changes in planned care will be able to affect it, the Target Change could be defined based on what other participants in the APM have achieved, or what participants in other initiatives have achieved.
- **Statistically Significant Change.** Since there is a considerable amount of patient-to-patient variation in utilization and spending on services, and not all of this variation is controllable by the APM participant or even predictable, the Target Change could be defined in such a way as to provide confidence that the change was not due to random variation.
- **Desired Level of Change.** The Target Change amount could also be set at a level that would achieve a specific amount of savings or a specific level of utilization.

tion that is desired by the payer and/or the providers and is believed to be achievable.

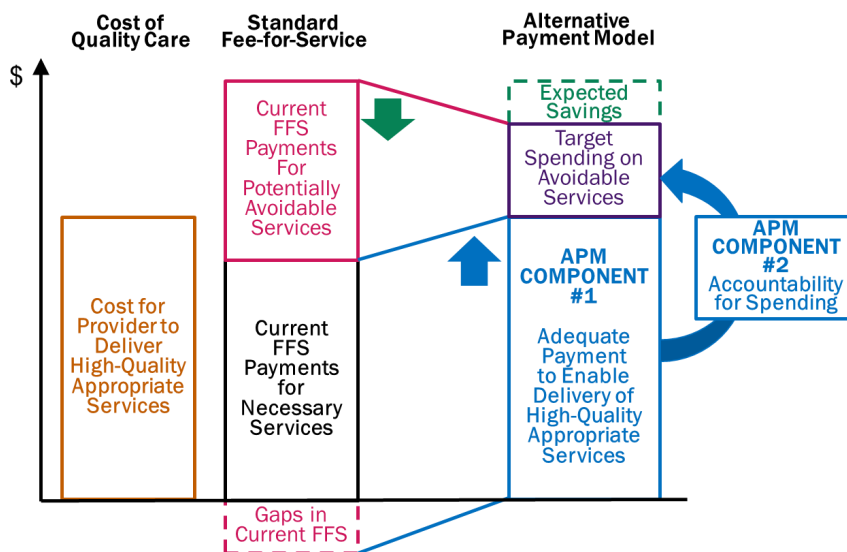
Issues in Defining Spending/Utilization Targets

Several additional issues need to be addressed in setting Targets for spending or utilization:

- **Prospective vs. Retrospective Targets.** A *Prospective Target* is determined before the beginning of the time period in which performance is going to be evaluated, whereas a *Retrospective Target* is determined afterwards. In general, it is preferable to use Prospective Targets so that providers know what is required for success and payers and patients can predict how much they will need to spend.
- **Common Targets or Participant-Specific Targets.** Although it is easier for a payer to assure that overall savings are being achieved if *each* provider participating in an APM is required to generate savings, this can penalize providers who had already found ways to reduce avoidable spending prior to the APM, and it can result in individual patients and payers paying more for care from APM participants that were able to

“achieve savings” simply by partially reducing use of services they had been overutilizing in the past.

- **Ensuring Similarity of Patients in Calculating Benchmarks.** If the patients used in calculating benchmarks are different from the patients participating in the APM, failure to adjust for the differences could result in the provider being inappropriately rewarded or penalized. Making adjustments solely based on diagnosis codes can be problematic, both because many important differences in patients are not captured by diagnosis codes and because the completeness and accuracy of coding is likely to be higher for the patients in the APM.
- **Revising Targets and Changing the Target Methodology Over Time.** Changes in costs, technology, and medical evidence require that Benchmarks and Targets be updated regularly. In addition, it may be necessary to change the methodology for setting Benchmarks or to move to a different approach to setting Targets if there is no longer a good basis for defining comparison groups.



3. Assessing Performance on Utilization and Spending

An assessment methodology is needed to determine the extent to which any difference between the measure and the Target was due to the APM participant’s performance rather than errors in calculation or measurement or the effects of uncontrollable factors, rare events, or random variation. Because there is a large amount of unexplained variation in most measures of utilization and spending, there will be considerable uncertainty as to whether a difference between the measured level of utilization/spending and the Target represents an actual change in utilization/spending and whether the change is attributable to actions by the providers participating in the APM.

Although it is important to recognize the impacts of random variation and to try to avoid drawing incorrect conclusions because of it, an excessive focus on statistical significance can be problematic. Although requiring high levels of statistical significance theoretically reduces the chance of inappropriately determining that an APM has been successful, it also increases the chance of inappropriately determining that an APM has failed (i.e., reducing “Type I errors” increases “Type II errors”). These tradeoffs are particularly important to consider if only a small number of patients are participating in the APM, if the patients are diverse, and if the performance period is short. A good performance assessment methodology should consider *both* the magnitude and the certainty of a provider’s performance in determining success or failure.

ALTERNATIVE WAYS OF SETTING TARGETS FOR UTILIZATION/SPENDING

	Strengths	Weaknesses	Examples
Patient-Level Target	Ensures that spending is appropriate for each patient	Not always possible to specify services individual patients should receive	No medications or tests ordered that are inconsistent with evidence-based guidelines
Population-Level Target	Does not require that spending be reduced for every patient	Allows spending to increase for some patients as long as spending is reduced for others	
A. Evidence-Based Target	Target is known to be achievable without adverse effects	Evidence may not be available for innovative approaches or the types of patients being treated	Average per-patient spending on medications used to achieve good outcomes for the condition in controlled trials
B. Competitive Target	Encourages innovation in lower-cost methods of care	Requires availability of multiple providers who can and will compete based on spending	Lowest average per-patient spending on condition-related medications by other APM providers who achieved good outcomes for similar patients
C. Benchmark-Based Target	Helps ensure Target spending is at or below levels expected under current payment system	Requires a way of determining what spending would have been in the absence of the APM	
1. Benchmark Definition			
a. Prior Performance Benchmark			
<i>Prior Performance for Same Patients</i>	Allows the Target for the provider to be based on the unique needs of the patients being treated	Cannot be used for new acute conditions; Patients with chronic conditions may have been undertreated previously or their needs may have increased	Per-patient spending on medications to treat the targeted health condition in the same patients during the prior year
<i>Prior Performance for Similar Patients of Same Provider</i>	Allows a provider-specific Target to be used for providers treating acute conditions	Will result in higher Targets for providers who have had higher spending in the past; Current patients may have different characteristics; Evidence about treatment may have changed	Average per-patient spending on medications ordered by the APM provider to treat the targeted health condition in similar patients during the prior year
b. Comparison Group Benchmark	Enables the Target to be equal to or lower than what has been achieved in the past for similar patients	Requires a comparison group that is similar in key respects	Average per-patient spending on condition-related medications for similar patients in the previous year treated by providers not participating in the APM
c. Counterfactual Benchmark	Allows the Target to be based on unique characteristics of patients and expected changes over time	Many assumptions must be made about what services would have been delivered in the absence of the APM	Estimated per-patient spending on condition-related medications in the current year based on patient characteristics

