State Health Policy Highlights

Categorizing Value-Based Payment Models According to the LAN Alternative Payment Model Framework

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STATE Health & Value STRATEGIES
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A grantee of the Robert Wood Johnson Foundation

February 2018

Introduction

As the movement from volume to value-based payment progresses, more state purchasers are requiring their contracted health plans to implement alternative payment models (APMs) with the goals of improving the quality of care and reducing costs for taxpayers. The Health Care Payment Learning and Action Network Alternative Payment Models Framework (the LAN APM Framework) is an increasingly common method being used by states to measure plan progress toward implementation of APMs. While the LAN offers purchasers a guidepost with which to categorize APMs, states still sometimes struggle with their interpretation of the LAN categories. This brief provides real-world examples of APMs within the LAN categories and can help states and other interested purchasers develop a common understanding of what types of payment models fit within the framework categories.

Questions? Contact Heather Howard at heatherh@princeton.edu.

Categorizing Alternative Payment Models

The LAN APM Framework has four broad categories of payment models, and within those categories, several subcategories that further differentiate payment arrangements. Below is a summary of each category and more detailed descriptions of the subcategories, as well as examples of actual payment models, can be found in the larger brief.

Category 1: Fee-for-Service—No Link to Quality and Value

Payment models within Category 1 pay providers to deliver a service without providing any incentive to improve quality or reduce costs. This is considered traditional fee-for-service.

Category 2: Fee-for-Service—Link to Quality and Value

Payment models within Category 2 utilize traditional fee-for-service payment, but provide enhancements or reductions to the payment as a way to create incentives and disincentives for superior performance on quality or completing certain activities that could lead to improved care.

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

Payment models within Category 3 are still built on the fee-for-service "chassis" as the means to administer payment, but are considered to be more advanced than Category 2 payment models because they utilize potentially more powerful incentives for well-coordinated care. Providers participating in Category 3 payment models are eligible to share in savings they generate with the payer, but may also be at financial risk, should costs exceed a budget.

Category 4: Population-Based Payment

Payment models in Category 4 break free from the fee-for-service chassis and are prospectively paid models—meaning the payer pays providers up front, in a lump sum once, or on a periodic basis. Category 4 encompasses models that focus on all care provided for a certain condition (e.g., cancer) or all care provided by a certain provider type (e.g., primary care or mental health). Quality plays a role in these payment models by adjusting future payments (up or down), or in the form of incentive payments or penalties.

Conclusion

Value-based payment goals and performance requirements are being defined by states across the country. This issue brief provides real-world examples of the complex arrangements that fall within each of the categories. By doing so, it concretizes an abstract framework that is designed to provide a common lexicon for purchasers, payers and providers, but may sometimes be difficult to interpret.

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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ABOUT BAILIT HEALTH

This brief was prepared by Megan Burns and Michael Bailit. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see *www.bailit-health.com*.