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An Overlooked Argument For A Single-Payer Healthcare System: Eliminating Misalignment Among Payment Models

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INTRODUCTION

The Affordable Care Act (ACA) reaffirmed the financing of health care in the United States through multiple sources, namely commercial insurers, self-insured employers, and public payers such as Medicare and Medicaid. This multi-payer system has allowed for tremendous innovation in how payers finance and support the healthcare system,[1] with the goal of improving the quality and efficiency of patient care.[2] Yet these efforts to improve the performance of the U.S. healthcare system have yielded mixed results,[3] as few healthcare providers have fundamentally changed how they care for patients.[4] Paradoxically, payment innovation among payers is a key reason

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[1] *See* KRISTOF STREMIKIS, ALL ABOARD: ENGAGING SELF-INSURED EMPLOYERS IN MULTI-PAYER REFORM 3 (2015), https://www.milbank.org/publications/all-aboard-engaging-self-insured-employers-in-multi-payer-reform/ (noting that a healthcare system with "multiple public and private payer entities facilities experimentation with a variety of payment structures and quality measurements.").

[2] *See infra* Part I (discussing the goals of alternative payment models).

[3] *See* RACHEL WERNER ET AL., THE FUTURE OF VALUE-BASED PAYMENT: A ROAD MAP TO 2030 6 (2021), https://ldi.upenn.edu/wp-content/uploads/2021/07/PennLDI-Future-of-Value-Based-Payment-WhitePaper.pdf ("The past decade of experimentation with APMs [alternative payment models] has had successes and failures," with the current APM landscape including "many underperforming models, which have failed to produce the desired practice transformation."); Marina A. Milad et al., *Value-Based Payment Models in the Commercial Insurance Sector: A Systematic Review*, 41 HEALTH AFF. 540, 546 (2022) (reviewing evidence on whether value-based payment models in the commercial insurance sector improved quality, reduced spending, and improved appropriate utilization and concluding that while there was evidence of improved quality outcomes there was less evidence of reduced spending and more appropriate utilization); Hannah L. Crook et al., *A Decade of Value-Based Payment: Lessons Learned and Implications for the Center for Medicare and Medicaid Innovation, Part 1,* HEALTH AFF. FOREFRONT (June 9, 2021), https://www.healthaffairs.org/do/10.1377/forefront.20210607.656313/ ("Overall evidence on cost and quality outcomes of the diverse [Medicare payment] reforms to date is mixed, with some payment models performing better than others."); MEDPAC, REPORT TO CONGRESS: MEDICARE AND HEALTHCARE DELIVERY SYSTEM 43, 55 (2021), https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf (stating that only some Medicare APMs generated savings for Medicare, and that population-based payment models to accountable care organizations (ACOs) across public and private payers has generated only "nominal" savings for payers).

[4] *See* Crook et al., *supra* note 3 (noting that the shift away from fee-for-service payments to alternative payment models has produce only modest impacts because, for providers, "there is little business case for investing in the infrastructure and personnel needed to transform care."); SEAN CAVANAUGH & GREGORY BURKE, A MULTIPAYER APPROACH TO HEALTH CARE

for this lack of care delivery innovation among providers. This Article explains how payers' wide-ranging experimentation with new payment models can stifle healthcare delivery reform, and why a single-payer healthcare system is more likely to push providers toward meaningful improvements in the quality and efficiency of care.

Part I of this Article discusses payers' shift away from fee-for-service payments to alternative payment methodologies designed to nudge providers toward care delivery models that improve quality and efficiency. Part II then examines why alternative payment models have thus far generated mixed results. Specifically, Part II.A explains that under a multi-payer system, providers must manage disparate payment rules and financial incentives, and that the resulting administrative complexity deters provider participation in alternative payment arrangements. Part II.B describes how interactions among different payers' payment models can dilute each model's financial rewards, thereby weakening a provider's incentives to transform their clinical and operational practices. Part II.C then explains how a multi-payer system deters individual payers from providing subsidies and technical assistance to providers that lack the expertise and resources to transform their practices on their own.

Part III evaluates efforts to address these concerns through collaborations among multiple payers looking to harmonize their payment rules and incentives. Although these multi-payer alignment initiatives can lessen the impediments to delivery reform described above, Part III concludes that various obstacles ultimately limit their potential impact. In contrast, as argued in Part IV, a single-payer healthcare system would remove the impediments to delivery reform identified in Part II and promote a healthcare system that provides higher quality, more efficient patient care.

The argument in favor of single-payer outlined in Part IV has been overlooked by other commentators. Moving forward, the debate over health care reform should also consider whether a single-payer system is more likely than a multi-payer system to give providers the means and motivation to fundamentally improve patient care practices.

I. ALTERNATIVE PAYMENT MODELS AND CARE TRANSFORMATION

Many health policy analysts contend that if the U.S. fundamentally changes how we pay for and deliver health care, we can achieve lower healthcare spending while simultaneously improving quality.[5] Public and

REFORM 3 (2010) (explaining that payers' have been unable "to effect meaningful change" in the health system's performance given their limited leverage over providers).