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ALTERNATIVE WAYS OF SETTING TARGETS FOR UTILIZATION/SPENDING (CONTINUED)

	Strengths	Weaknesses	Examples
Population-Level Target			
C. Benchmark-Based Target			
2. Target Change			
a. Min/Max Change Needed for Success	Directly ensures net savings by tying savings goal to amount of added spending	May achieve less savings than is possible	Reduction in medication spending needed to offset payments for new services delivered to patients
b. Comparison Group Change	Ensures the Target Change will be equal to or greater than what has been achieved for similar patients	Requires identification of providers not participating in the APM who have similar patients and similar environments	Reduction in per-patient spending on condition-related medications achieved for similar patients by providers not participating in the APM
c. Statistically Significant Change	Ensures that the Target Change cannot be achieved through random variation alone	Biased against providers with small numbers of patients and services with high variability across patients	Reduction in per-patient spending on condition-related medications that is different from zero by a statistically significant amount
d. Desired Level of Change	Ensures that the APM achieves sufficient savings to justify the effort in implementing it	May not be realistic to achieve, particularly for providers who already have low levels of spending	Amount of savings on medications desired by payers or patients

4. Making Performance-Based Adjustments to Payments

Once the spending measures, targets, and methods of assessing performance are defined, the final step is defining the mechanism of accountability, i.e., the actions that will be taken if the actual performance on one or more of the measures is determined to have fallen short of the target level. There are five basic options for accountability:

Option 1: Penalties or Bonuses in Addition to Service-Based Payments

Under this option, the healthcare provider that is participating in the APM is paid for delivering the desirable services using whatever methodology is defined in Component #1, but the provider is required to pay a penalty if the Targets on one or more utilization/spending measures are not achieved.

In general, it is desirable to make the penalty proportion to performance on the measure. In addition, a method is needed for determining the absolute amount of the penalty. Two options for determining the absolute amount of the penalty are:

- Basing the penalty on the amount the provider is paid for *planned* services.
- Basing the penalty on the *Target Change* in spending for the provider's patients.

In addition, limits can be placed on the penalties in order to limit the financial impact of poor performance on the provider, and bonuses can be used in addition to penalties to reward and encourage performance that is better than the Targets.

Option 2: Outcome-Based Payments for Services

Under this option, the APM participant would receive no payment under the APM for an individual patient unless (a) the provider delivered the services the patient was supposed to receive, and (b) that patient did *not* receive the planned or unplanned services that the APM was supposed to avoid.

From the patient's perspective, this is how a value-based payment should work: a patient only pays for services (or only pays the full price) if they received the right services and those services achieved the desired outcome. Under Option 2, the amount the APM pays for planned services would need to be increased to reflect not only the cost of the services but the likelihood that

the provider will achieve the Target. Limits could also be placed on the maximum amount that a provider could lose.

Option 3: Bundled/Warrantied Payments for Services

Under Option 2, a patient or payer would not have to pay a provider for planned services if the services did not achieve the desired outcome, but the patient/payer would still have to pay for the unplanned services or increases in spending they had expected to avoid. Under Option 3, the provider would be expected to use the payment not only to support the planned services but also to pay for any unplanned services that were supposed to be avoided.

This is analogous to a warranty on a product or service. The APM participant is not guaranteeing that no complications or other unplanned services will occur, it is merely agreeing to pay to treat them if they do occur without receiving any additional payments from the patient or payer. Similar to warranties in other industries, the amount of a bundled/warrantied payment for a service would be higher than payments today because it would cover unplanned services that would otherwise be paid separately.

Option 4: Terminating a Provider's Participation in the APM

Options 1-3 all assume that a provider that fails to meet a Target will pay some type of financial penalty and continue participating in the APM (if they wish to do so). A fourth option is to simply terminate the provider's participation in the APM altogether if the provider does not achieve success on the performance measures. This allows greater flexibility to consider the circumstances that may have led to failure or success in meeting the targets.

Option 5: Terminating the APM

A final option is simply to stop using the APM altogether. If APM participants collectively are not succeeding in reducing spending or maintaining spending while improving quality, then it makes sense to modify the design of the APM or to terminate it and develop something different.

APM Component #3: Creating Accountability for Quality

It is not enough for an Alternative Payment Model to maintain or reduce spending; there must also be a way of assuring that the quality of care for patients is maintained or improved. There are four distinct elements in an accountability component for quality:

1. One or more *measures of quality* that need to be maintained or improved by the services supported by the APM;
2. *Targets* for the level of quality that must be maintained or the improvement that must be achieved in

each aspect of quality in order for the APM to be deemed successful in achieving its goal;

3. A *performance assessment methodology* to determine whether a specific provider participating in the APM has achieved the quality Targets; and
4. A *mechanism for adjusting payments based on performance*, i.e., what changes will be made in payments if the Targets are not achieved.

1. Defining the Accountability Measures

Many current APMs have chosen to hold APM participants accountable only for aspects of quality where measures already exist. However, if those measures do not match the specific aspects of quality likely to be affected by the APM, they will not provide adequate protection for patients and they will divert providers' attention from the intended goals of the APM. Determining whether existing or new measures are most appropriate requires three separate steps:

- a. Identifying the aspects of quality affected by the APM;
- b. Determining how to assess changes in quality; and
- c. Determining whether and how data needed to make such assessments can be obtained.

a. Identifying the Aspects of Quality Where Accountability is Needed

There are four general areas that should be examined to determine what quality measures are needed:

- Aspects of quality where the APM is intended to make improvements.
- Aspects of quality that could be harmed by changes in services that are explicitly encouraged by the APM.
- Aspects of quality that could be harmed by incentives created through the payment methodology or spending accountability components of the APM.
- Aspects of quality necessary to ensure accurate payment under the APM (e.g., accuracy of data on diagnosis and outcomes).

b. Determining How to Assess a Particular Aspect of Quality

Ideally, the quality of care would be assessed based on the outcomes achieved for patients. However, relatively few outcome measures have been developed and even fewer are currently in use because of the challenges in collecting and interpreting outcome measures. In addition, most outcomes are not totally under the control of healthcare providers. "Process" measures, i.e., measures of whether a particular activity was performed,

are more commonly used because they are easier to collect and because they tend to focus on aspects of care delivery that the provider can control. However, process measures can be problematic if a goal of the APM is to enable care to be delivered in different ways. A third option is "intermediate outcomes," such as laboratory test results and other biomarkers, if they are highly correlated with longer-term outcomes.