[5] *See generally* COUNCIL ON HEALTH CARE SPENDING & VALUE, A ROAD MAP FOR ACTION:

private payers have embraced this philosophy and increasingly are turning to payment models that incentivize providers to increase efficiency and better manage their patients' health care needs.[6] This Part describes this shift to value-based payment and care delivery models.

Although government payers sometimes pay healthcare providers directly for patient care, most patients receive their health coverage from private insurers actively competing with one another.[7] Specifically, commercial insurers compete for the business of individuals and employers,[8] while private insurers contracting with Medicare and Medicaid compete for Medicare and Medicaid beneficiaries.[9] A private insurer's competitive

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RECOMMENDATIONS OF THE HEALTH AFFAIRS COUNCIL ON HEALTH CARE SPENDING AND VALUE 18-23 (2023), https://www.healthaffairs.org/pb-assets/documents/CHS_Report/CHS_Report_2022_R5-1675432678.pdf (recommending continued development of value-based payment models); *see also* Mark B. McClellan et al., *Payment Reform for Better Value and Medical Innovation*, NAT'L ACAD. OF MED. (Mar. 17, 2017), https://nam.edu/payment-reform-for-better-value-and-medical-innovation/.

[6] *See* McClellan et al., *supra* note 5 (noting that payment reform efforts are focusing on value-based care models that strive to promote the best care at the lowest cost).

[7] According to the U.S. Census Bureau, in 2021, approximately 2/3 of the insured U.S. population was covered by private health insurance, defined to include employer-sponsored plans, coverage purchased directly from a private insurer, and TRICARE (the health program for uniformed service members and their families). *See* KATHERINE KEISLER-STARKEY & LISA N. BUNCH, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2021, CURRENT POPULATION REPORTS 1-2 (2022), https://www.census.gov/library/publications/2022/demo/p60-278.html. Moreover, 40 percent of Medicare beneficiaries and over 70 percent of Medicaid beneficiaries receive coverage from private plans contracting with the Medicare and Medicaid programs. *See infra* note 9.

[8] *See generally* Laura Green, *Commercial Health Insurance: Definitions, Types, and Examples*, INVESTOPEDIA (last updated Feb. 7, 2023), https://www.investopedia.com/terms/c/commercial-health-insurance.asp. Self-insured employers often contract with private insurers to administer their group plans. *See* FAIR HEALTH, INC., INSURED VS. SELF-INSURED PLANS, https://www.fairhealthprovider.org/download/choosing-a-health-plan/Insured%20vs%20Self-Insured%20Plans.pdf (discussing commercial insurance and self-insured plans, and explaining that employers may contract with commercial insurers to serve as third-party administrators to oversee the day-to-day plan administration of their self-insured plans). Consequently, many private insurers operate two lines of business, the first of which offers health insurance to employers and individuals, and the second of which offers administrative services to self-insured employers. *See* CAVANAUGH & BURKE, *supra* note 4, at 7.

[9] *Total Number of Medicare Beneficiaries by Type of Coverage*, KAISER FAM. FOUND., https://www.fairhealthprovider.org/download/choosing-a-health-plan/Insured%20vs%20Self-Insured%20Plans.pdf (last visited Mar. 13, 2023) (displaying that in 2020, approximately 40 percent of Medicare enrollees obtained their coverage through Medicare Advantage and other health plans); *Total Medicaid MCO Enrollment,* KAISER FAM. FOUND., (last visited Mar. 13, 2023) (showing that among Medicaid beneficiaries, in 2020, over 70 percent were enrolled in Medicaid managed care plans).

success depends on its ability to differentiate its plans from competitors' plans, particularly on factors related to price and quality of care.[10] Because the manner in which an insurer pays providers can impact the quality and efficiency of care, insurers' payment methodologies are a source of competitive differentiation.[11]

Historically, payers have reimbursed providers on a fee-for-service basis, with providers receiving a fee for each visit, test, procedure, or other service they perform.[12] The fee-for-service payment model, however, is a key contributor to the systemic inefficiencies that plague the U.S. healthcare system, resulting in higher costs, inappropriate utilization, poor patient outcomes, and health disparities.[13] Significantly, piecemeal payment for care rewards volume over value, which can lead to costly, unnecessary care.[14] In addition, fee-for-service incentives promote a health delivery system designed around the detection and acute treatment of disease, to the neglect of interventions that can prevent poor health.[15] Moreover, paying providers separately for their services promotes providers operating independently from one another rather than coordinating patient care,[16] which can lead to patients receiving duplicative or incompatible care[17] and suffering avoidable complications.[18] In response, private payers increasingly have shifted away