The choice of measures should be based on the goals of the APM and the care it is designed to support:

- **Outcome measures** will be preferable when providers can control the factors that affect outcomes.
- **Process measures** will be appropriate when the goal is to achieve more reliable or efficient delivery of current evidence-based processes.
- **A combination of process and outcome measures** will be desirable when the goal is to deliver care in ways that are not supported by the current payment system. The process measures would ensure that desirable changes are made in care, and the outcome measures would ensure the changes are having positive impacts on the patients.

c. Obtaining Data to Assess the Quality of Care

No matter which quality measures would be most desirable in theory, it will only be possible to use measures for which the necessary data can be obtained in an accurate, reliable, affordable, and timely way. If data that match the definition of quality needed for the APM are not collected currently, new or modified data will be needed, and the APM will need to pay enough to cover the costs associated with collecting these data.

For each quality measure, the Target level of quality the APM participants will be expected to achieve must be defined. At a minimum, the Target should ensure that the quality of care did not decrease, and if the APM is intended to improve quality, the Target would need to reflect that.

2. Setting the Performance Targets for Quality

Using Patient-Level Targets to Ensure Quality Does Not Decrease

Most current quality measures cannot be used to ensure that the quality of care is not harmed by an APM. These population-based quality measures calculate the percentage of patients for whom a process was performed or a particular outcome level was achieved, and compare that percentage to a previous period or to patients who are not participating in the APM. However, the fact that a similar or higher *percentage* of patients is receiving high quality care under the APM does not mean that every patient is receiving equal or better quality care.

From a patient's perspective, what matters is whether the APM is maintaining or improving the quality of care that *individual patient* receives, not what happens to *other patients*. Consequently, the starting point in setting quality targets for an APM is to define appropriate *Patient-Level Targets*, i.e., the threshold(s) that will be used for determining if an *individual patient* is benefiting or being harmed by participating in the APM.

There are several approaches that can be used to define Patient-Level Targets for quality:

- **Maintaining Prior Levels of Quality**, if the patients have been receiving treatment for the same condition in the past;
- **Achieving Evidence-Based Standards or Guidelines**;
- **Achieving Statistically Significant Improvement**;
- **Achieving Clinically Important Improvement**; and
- **Achieving Patient-Specific Goals**.

Using Population-Level Targets to Assess Improvements in Quality

If the APM is intended to *improve* quality on a particular measure, a *Population-Level Target* can be used in addition to a Patient-Level Target. Although it is problematic if any individual patients are being harmed by participation in the model, it is not necessary that every patient receive better care in order for the APM to be deemed successful in improving care, just as an APM can be successful financially if savings are achieved for some but not all patients. Consequently, if the APM is expected to improve quality, two sets of Targets should be defined:

- a Patient-Level Target that defines the *minimum* level of quality that must be achieved for *each patient*; and
- a second Patient-Level Target that defines the higher-than-minimum level of quality that is desired for each patient, and an associated Population-Level Target defining the proportion of patients who need to achieve the higher Patient-Level Target in order for the APM to be viewed as successful.

There are three basic approaches that can be used to define Population-Level Targets for quality:

- **Status Quo-Based Targets**, i.e., improvements in quality compared to current or recent quality levels for the same or similar patients. This requires both a method of defining the "Status Quo" and also defining the Target Change from the Status Quo. Alternative ways of defining the Target Change include:
 - ◆ **Goal-Based Change**, e.g., the level of improvement that would be viewed as sufficient by either payers or providers to justify implementing the APM.
 - ◆ **Statistically Significant Change**, i.e., the minimum change needed to provide assurance that a change is not due to random variation.
 - ◆ **Clinically Important Difference**, i.e., the minimum change needed to be perceived by patients as an improvement in one or more outcomes.
 - ◆ **Comparison Group Change**, i.e., the change in quality for a comparison group not participating in the APM.
- **Evidence-Based Targets**, if there is research showing the quality of care or outcomes that can consistently be achieved for the types of patients participating in the APM when they receive the services the APM is designed to support.
- **Competitive Targets**, i.e., allowing individual providers to determine the level of quality they believe they can achieve.

Issues in Defining Quality Targets

The issues described in Component #2 with respect to targets for utilization/spending measures also apply to the targets for quality measures.

- **Prospective vs. Retrospective Targets**. In general, it is preferable to use Prospective Targets so that providers know what is required for success.
- **Common Targets or Participant-Specific Targets**. Although Participant-Specific Targets can encourage participation by lower-performing providers, they can be problematic from the perspective of patients since they result in the same amount of payment for different levels of quality.
- **Revising Targets and Changing the Target Methodology Over Time**. Changes in technology and medical evidence require that Quality Targets be updated regularly. In addition, it may be necessary to change the methodology for setting Targets if there is no longer a good basis for defining comparison groups.

ALTERNATIVE WAYS OF SETTING TARGETS FOR QUALITY

Alternative	Strengths	Weaknesses	Examples
I. Patient-Level Target	Ensures that quality is maintained or improved for each patient	Assumes that care can be designed to address the needs of each patient	
A. Prior Level of Quality for the Patient	Ensures quality is maintained or improved from what patient has experienced previously	Prior level of quality may have been unacceptably low or anomalously high	Patient can walk without pain or shortness of breath the same distance as previous year
B. Evidence-Based Standard	Ensures the quality goal is feasible to achieve	Patient may have already been achieving better outcomes; Evidence may not exist for how to feasibly and reliably achieve good quality for similar patients	Patient can walk without discomfort for a distance similar to what patients could walk in a controlled trial following the type of treatment supported by the APM
C. Statistically Significant Difference	Ensures that a change in quality is not due solely to random variation	Penalizes small providers because significance is primarily driven by number of patients	The distance the patient can walk increased by more than normal random variation
D. Clinically Important Difference	Ensures the change in quality has a meaningful impact on patients	The change may not be large enough to justify implementing the APM	The patient feels they are better able to perform activities without pain or shortness of breath
E. Patient-Specific Goal	Ensures that change in quality is important to the patient or payer	The goal may not be feasible to achieve	The patient has the ability to adequately perform all activities of daily living without pain or shortness of breath
II. Population-Level Target	Allows quality to be improved for some but not all patients	Could result in lower quality for a subset of patients if quality improves sufficiently for others	
A. Evidence-Based Target	Ensures the quality goal is feasible to achieve	Patients may have already been achieving better outcomes; Evidence may not exist for how to feasibly and reliably achieve good quality for similar patients	Rate of hospital-acquired infections (HAIs) repeatedly achieved in a controlled trial using a standard infection prevention protocol
B. Competitive Target	Encourages innovation in achieving higher quality	Requires multiple providers to compete based on quality/outcomes; May or may not represent improvement over current levels of quality	Lowest rate of HAIs achieved by other APM participants
C. Status Quo-Based Target	Helps ensure quality is not below current levels	May be lower quality than what is feasible to achieve	
1. Status Quo Definition			
a. Prior Performance for Same Patients	Allows quality Target to be based on unique characteristics of the patients	Cannot be used for new acute conditions; Patients with chronic conditions may have received poor quality care previously	Rate of HAIs during previous hospitalizations for the patients (e.g., patients with a chronic disease who are frequently hospitalized)
b. Prior Performance for Patients of Provider	Allows a provider-specific Target to be used for providers treating acute conditions	Will result in lower-quality Targets for providers who have had lower quality in the past	Rate of HAIs for similar patients treated by the provider for the same condition
c. Comparison Group	Ensures quality will be no worse than expected in the absence of the APM	Patients in the APM may have different characteristics than those not participating	Rate of HAIs among similar patients not participating in the APM