[10] *See* CAVANAUGH & BURKE, *supra* note 4, at 6 ("Payers compete with each other to sell insurance policies, and their success is based on their ability to argue convincingly that their product is superior to others available in their marketplace, based on such things as price, quality, network, service, and price.").
[11] NAT'L ACAD. OF SCI., ENG'G, & MED., IMPLEMENTING HIGH-QUALITY PRIMARY CARE: REBUILDING THE FOUNDATION OF HEALTHCARE 311 (2021).
[12] *Fee for Service,* HEALTHCARE.GOV, https://www.healthcare.gov/glossary/fee-for-service/ (last visited Mar. 13, 2023) (defining 'fee-for-service').
[13] *See* NAT'L ACAD. OF MED., PRIORITIES IN ADVANCING HIGH QUALITY VALUE-BASED HEALTH & HEALTH CARE 1 (May 2021) ("It is very clear that the 'fee-for-service' chassis on which the US health system is constructed cannot deliver effective, efficient, and equitable results in today's, and certainly not tomorrow's environment. On this, there is virtual consensus."); Jessica L. Mantel, *Accountable Care Organizations: Can We Have Our Cake and Eat it Too?*, 42 SETON HALL L. REV. 1393, 1403-1409 (2012) (discussing the problems with fee-for-service).
[14] *See id.*
[15] *See* Bobby Milstein et al., *Analyzing National Health Reform Strategies with a Dynamic Simulation Model*, 100 AM. J. OF PUB. HEALTH 811, 811 (2010) (commenting that the medical industry "overemphasiz[es] disease detection and treatment while missing opportunities to reduce preventable risk and protect people's health").
[16] *See* Mantel, *supra* note 13, at 1406.
[17] *See* Robert A. Berenson, *Shared Savings Program for Accountable Care Organizations: A Bridge to Nowhere?,* 16 AM. J. MANAGED CARE 721, 721 (2010) (noting that the fragmented care that results from competent clinicians practicing in silos produces different diagnoses and treatment plans and prescribing incompatible medications).
[18] For example, patients may not receive appropriate follow-up care after being discharged

from fee-for-service to alternative payment methodologies[19] that encourage providers to invest in more effective care delivery models.[20]

Payer's alternative payment models (APMs) reward providers who both improve the quality of care delivered to patients and lower healthcare spending.[21] For example, pay-for-performance models link providers' payments to their performance on select quality and efficiency measures, rewarding high performers with either bonuses or upward adjustments to their fee-for-service payment rates and/or penalizing poor performers with downward payment adjustments or other penalties.[22] Shared savings and bundled payments reward providers who effectively manage a set of procedures, an episode of care, or all healthcare services by sharing with the providers all or a portion of any cost savings they generate, coupled with upward or downward adjustments for high or poor performance on quality measures.[23] More advanced population-based payment models, such per-member-per-month payments or capitation, replace fee-for-service's volume-based payments with fixed prospective payments that cover all or a range of services, with potential adjustments for a provider's quality-related performance.[24] Importantly, in contrast to fee-for-service, these so-called risk-based arrangements shift insurance risk to providers, with the provider partly or fully assuming the risk that the cost of caring for a patient population will exceed the providers' payments.[25]

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from an emergency room or hospital if the patients' primary care providers are not informed of the emergency or acute care episode. *See* Mantel, *supra* note 13, at 1407 (explaining that the lack of coordination among providers can exacerbate preventable complications).

[19] The term "alternative payment models" and "value-based payment models" often are used interchangeably. In general, value-based payment models refers to the broad array of approaches public and private payers use to align financial incentives with approaches to improving efficiencies and patient outcomes, whereas alternative payment models refer to the specific payment mechanisms for implementing these approaches. *See* Athena Chapman & Samantha Pellón, *Medi-Cal Explained: What Are Alternative Payment Models?*, CALIFORNIA HEALTH CARE FOUND. (May 2022) For purposes of this article, the author uses the term alternative payment models to include various value-based payment models.

[20] *See* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, COMMON ALTERNATIVE PAYMENT MODEL (APM) APPROACHES: REFERENCE GUIDE 1 (explaining that APMs give providers financial incentives to provide high-quality and cost-efficient care).

[21] *See generally id.* (explaining key features of alternative payment models include financial incentives for providers who meet certain objectives).

[22] *See* HEALTH CARE PAYMENT LEARNING & ACTION NETWORK, *Alternative Payment Model Framework* 23-24 (2017), http://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf (describing the effects of performance on payments received by providers in an APM framework).

[23] *See id.*, at 25-27.

[24] *See id.*, at 23, 27-29.

[25] *See* PLEXIS HEALTHCARE SYS., *Risk Contract* (defining the term "risk contract"), https://www.plexishealth.com/glossary/risk-contract.