(CONTINUED)

**ALTERNATIVE WAYS OF SETTING TARGETS FOR QUALITY
(CONTINUED)**

Alternative	Strengths	Weaknesses	Examples
II. Population-Level Target			
C. Status Quo-Based Target			
2. Target Change			
a. Goal-Based Change	Ensures that the APM achieves results that justify the effort in implementing it	May achieve lower quality than is possible; Goal may not be feasible to achieve	Elimination of HAIs
b. Statistically Significant Change	Ensures the improvement was not due solely to random variation	Change could be very small if number of patients is large enough; Penalizes providers with small numbers of patients; Cannot be used for low frequency events	Statistically significant reduction in HAIs
c. Clinically Important Difference	Ensures the change in quality has a meaningful impact on patients	Impact may not be large enough to justify implementation of APM	Reduction in number of HAIs that result in death or permanent disability
d. Comparison Group Change	Ensures quality will be equal to or better than what is achieved for similar patients not participating in the APM	Could permit a reduction in quality for the patients in the APM if quality is decreasing elsewhere; Does not define how much quality should improve if the APM is intended to achieve improvements; Patients in the APM may have different characteristics than those not participating	Change in HAIs equal to or better than the change achieved for similar patients not participating in the APM

3. Assessing Performance on Quality

As with Component #2, a methodology is needed to determine the extent to which any difference between the measured level of quality and the Target was due to the APM participant's performance rather than errors in calculation or measurement or the effects of uncontrollable factors, rare events, or random variation. Requiring high levels of statistical significance reduces the chance of inappropriately determining that an APM has been suc-

cessful, but increases the chance of inappropriately determining that an APM has failed (i.e., reducing "Type I errors" increases "Type II errors"). These tradeoffs are particularly important to consider if only a small number of patients are participating in the APM, if the patients are diverse, or if the performance period is short.

4. Making Performance-Based Adjustments to Payments

Once the quality measures, Targets, and methods of assessing performance are defined, the final step is defining the mechanism by which APM participants will be penalized or rewarded based on how actual performance compares to the Targets. There are five options, which are similar, but not identical, to those described in Component #2:

Option 1: Penalties or Bonuses in Addition to Service-Based Payments

Under this option, the healthcare provider that is participating in the APM is paid for delivering the desirable services using whatever methodology is defined in Component #1, but the provider is required to pay a penalty if the Targets on one or more quality measures are not achieved.

In general, it is desirable to make the penalty proportional to performance on the measure. Three different approaches can be used to determine the absolute amount of the penalty:

- Basing the penalty on the *perceived value of quality*, i.e., a dollar amount would be assigned to the shortfall in quality based on the patient's or payer's view of the value of achieving the Target.
- Basing the penalty on the *amount of payment for planned services*, e.g., a percentage of the payment the provider in the APM would have received if the Target had been achieved.
- Basing the penalty on the *penalty or bonus for utilization/spending* in Component #2. This approach is used in many APMs, but it is undesirable because it can result in no penalty for quality problems, regardless of how serious they are, as long as spending targets are met.

Limits can be placed on the penalties in order to limit the financial impact of poor performance on the provider.

It is challenging to provide bonuses for higher-than-expected quality under an APM because the bonus could potentially increase overall spending under the APM.

Option 2: Outcome-Based Payments for Services

Under this option, the APM participant would receive no payment under the APM for an individual patient unless the provider achieved the Patient-Level Targets for that individual patient. From the patient's perspective, this is how a value-based payment should work: a patient only pays for services (or only pays the full price) if they received the right services and those services achieved the desired outcome. However, this approach would work best for quality measures where it is feasible for a provider to achieve nearly 100% success.

Option 3: Warranted Payments for Services

Under Option 2, a patient or payer would not have to pay a provider for planned services if the services did not deliver adequate quality care, but the patient would still experience the negative effects of the poor-quality care. Under Option 3, the provider might still receive the standard payment for the services that were delivered to the patient, but the provider would pay the patient some amount of compensation to offset the impacts of the poor-quality care.

Option 4: Terminating a Provider's Participation in the APM

Options 1-3 all assume that a provider that fails to meet a Target will pay some type of financial penalty and continue participating in the APM (if they wish to do so). A fourth option is to simply terminate the provider's participation in the APM altogether if the provider does not achieve success on the performance measures. This allows greater flexibility to consider the circumstances that may have led to failure or success in meeting the targets.

Option 5: Terminating the APM

A final option is simply to stop using the APM altogether. If APM participants collectively are not succeeding in maintaining or improving the quality of care, then it makes sense to modify the design of the APM or to terminate it and develop something different.

APM Component #4: Defining the Eligible Patients

Even if an Alternative Payment Model is successful in reducing use of unnecessary services, there is the risk that the services supported by the APM will be overutilized in ways that can compromise its success in achieving savings. In order to address this, eligibility criteria can be defined that limit participation to the patients who would have been most likely to receive the unnecessary services and/or to benefit from the services supported by the APM.

However, caution is needed to avoid having eligibility criteria encourage overdiagnosis or overtreatment. Narrowly-defined eligibility criteria can create a perverse incentive for both the patient and the provider to find ways for the patient to meet the criteria in order to receive desirable services available only through the APM. An alternative is to stratify the payment amounts and accountability measures in the APM, so that patients with lower levels of need can still participate but receive services matched to their needs.

It is essential that the determination of whether a patient is eligible for an APM be made *prospectively*, i.e., before the provider participating in the APM begins delivering services supported by the APM to the patient. Many current Alternative Payment Models make the determination of whether a patient is participating in the APM *retrospectively*, i.e., after services have already been delivered, but this approach, and the “attribution”

methodologies used to implement it, creates a number of serious problems that are virtually impossible to overcome.

In most cases, the eligibility determination should be made by the provider(s) of services, not by the payer, particularly if the eligibility criteria are based on patient characteristics that are not currently recorded on standard claims forms. Prospective eligibility determinations also enable the patient to understand what services they can expect to receive and agree to whatever actions they will need to take in order for the providers in the APM to achieve the goals of the APM. A Patient-Provider Care Agreement could be required as part of the eligibility criteria for the APM to ensure that both the provider and patient have discussed and agreed to their mutual responsibilities.

It is also important to ensure that the providers participating in an APM do not selectively avoid patients who need more services and/or are less likely to have favorable outcomes (i.e., “lemon-dropping”) or to limit their services only to the patients who are likely to have the most favorable outcomes (i.e., “cherry-picking”). This can be done by identifying the factors that affect how many services a patient will need and the outcomes they will experience and incorporate those factors into the design of the APM so that providers receive appropriate payments for higher-need and lower-need patients.

Finalizing the APM Design

There are multiple options for designing each of the four components of an Alternative Payment Model. The advantages and disadvantages of the different options will depend on the specific types of opportunities for savings and quality that are being pursued, the approaches to care delivery that will be used to address those opportunities, and the specific barriers in the current payment system that need to be corrected. In addition, the choice of options within each component will also depend on which options are chosen for other components.

It is likely that one of the following four designs will be appropriate in most situations where an APM is needed:

- **Accountable Payment for Service.** A provider receives a new or revised payment for delivering a specific service to patients, and the payment is reduced if targets for spending on specific services and performance on quality measures are not achieved.
- **Accountable Bundled Payment.** A provider or team of providers receives a bundled payment to enable delivery of a group of services to patients or to treat a particular condition, and the payment is reduced if targets for spending on specific services and performance on quality measures are not achieved.

- **Outcome-Based Payment.** A provider is only paid for a service or group of services if standards or targets for quality and spending are achieved.
- **Bundled/Warranted Payment.** A provider or team of providers receives a bundled payment to deliver a group of services to patients, and the provider team is responsible for using the payment to cover the costs of necessary services and also to pay for avoidable services or services needed for complications of treatment.

Once a preliminary APM design has been developed, analyses should be performed to ensure that the APM design would:

- Remove or adequately mitigate the barriers in the current payment system to enable the desired services to be delivered; and
- Pay amounts for services and achieve levels of savings and quality that create a desirable business case for both payers and providers to implement the APM. This includes ensuring that (a) payments will be adequate to cover the costs providers will incur in delivering services, and (b) the savings expected to be generated will be sufficient to offset any increases in payments compared to the current payment system.

STEP 5: OPERATIONALIZE THE APM DESIGN

Once decisions have been made about the options for each of the components of the Alternative Payment Model, additional details are needed in order to *operationalize* the APM. Mechanisms are needed for making determinations as to whether and how much providers participating in the APM should be paid for specific patients in specific situations, and these mechanisms need to be feasible for payers and providers to implement.

An APM will be easiest to operationalize if it can use existing billing systems, claims payment systems, and data collection mechanisms to the maximum extent possible. Even though current claims forms and coding systems were designed for the current fee-for-service system, the same forms and systems can also be used to operationalize most aspects of APMs by translating the structure of the APM into the “language” of billing and claims payment systems, i.e., procedure codes, modifiers, diagnosis codes, edit processes, etc.

A. Operationalizing New and Different Payments for Services

Most of the options for paying providers differently under Component #1 can be operationalized by adding one or more new codes to the Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) lists. Payers would only pay a provider for one of these new codes if the provider is participating in the APM.

This approach can also be used to pay a higher (or lower) amount for an existing service when it is delivered to a patient who is part of an APM. A new code would be established for the service to easily distinguish when a different amount should be paid. Alternatively, a CPT/HCPCS modifier could be added to the existing code to distinguish when a different amount should be paid. Similarly, if payment amounts are to be stratified by patient characteristics or phases of care, different codes could be established for each stratum or phase.

Although most current CPT/HCPCS codes describe individual services, there are also currently codes that define a bundle of services. Many current codes also have a “global period” that defines the period of time that a payment is supposed to cover. These same approaches to bundled codes and “global periods” can be used to define a bundled payment or condition-based payment under an APM.

If the APM is intended to pay for a new service instead of an existing service, or to pay for a bundle of services instead of the individual services, this can be operationalized through modifications to the files used as part of the National Correct Coding Initiative that define when two codes cannot be billed at the same time.

Multi-provider bundled payments can be operationalized in several ways:

- define a bundled payment code and make the payment for that code to one provider or to an entity rep-

resenting multiple providers that will then divide the payment among the participating providers.

- pay each provider a pre-determined allocation of the bundled payment amount.
- pay each provider a reduced amount for their individual services as the services are delivered, and then pay the remainder after comparing the total payments to the bundled payment amount.

B. Operationalizing Eligibility Determinations

The approach to coding and billing described above can also be used to operationalize prospective eligibility determinations for patients and eliminate the need for problematic retrospective attribution systems. When a provider submits a claim form for a patient using a billing code that is created specifically for the APM, the provider would be explicitly indicating that the patient was eligible for the APM and that the provider agreed to take accountability for achieving spending and quality Targets for that patient as required under the APM. If a patient chose to transfer their care to a different provider, the new provider would bill for the appropriate code, and the payer would know immediately that accountability had shifted to the new provider, rather than waiting for calculations to be made under an attribution methodology.

C. Operationalizing Accountability for Spending and Quality Performance

Operationalizing the accountability components of the APM requires obtaining the data needed to calculate spending and quality measures as well as modifying payments based on a provider’s performance on those measures

1. Measuring Performance

Some of the aspects of utilization and spending for which a provider will be accountable under an APM are services that the provider either delivers or orders. If there are performance measures that focus solely on these services, the provider should be able to calculate the measures in order to determine performance. However, if performance measures include services that are not directly delivered or ordered by the provider (e.g., emergency department visits by a primary care physician’s patients), claims data maintained by the patient’s health insurance plan will be needed to ensure all aspects of utilization and spending are included.