Concurrent with the wide-spread adoption of APMs among private payers, public payers similarly have launched various APMs. For example, Medicare's Merit-based Incentive Payment System (MIPS) and Hospital Value-Based Purchasing Program link physicians and hospitals' payments to their performance on various performance measures,[26] while the Medicare Shared Savings Program pays bonuses to participating organizations that generate savings for Medicare while penalizing those that increase program costs.[27] The Centers for Medicare & Medicaid Services (CMS) also sponsors several payment demonstrations[28] testing APMs, such as bundled payments for certain clinical episodes[29] and population-based payments to primary care practices.[30] State Medicaid programs similarly are experimenting with APMs, including in their contracts with Medicaid managed care plans.[31]

Success under these alternative payment models requires providers to find innovative ways to improve patient outcomes and lower costs, such as by decreasing the intensity of services, reducing emergency department visits and hospitals admissions, and preventing post-procedure complications.[32]

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[26] *Medicare FFS Physician Feedback Program/Value-Based Payment Modifier*, CMS (Dec. 1, 2021), https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram (describing the Merit-based Incentive Payment System also known as "MIPS"); *The Hospital Value-Based Purchasing (VBP) Program*, CMS (Dec. 1, 2021), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing (describing the Hospital Value-Based Purchasing Program and outlining incentives for organizations under the program).

[27] *Shared Savings Program*, CMS (Jan. 17, 2023), https://www.cms.gov/medicare/medicare-fee-for-service-payment/sharedsavingsprogram/about (describing the Medicare Shared Savings Program).

[28] Medicare and Medicaid "demonstrations" mean "a program that is carried out in miniature — whose effects are rigorously evaluated," thereby offering "policymakers an evidentiary basis for justifying large-scale reform." Philip Rocco & Andrew S. Kelly, *An Engine of Change? The Affordable Care Act and the Shifting Politics of Demonstration Projects*, 5 RUSSELL SAGE FOUND. J. OF SOC. SCI. 67, 69 (2020).

[29] CTR. FOR MEDICARE & MEDICAID SERV., https://innovation.cms.gov/innovation-models#views=models (last visited Mar. 13, 2023).

[30] CTR. FOR MEDICARE & MEDICAID SERV., https://innovation.cms.gov/innovation-models/primary-care-first-model-options (last visited Mar. 13, 2023).

[31] *See Value-Based Payment,* MEDICAID AND CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/subtopic/value-based-purchasing/ (last visited Mar. 13, 2023) ("State Medicaid programs are increasingly implementing a variety of value-based payment models (VBP) that aim to drive system change towards greater efficiency and improve health outcomes."); Crook et al., *supra* note 3 ("[S]tate Medicaid programs have increasingly included payment reforms in their [section 1115] waivers and Medicaid managed care contracts.").

[32] *See* MARK W. FRIEDBERG ET AL., EFFECTS OF HEALTH CARE PAYMENT MODELS ON PHYSICIAN PRACTICE IN THE UNITED STATES: FOLLOW-UP STUDY 15 (2018) (explaining how APMs such as global capitation create financial incentives for providers to reduce

These incentives have prompted some providers to shift from their traditional focus on acute episodes to care delivery models that emphasize evidence-based treatment protocols, care coordination, preventive care, and helping patients and their caregivers more effectively manage health conditions.[33] For example, many hospitals and other institutions utilize care coordinators who, following a patient's discharge, will follow-up with the patient and their post-acute care providers, sharing guidelines designed to prevent unnecessary rehospitalizations.[34]

More recently, growing appreciation of the interconnectedness between patients' health and unmet social, economic, and behavioral health needs has generated immense interest in care delivery models that take a holistic view of patients' health.[35] For instance, some physician practices have established multidisciplinary care teams that integrate a broad range of medical, behavioral health, and social services, coordinating care across the health care, public health, and social services sectors and linking patients to community resources.[36] In particular, population-based payment models that decouple payments from volume offer providers the flexibility to invest in new staff and services, such as care coordinators and community health workers, nutritional counseling, and transportation services.[37]

Studies evaluating APMs highlight numerous successes where providers have improved patient outcomes and produced cost savings for payers.[38]

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unnecessary referrals, hospital admissions, prescriptions, tests, and other care) [hereinafter "Friedberg Follow-up Study"].

[33] *Id.* at xii (summarizing the strategies implemented by physician practices in response to APMs and noting that shared savings paid to accountable care organizations in particular promoted increased coordination across different healthcare delivery organizations).

[34] *See id.* at 10.

[35] *See* Jessica Mantel et al., *Developing a Health Care Workforce That Supports Team-Base Models That Integrate Health and Social Services*, 15 SAINT LOUIS U. J. HEALTH L. & POL'Y 239 (2022); NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 11, at 163 (discussing interprofessional teams based in primary care practices).

[36] *See* MARK W. FRIEDBERG ET AL., EFFECTS OF HEALTH CARE PAYMENT MODELS ON PHYSICIAN PRACTICE IN THE UNITED STATES 47 (2014) ("[A]lternative payment models have encouraged the development of team-approaches to care management . . . .").