However, using claims data can be problematic for some types of utilization measures (e.g., potentially avoidable services or spending on complications) if the information needed to determine whether a particular service should be included in the measure is not available in the data. Claims have also been the most common source of data for the quality measures that are used in payment systems, and this has been problemat-

ic because key data elements needed to accurately calculate the measure are recorded in electronic health records but not on claims forms.

Many of the weaknesses in claims data can be addressed simply by creating additional CPT/HCPCS codes or modifiers and/or additional ICD-10 diagnosis codes and asking providers to record the codes on claims forms. It will likely be more efficient for providers to extract the information from their EHR and report it using their billing system than to have payers create a quality reporting system that is separate from the billing and claims payment system and then trying to merge the data. If the data needed are not currently being collected, the provider could use whatever method for data collection is most feasible and report the results through standard billing and claims data systems using codes designed for that purpose. For example, patient outcome measures could be collected by surveying patients and then reporting the information using codes recorded on claims forms.

An advantage of using CPT/HCPCS codes for reporting quality measures is that it easily allows a provider that is submitting the code to be paid if there is a significant cost associated with collecting and submitting the data. This would also provide a mechanism for compensating providers who are not participating in the APM for collecting quality and utilization data needed for comparison purposes.

2. Performance-Based Adjustments to Payments

Penalties for failure to achieve a patient-specific performance target (Option 1 in Components 2 and 3) can be operationalized relatively easily by (a) decreasing the standard amount that is paid for the services and then (b) making an additional payment for each patient for whom the performance target is reached. The amount of the reduction in the payment for services would be such that when the provider achieved the minimum performance level needed to avoid a penalty, the sum of the additional payments would be equal to the sum of the reductions in the payments for the services/conditions, i.e., the provider would receive the same amount of revenue as if there was no performance adjustment. This is equivalent to what is commonly described as a “withhold” – a portion of the provider’s payment is withheld and paid only after the necessary performance has been achieved.

Outcome-Based Payments (Option 2 in Components 2 and 3) can be operationalized by requiring that the relevant Target(s) be achieved before a provider could submit a claim for payment. For outcomes that can only be measured after a long period of time, it may be desirable for the provider to receive a partial payment when the service is delivered, and then the balance of the payment when the outcome is achieved. Two separate CPT/HCPCS codes could be created for this purpose.

Under Bundled/Warranted Payments (Option 3 in Components 2 and 3), if an avoidable service is delivered, or if an additional service is needed to correct a defect in quality (or if some form of compensation were to be paid for the defect), the accountable provider would be required to pay for that from the bundled/warranted payment.

STEP 6: IMPLEMENT THE APM

Four sets of activities are needed for successful implementation of an APM:

- Obtaining agreements by payers, providers, and patients to participate in the APM;
- Finalizing the details of the APM design;
- Evaluating the APM to make decisions about continuation/expansion; and
- Updating the APM parameters over time.

A. Obtaining Participation by Payers, Providers, and Patients

An APM is only a concept until at least one payer agrees to implement it, at least one provider who is paid by that payer agrees to participate, and at least some of the patients insured by the participating payer and receiving care from the participating provider are willing to accept the different approach to care delivery and payment.

1. Encouraging Participation by Payers

Many payers have failed to implement APMs even when there are significant opportunities for savings and there are documented barriers in the current payment system that prevent those opportunities from being achieved. There are several common reasons for this:

- administrative costs for payers to implement the APM;
- disincentives for insurance companies to encourage reductions in healthcare spending;
- benefits to payers of being a “free rider;” and
- barriers in provider contracts.

One or more of the following approaches will likely be needed to encourage payer participation:

- designing the APM to work within existing payer administrative systems.
- using a similar approach to coding as in other APMs.
- designing APMs in ways that can be used with self-insured purchasers.
- requiring payers to publicly disclose the payment methods they use.
- prohibiting provisions of payer-provider contracts that limit the ability to implement desirable APMs.

Purchasers, such as businesses and union trusts that pay for services or buy insurance on behalf of their members, are those who ultimately suffer when spending is higher than necessary, and they can take additional actions to encourage payers to implement APMs:

- selecting payers based on APM participation.
- contracting for insurance and care delivery through purchaser coalitions.
- using direct purchaser-provider contracting.

Providers can also encourage payer participation by:

- refusing to contract with payers who do not implement APMs.
- developing the capability to contract directly with purchasers or to sell insurance products.

2. Encouraging Participation by Providers

Lower-than-expected participation in APMs is often attributed to a preference by providers for traditional fee-for-service. However, in most cases, there are other reasons that providers don't want to participate in APMs, including:

- problems with the design of the APM;
- a small number of payers using the APM;
- the inability to cover extra costs incurred during the transition to the APM;
- lack of reserves to manage financial risk;
- lack of data to estimate potential savings and risks;
- no assurance of stability or continuation of the APM;
- failure of the APM to address specific types of patient needs or unique issues in the community;
- requirements in federal or state laws or regulations that prohibit or limit the ability to implement the APM; or
- unwillingness of the provider to make the reductions in cost or improvements in quality needed to succeed.

APMs are far more likely to be successful if providers are participating willingly. Rather than trying to mandate that providers participate in APMs they find problematic, it makes sense to design the APMs in ways that avoid the problems described above by:

- involving providers in the design of APMs.
- designing APMs using Regional Health Improvement Collaboratives or with state government oversight.
- standardizing designs and measures where possible, but allowing flexibility where necessary.
- enabling providers to access claims data or other sources of information on the services their patients are receiving that are relevant to the APM.
- encouraging payers to participate in Medicare APMs both before and after providers begin participation.
- enabling Medicare to participate in APMs that are being used by private payers.
- reducing the higher financial risks for providers during the initial implementation period for the APM.
- revising laws and regulations that create barriers to implementing APMs.
- refusing to use providers who do not participate in the APM.

3. Encouraging Participation by Patients

The fact that an APM is viewed favorably by payers or providers does not necessarily mean it is desirable from the perspective of the patients who would be receiving healthcare services supported by the APM. A patient will be understandably concerned about an APM if it:

- forces the patient to receive their care from a narrow list of providers that were selected based primarily on the price the providers were willing to charge rather than the quality of care they committed to provide;
- requires the patient to pay more in cost-sharing than they would have paid under the fee-for-service system for the specific services they receive;
- financially penalizes the patient's physician if the physician has to order more services or more expensive services to meet the patient's needs;
- financially rewards a provider if that provider delivers fewer services than the patient needs;
- requires the patient to pay for services even if the quality of care that patient received is poor, as long as the quality of care for most other patients was acceptable; and/or
- fails to evaluate the outcomes achieved or the quality of care delivered for the specific types of health problems the patient has.