[37] *See* Edith Coakley Stowe et al., SUPPORTING THE FUTURE OF PRIMARY CARE IN CALIFORNIA THROUGH ALIGNED HYBRID PAYMENT MODELS, MANNATT HEALTH (Nov. 2021) (explaining that when revenue is decoupled from volume, providers have "the latitude to invest in new services, new staff or improved infrastructure,...[whereas] [a]chieving these goals is impossible under fee-for-service, where practices face limited flexibility and are forced to self-fund many of these nonbillable activities that are needed to best serve their patients."); Crook, *supra* note 3 ("[Alternative payment] models based around prospective payments to providers have more flexibility to support the delivery of services (e.g., nutritional support, transportation services) that can address many of the social factors that impact health outcomes . . . .").

[38] Werner, *supra* note 3, at 6 (noting that among advanced APMs, there have been "notable

These successes have generated confidence that APMs have the potential to drive providers toward more effective care delivery models.[39] Overall, however, APMs have yielded mixed results,[40] with one commentator rightly bemoaning that "the current APM landscape includes many underperforming models, which have failed to produce the desired practice transformation."[41] Other commentators and payers similarly report that APMs are "often unsuccessful"[42] or produced "only modest impacts"[43] and "uneven" progress.[44] Part II explains how our multi-payer system has contributed to these disappointing results.

II. AN OBSTACLE TO CHANGE: THE U.S. MULTI-PAYER SYSTEM

In theory, public and private payers' experimentation with a variety of APMs should, over time, propel the healthcare system toward cost savings and better patient outcomes. In practice, however, this payment experimentation creates obstacles to providers transforming how they care for patients. As explained below, a multi-payer system means providers must operate in a sea of confusing and conflicting payment rules and incentives. This causes significant administrative burdens for providers participating in APMs and weakens the business case for investing in new delivery care models. Moreover, under a multi-payer system, public and private payers are less likely to provide financial and technical assistance to providers who lack the skills and resources to transform their practices on their own.

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successes"); MedPAC, *supra* note 3, at 43, 55 (summarizing the literature on APMs and finding that some models, including population-based payments to accountable care organizations, have generated small savings for payers and improved patient outcomes, including lower rates of emergency department and inpatient care and increased delivery of preventive care and chronic disease management services).

[39] *See* Werner, *supra* note 3, at 6 ("The past decade of experimentation with APMs . . . has provided proof-of-concept that if designed well, APMs are capable of driving cost savings and value improvements."); MedPAC, *supra* note 3, at 57 (commenting that success among Medicare shared savings and episode-based bundled payment models "is a promising indicator" that APMs can successfully incentivize providers to invest in improving their patient care infrastructure and changing their clinical practices).

[40] *See supra* note 3. *See also* NAT'L ACAD. OF MED., *Multi-Payer Alignment on Value-Based Care*, NAM DISCUSSION PROCEEDINGS (2022) (commenting that APMs have "been uneven in reducing cost, improving quality, achieving equity, or facilitating widespread model adopt," and that transitioning from fee-for-service to APMs "remains an aspirational goal").

[41] Werner, *supra* note 3, at 6.

[42] CAVANAUGH & BURKE, *supra* note 4, at 4.

[43] Crook et al., *supra* note 3.

[44] NAT'L ACAD. OF MED., *supra* note 40 at 6.

A. The Administrative Burden of Managing Multiple Payment Arrangements

Providers facing a multiplicity of payment arrangements must manage a range of disparate rules, performance measures, and reporting requirements.[45] As described below, providers report that this creates a "heavy administrative burden"[46] that significantly complicates their operations under APMs.[47]

Providers cite the challenge of managing an expanding array of performance measures as a particular source of concern and frustration.[48] Many commercial payers have rejected calls to adopt a common set of performance measures developed by public authorities,[49] citing their prior investment in developing their own set of measures and reporting system.[50] In addition, payers desire to differentiate their plans from competitors' rather than make them more similar.[51] With each payer adopting their own performance measures, providers typically must comply with hundreds of performance measures.[52] This in turn requires providers to dedicate significant resources to data collection,[53] including ensuring that their

[45] Grace Anglin et al., *Strengthening Multipayer Collaboration: Lessons From the Comprehensive Primary Care Initiative*, 95 MILBANK Q. 602, 604 (2017).
[46] Friedberg et al., *supra* note 36, at 63.
[47] *See* Stowe et al., *supra* note 37, at 8 ("When practices are paid multiple ways under multiple contracts, operating a business becomes unnecessarily complicated.").
[48] *See* Friedberg, *supra* note 36, at 64 ("[W]ith [pay-for-performance] incentives and other alternative payment models becoming more common, physician practices . . . reported heavy administrative burdens from the growing cacophony of metrics."); Stephanie M. Kissam et al., *States Encouraging Value-Based Payment: Lessons from CMS's State Innovation Models Initiative*, 97 MILBANK Q. 506, 532 (2019) (describing providers' concerns about the administrative burden of reporting different quality measures to different payers).
[49] *See* Kelsey Waddill, *CQMC Finds Quality Measures Gaps, Supports Digital Measures* (Mar. 28, 2022), https://healthpayerintelligence.com/news/cmqc-finds-quality-measurement-gaps-including-in-equity-measures (noting that although CMS, in partnership with America's Health Insurance Plans (AHIP), have developed core sets of quality measures for use in APMs, there is limited evidence that they have been widely adopted); Kissam et al., *supra* note 48, at 532 (stating that payers in Maine were unwilling to adopt the common measure set developed by the state).
[50] Kissam et al., *supra* note 48, at 532.
[51] *See generally* CAVANAUGH & BURKE, *supra* note 4, at 6, 14 ("Generally, competing firms seek to differentiate their products form their competitors' rather than make them more similar...But, when payors cooperate with their competitors, they begin to lose their product differentiation, the ability to make the case that their offering is unique.").
[52] *See* Tricia McGinnis & Jessica Newman, *Advances in Multi-Payer Alignment: State Approaches to Aligning Performance Metrics across Public and Private Payers*, MILBANK MEMORIAL FUND ISSUE BRIEF (2014) (commenting that providers often must collect and report "hundreds" of different performance measures).
[53] *See id.* ("[P]roviders must respond to multiple distinct data requests and program

electronic health records systems are configured to capture all relevant data.[54] As found by one study of physician practices, even "[m]inor differences in measure specifications, by requiring practices to develop different data collection tools to capture similar data in slightly different ways, multiplied the burden of data entry and management."[55]

Managing multiple APMs increases the administrative burden on providers in other ways. As explained by MedPAC in its 2021 report to Congress, "many APMs' specifications can run more than 100 pages and require substantial changes in provider workflow, infrastructure, and behavior to be successful."[56] Understanding these APMs and devising strategies for success requires significant staff time, with many providers hiring consultants to assist with the process.[57] Not all providers can overcome these challenges, however, with small physician groups in particular reporting confusion and uncertainty over how to modify their operations so as to ensure success under APMs.[58] Moreover, building the internal capacity to both analyze an organization's performance under multiple APMs and track their numerous requirements is taxing for even sophisticated provider organizations.[59]

Providers also contend that formulating a coherent response to multiple payment models can prove very challenging.[60] For example, many physician

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requirements,... [which] creates significant financial, administrative, and resource burdens for providers."); Friedberg et al., *supra* note 36, at 102-103 (commenting that nonalignment among performance measures "required physician practices to devote significant resources to formulating a coherent response").

[54] *See* Friedberg et al., *supra* note 36, at 52 (explaining that physician practices participating in APMs made significant investments in their data management capabilities, including upgrading their EHRs).

[55] Friedberg et al., *supra* note 36, at 103. *See also* Kissam et al., *supra* note 48 at 523 ("[P]roviders noted concern with having to produce slightly different versions of essentially the same measures based on the requirements of individual payers.").

[56] MedPAC, *supra* note 3, at 57.

[57] *See id.* (reporting that providers describe APMs as requiring "significant investments of time or consultants to understand"); Friedberg Follow-up Study, *supra* note 32, at 48 ("More than one practice leader underscored the challenge of investing staff time to understand and devise strategies to respond to new and unfamiliar payment programs.").

[58] *See* Friedberg Follow-up Study, *supra* note 32, at xiv ("The complexity of new APMs has confused some physician practice leaders...When practices do not understand APMs, they are unsure of whether to invest in care improvement, or how to do so in ways that will be financially rewarded or reimbursed.").

[59] *See id.* at 53 (noting that practices of all sizes reported investing significant resources in building internal capabilities to analyze APMs); Friedberg et al., *supra* note 36, at 12 (commenting on the challenge of keeping track of payment performance details that vary from payer to payer, especially for smaller and medium practices).

[60] *See* Friedberg Follow-up Study, *supra* note 36, at 97, 102-103 (reporting that "[p]ractice leaders expressed considerable uncertainty about best strategies for responding to the

practices report difficulties in devising a meaningful response to the many performance measures they face.[61] As vividly described by one practice manager, "it's like [having] 50 people shouting their priorities at you, and then trying to prioritize those into some semblance of order."[62] This complicates provider organizations' operations in two ways. First, they must decide which performance measures they will pay attention to and which they will ignore.[63] Second, they must translate the selected measures into manageable performance standards that can be easily understood by the organization's practicing clinicians.[64] While well-resourced organizations such as hospital systems and large multispecialty physician practices may have the capacity to harmonize performance measures, smaller organizations often struggle to do so.[65]

The administrative complexity of complying with multiple APMs is a significant obstacle to providers embracing new payment models.[66] For some providers, the time, effort, and expertise needed to manage disparate payment requirements and performance measures is simply beyond their capacity.[67] Small providers, in particular, report confusion over and disengagement with APMs.[68] For other providers, the administrative burden may increase their operating expenses to the point of outweighing the potential financial rewards under APMs.[69] These challenges have dissuaded many providers from participating in APMs.[70]

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combination of alternative payment models that they faced," and had to devote "significant resources to formulating a coherent response").

[61] *See id.* at 93.

[62] *Id*.

[63] *See id.* at 64 (explaining that the profusion of performance metrics requires providers to filter performance metrics, "deciding which ones are worth paying any attention to and which are not").