At the other extreme, some patients who could potentially benefit from an APM might be unable to do so if the design of the APM would cause providers to lose money caring for those patients. For a patient who has multiple, unusual, or complex needs, the APM should:

- provide higher payments to the provider to cover the costs of the additional time or resources needed to care for that patient;
- exclude or adjust for the legitimately higher utilization or spending on the patient when determining penalties or bonuses for utilization/spending;
- exclude or adjust for differences in care delivery or outcomes when determining penalties or bonuses based on quality.

If APMs are going to be attractive to patients who have choices, they need to be designed to benefit the patients, not just payers and providers. In order for providers to be willing and able to care for patients with higher needs, APMs need to be designed so as to not penalize the provider for taking care of those patients. The solution to both problems is to design an APM to be as *patient-centered* as possible by including the following characteristics:

- setting payment amounts based on patient needs.
- focusing accountability for spending on avoidable services and costs.
- hold providers accountable for quality for each individual patient.

B. Finalizing the APM Parameters

In many cases, it will be difficult to specify the “right” payment amounts and targets for spending and utilization before an APM is actually implemented. Information on costs and achievable performance levels can only be obtained from providers that are delivering services in a different way, but providers cannot deliver services in that way without having an alternative payment model to support them. The more innovative the APM – i.e., the more it differs from the current payment system – the more likely there will be a need for an initial “beta testing” process and potentially additional rounds of refinement after the APM is implemented more widely. The beta testing phase will involve:

- participation by a limited number of interested providers;
- using “best estimate” parameters to initiate APM testing;

- protecting providers, payers, and patients against financial harms during the beta testing process; and
- providing extra resources to enable data collection by providers.

The purpose of beta testing is to *refine* the APM, not to evaluate whether it “works.” In fact, it is likely that an evaluation conducted before an APM has been adequately refined will conclude that the APM is less effective in reducing costs or improving quality than it would ultimately be, and this could cause it to be terminated prematurely or discourage other payers or providers from implementing it.

C. Evaluating the APM

Newly implemented APMs should be evaluated in order to identify and correct any problems. However, an evaluation of an APM must be structured correctly and its results must be interpreted properly. The primary focus of the evaluation should *not* be to determine whether spending was lower and/or quality/outcomes were better, because an APM does not *directly* reduce healthcare spending or improve the quality of care. Instead, the focus should be on whether the APM successfully changed the aspects of payment that were viewed as barriers to delivery of services in a different and better way. If the APM successfully removes the payment barriers it was intended to remove but savings are not achieved or quality is not maintained or improved, the care delivery model may need to be improved, or additional actions besides the change in payment may be needed to support the desired outcomes.

Defining APMs as time-limited demonstration projects can have the perverse effect of reducing the likelihood of success, since healthcare providers are unlikely to funda-

mentally change the way they deliver care in response to a payment change that may only last a few years. Payers and providers should make a commitment to continue implementing an APM for a long enough time to ensure that changes in care delivery can be fully implemented and to recoup the costs incurred in participating in the APM. Payers should also agree to modify the APM in an effort to correct any weaknesses before terminating it.

It is undesirable to mandate participation of providers in an APM simply to support a more robust evaluation. If it is not yet clear that the APM is designed correctly, it is inappropriate to force providers and patients to participate in it. Also, the true potential impact of the APM will be masked by including providers who are unwilling or unable to successfully implement the care delivery changes that the APM is intended to support. Moreover, even if the APM is successful, that does not mean it would be desirable for every provider to implement it; in many cases, it will likely be both desirable and appropriate to create permanent but voluntary APMs.

D. Revising the APM Parameters

The parameters of the APM (i.e., the amounts paid for individual services or bundles of services, the utilization/spending targets, the quality targets, etc.) will have to be updated regularly to reflect changes in the costs of delivering services, new evidence about the causes and appropriate treatments of diseases, new technologies for diagnosing or treating disease, and changes in the prevalence or severity of health conditions. Failure to do so could mean that the APM would no longer adequately enable and encourage the best quality care at the lowest possible cost. Moreover, healthcare providers may be unwilling to participate if they do not believe appropriate adjustments will be made over time. Once the desired reduction in spending or improvement in quality has been achieved, the Target(s) for the APM would need to change to *maintaining* that lower spending level or improved level of quality.

The creation of an Alternative Payment Model can reveal disparities in the amounts that are being spent for care and the outcomes that are being achieved for that spending that were not visible under the current payment system. To address this without discouraging participation by providers, an APM can begin with customized payments amounts and targets for each provider that are based on the past performance levels of that provider, and then transition over time to payment amounts and targets that are common to all providers or all providers with similar characteristics.

Two fundamentally different approaches can be used to update the parameters of an APM:

- An **analytic approach** that uses analyses of data about costs, outcomes, etc. in an effort to determine what the “right” changes in the APM parameters should be for all providers.
- A **competitive approach** that allows individual providers to determine the prices and Targets based on the costs and outcomes they believe they can achieve, with payers or patients choosing providers based on the parameters they set.

There are advantages and disadvantages to both approaches. In healthcare, analytic approaches and population-level competition are used far more often than patient-level competition, whereas in other industries, the reverse is true.

An effective competitive approach can be developed by combining a well-designed Alternative Payment Model with appropriate mechanisms for transparency and patient cost-sharing. This could be done by:

- setting default parameters using an analytic approach;
- allowing individual providers to set different prices and performance targets;
- allowing patients to choose providers based on prices and quality; and
- updating default parameters based on provider-determined prices and quality targets.

CREATING BETTER VALUE-BASED PAYMENT MODELS

Many current Alternative Payment Models have failed to achieve significant savings or improvements in quality because they have not been designed in ways that will correct the problems created by the current fee-for-service payment. A well-designed APM will:

- pay for the high-value services needed to improve patient care;
- align the amount of payment with the cost of delivering good care;
- assure patients that they will receive appropriate, high-quality care that will achieve a good outcome for them (not just other patients); and
- make the cost of healthcare services more predictable and comparable.