[64] *See id.* (explaining the need to harmonize performance measures for practicing clinicians).

[65] *See id.* at 63-64, 95 (reporting that several types of larger organizations have "stepped up and taken leadership roles in synchronizing performance metrics," but that confusion was common among small primary care or single-subspecialty practices).

[66] *See* Werner et al., *supra* note 3, at 8-9 ("The extensive administrative complexity of the value-based payment landscape remains a significant barrier to participating in APMs . . . [and] dissuades adoption.").

[67] *See* Friedberg et al., *supra* note 36, at 63 ("Merely keeping track of payment program details, which vary from payer to payer, required management efforts that could be beyond the capacity of some practices.").

[68] *See* Friedberg Follow-up Study, *supra* note 32, at xiv, 53 ("The complexity of new APMs has confused some physician practice leaders, [and] disengaged others," with "leaders of smaller, independent practices more likely to express confusion and disengagement.").

[69] *See* Friedberg et al., *supra* note 36, at 22, 64 (explaining that managing the reporting requirements for multiple payers is "a major reason for rising practice expenses," and that the administrative burden of complying with certain performance measures can be disproportionate to the financial reward).

[70] *See* Werner et al., *supra* note 3; Friedberg Follow-up Study, *supra* note 32.

Among providers that have entered into APMs, the administrative challenges of managing different payment models and performance measures complicates their efforts to successfully transform their patient care practices. As explained by the administrative leader of a medium-sized physician practice:

> "We're so constrained on staff that the time to investigate [each new payment program], the time to do the thinking, the time to ask questions is hard to come by. And so because of that, I don't think we're doing it as efficiently as we could . . . and we're just scraping by. And so, A) we're not getting everything done that we could get done, and B) we don't have the time to really think about how to do it better."[71]

Relatedly, when the administrative burden of APMs is disproportionate to the potential financial rewards, it can weaken the business case for providers actively endeavoring to improve their performance outcomes.[72] As a result, providers may make only modest changes in their operations rather than fundamentally changing how they care for patients.

B. Diluted and Conflicting Financial Incentives

When providers participate in multiple APMs across different payers, not only do they face significant administrative burdens, but interactions or interference among payment models can also weaken each model's effectiveness.[73] Specifically, as described below, covering only a small subset of a provider's patient panel dilutes each payer's APM incentives. In addition, conflicting incentives across different payment models can complicate a provider's shift to new patient care models.

Because providers contract with multiple public and private payers, each plan covers only a portion of a providers' patient population. This dilutes the financial incentives under each payer's APM, weaking any individual payer's leverage to push a provider toward more advanced care delivery approaches.[74] As explained by two commentators, "[the APM] incentives

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[71] Friedberg Follow-up Study, *supra* note 32, at 48 (quoting a primary care practice leader interviewed by the authors).

[72] *Cf.* McGinnis & Newman, *supra* note 52, at 2 (explaining that the "chaos" of facing multiple performance measures "greatly limits the business case for providers to improve specific performance outcomes").

[73] *See* MEDPAC, *supra* note 3, at 58-59 (noting that when providers participate in multiple Medicare APMs simultaneously, "it can lead to problematic interactive effects"); Friedberg Follow-up Study, *supra* note 32, at 35 (commenting that another challenge arising from APMs is "the potential for interactions or interference between payment models").

[74] *See* MEDPAC, *supra* note 3, at 59 ("When a provider participates in multiple APMs, each

offered by any individual payer are unlikely to be of sufficient magnitude or scale to make it worth the provider's time and energy to fundamentally change the design or operations of his or her [or their] practice."[75] For example, if two payers each cover only 10-15 percent of a provider's patient panel, with one payer's APM rewarding reductions in total per capita spending and the second payer's APM rewarding increases in preventive services, the financial rewards from each payer may be too small to motivate the provider to achieve either objective.[76] In contrast, a provider would be motivated to transform their practices if the financial incentives across multiple payers are both in alignment and sufficiently large in the aggregate;[77] however, "[i]n a world with many competing payers all going it alone, these conditions are seldom met."[78]

Similarly, the misalignment across payers can limit providers' ability to fundamentally transform their patient care practices. For practical and ethical reasons, providers generally do not transform their practices for only one segment of their patient population, but instead, treat all patients similarly.[79] For example, if a physician practice hires care managers in an effort to

covering a different subset of a provider's patient panel, it can dilute each individual APM's incentives."); Stremikis, *supra* note 1, at 3 ("[O]ften any individual health plan represents only a fraction of a provider's total revenue, and thus the overall impact of a specific reform initiative can be small and the leverage of any given payer to drive performance improvement can be limited."); Cavanaugh & Burke, *supra* note 4, at 4 ("Because health coverage is fragmented among multiple public and private health plans, any individual health plan typically represents a small share of any practice's patients and, therefore, has insufficient leverage to spur improvements in quality and to control costs.").