Many current APMs have also had poor results because they fail to preserve four important strengths of the fee-for-service payment system. A well-designed APM will also:

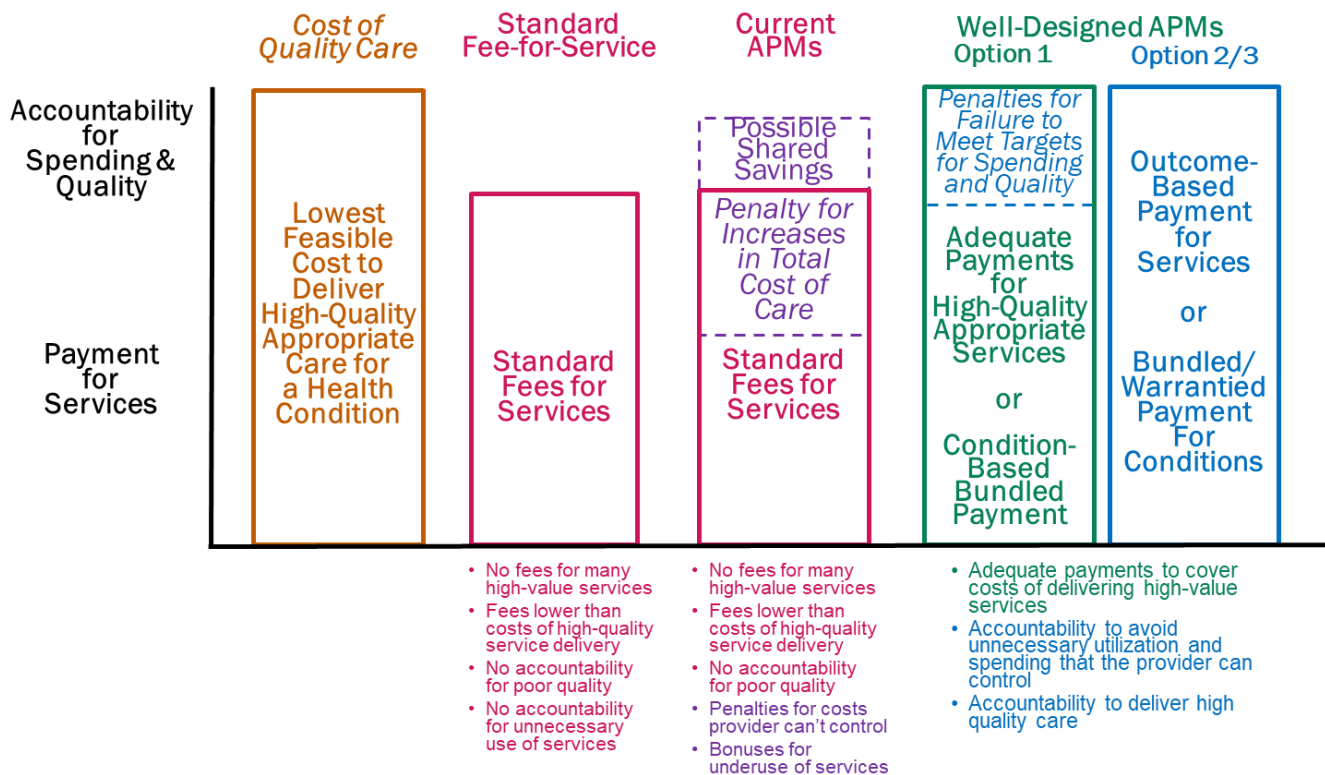
- pay a provider only if a patient receives care;
- make higher payments for patients who need more services;
- base a provider's payment on things the provider can control; and
- enable a provider to know how much they will be paid before delivering a service.

There is no one Alternative Payment Model that will be able to effectively support high-quality care for every type of patient or to effectively address all of the different opportunities for improvement. Multiple, different APMs will be needed. Creating multiple service-specific and condition-specific APMs will not increase fragmentation of care nor will it undercut efforts to improve coordination such as Accountable Care Organizations. In fact, well-designed APMs can help ACOs be more successful than they are today by providing a means to pay the individual providers in the ACO in a way that supports higher-quality, lower-cost care. In contrast, capitation and other "population-based payment systems" simply shift the problems with fee-for-service payments from payers to large provider groups and health systems.

There are also many situations where poor quality of care is caused by underpayment for services and where there are serious risks of losing existing services and seeing outcomes for patients get worse due to inadequate payments. APMs cannot address these problems because spending will need to increase in order to preserve existing services and improve quality and outcomes. Other types of payment reforms will be needed before it is too late to preserve what currently exists.

There is an urgent need to address the high and growing cost of healthcare in America and to do so in a way that improves, rather than worsens, the quality of care for citizens. Alternative Payment Models and other types of payment reforms hold the potential for accelerating progress toward more affordable as well as higher-quality care if, but only if, they are designed in the right way. Faster progress in developing and implementing truly effective healthcare payment systems needs to be a national priority.

STRENGTHS OF WELL-DESIGNED APMs vs. FEE-FOR-SERVICE AND CURRENT APMs



COMPARISON OF WELL-DESIGNED APMs TO CURRENT APMs and FFS

	Current APMs		Well-Designed APMs			
	Shared Savings	Population-Based Payment	Accountable Payment for Services	Accountable Bundled Payment	Outcome-Based Payment	Bundled/Warrantied Payment
Component #1: Adequate Payment for Needed Services	No change in FFS	Flexible payment for each patient; higher amounts for some but not all needs	Payments for new high-value service(s) and/or higher payments for existing service(s)	Bundled payment for group of services from a provider team	Payments for new high-value services and/or higher payments for existing services	Bundled payment for group of services from a provider team
Component #2: Accountability for Spending	Penalty for increase in total cost of care	Fixed payment regardless of services needed or delivered	Penalty if spending controllable by provider exceeds target		Penalty if spending controllable by provider exceeds target	
Component #3: Accountability for Quality	None	Penalties for poor performance on population-level quality measures	Penalty if quality controllable by provider falls short of target for individual patient	Penalty if quality controllable by provider falls short of target for individual patient	No payment if quality standards are not met	Compensation for problems caused by failure to deliver high-quality care
Component #4: Patient Eligibility Determination	Attributed based on service utilization	Attributed based on service utilization	Patient selects provider team	Patient selects provider team	Patient selects provider team	Patient selects provider team

ADDRESSES WEAKNESSES IN FEE-FOR-SERVICE PAYMENT?

Flexibility to deliver all needed high-value services?	NO	YES	YES	YES	YES	YES
Aligns payment with cost?	NO	NO	YES	YES	YES	YES
Assures each patient receives high-quality care?	NO	NO	YES	YES	YES	YES
Makes payments predictable and comparable?	NO	YES	YES	YES	YES	YES

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

No payment unless a patient receives care?	YES	NO	YES	YES	YES	YES
Higher payments for patients who need more services?	YES	NO	YES	YES	YES	YES
Payment based only on things provider can control?	NO	NO	YES	YES	YES	YES
Provider knows payment before delivering services?	NO	YES	YES	YES	YES	YES



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