[75] Cavanaugh & Burke, *supra* note 4, at 4; *see also* Crook et al., *supra* note 3 ("[I]f an APM only affects a small percentage of an organization's payments, there is little business case for investing in the infrastructure and personnel needed to transform care.").

[76] *Cf*. MEDPAC, *supra* note 3, at 58-59 (offering an illustrative example of why providers participating in multiple Medicare APMs may not implement care changes).

[77] Experts estimate that providers have strong incentives to shift to new care delivery models only if APMs cover at least half of their patient panel. *See, e.g.,* Crook et al., *supra* note 4 (reporting that anecdotal feedback received by the authors "suggests that at least 50 percent of a [provider's] book of business needs to be in a significant value-based arrangement to support the substantial shifts in care delivery needed to succeed in new care models"); Stowe et al., *supra* note 37, at 7 (reporting that a Harvard Medical School study found that primary care practices would both profit financially and shift their practices to encompass non-patient visits forms of care when capitated patients accounted for 63 percent of their practice revenue); NAT'L ACAD. OF SCI., ENG'G, & MED, *supra* note 11, at 311 (commenting that the literature suggests that any payment methodology will promote change if it constitutes at least 60 percent of a primary care practice's patient-panel).

[78] Cavanaugh & Burke, *supra* note 4, at 4.

[79] *See* Friedberg et al., *supra* note 36, at 67 ("For practical and ethical reasons, physician practices reported generally applying the same treatment protocols to all patients…. The assumption is, when a patient is in an exam room and the physician is in there, they're not really concentrating on who the payer is."); Cavanaugh & Burke, *supra* note 4, at 6 ("[P]roviders cannot make fundamental changes for just one segment of their patients.").

increase their financial rewards under shared savings arrangements, they will provide care management services to all high-risk patients, and not just those insured by payers offering shared savings.[80] Consequently, providers cannot implement quality care improvements unless they receive predictable revenue from multiple payers covering a significant proportion of their patient population.[81] Too often, however, only a handful of payers will pay a provider in a manner that supports these activities.[82]

In addition, when providers have contracts with multiple payers, the different payment approaches may conflict with one another.[83] Often the behaviors necessary for a provider to achieve financial success under a particular payment model directly conflict with the financial incentives created under payment arrangements,[84] a dynamic that providers vividly describe as having their feet in two canoes that are moving in different directions.[85] In particular, the financial incentives under fee-for-service

[80] *See, e.g.,* Friedberg et al., *supra* note 36, at 67 (noting how the physician leader of a practice participating in Medicare's shared savings program for ACOs "described care management services as one of the key responses to participating in an ACO—but those services were made available to all high-risk patients in the practice and not just those in the Medicare ACO panel").

[81] *See* Stowe et al., *supra* note 37, at 8 ("It takes multiple payers willing to invest and pay upfront population-based fees in a similar fashion to be able to create and sustain services such as dedicated care managers, pharmacists for medication reconciliation, telehealth, remote monitoring and integrated behavioral health."); NAT'L ACAD. OF SCI., ENG'G, & MED. *supra* note 11, at 299 ("[W]ithout a substantial source of new, predictable, and sustainable revenue from multiple payers to maintain and expand new services, [patient -centered medical home] practices find it difficult to maintain focus on overlapping practice transformation aims, including quality improvement, team formation, chronic care coordination, and patient engagement."); Mary Takach et al., *Making Multipayer Reform Work: What Can Be Learned From Medical Home Initiatives*, 34 HEALTH AFFAIRS 662, 662 (2015) ("Providers and health systems can afford to make necessary investments and long term improvements to meet health system goals when they are working with common signals or expectations from payers and receiving reliable funding streams that cover significant proportions of their patient populations.").

[82] *See generally* Stremikis, *supra* note 1, at 3 (explaining that when providers face a myriad of payment programs, they may "fail to provide large enough incentives to undertake certain activities or invest in the infrastructure needed for improvements").

[83] *See* Anglin et al., *supra* note 45, at 603 (commenting that providers who typically contract with multiple payers face "a large, disparate, and ultimately muddied set of financial incentives"); Stremikis, *supra* note 1, at 3 ("From the provider's perspective myriad payment programs have the potential to conflict with one another.").

[84] *See* Stowe et al., *supra* note 37, at 8 ("When practices are paid in multiple ways under multiple contracts, . . . [t]he behaviors that the payment models are designed to incent can be in direct conflict with one another."); Friedberg Follow-up Study, *supra* note 32, at 35 (commenting that different payment models can conflict when they impose on providers different incentive structures).

[85] *See* Friedberg Follow-up Study, *supra* note 32, at 35-36; *see also* Friedberg et al., *supra* note 36, at 66.

payment models can blunt the incentives under risk-based contracts designed to nudge providers to more efficient care delivery models.[86]

Many providers that have entered into risk-based APMs still derive a significant share of their revenue from fee-for-service arrangements. In 2021, for example, fee-for-service payments with no link to quality and value accounted for the majority of provider payments from commercial plans and over 40 percent of provider payments across all payers.[87]

Treating a combination of patients attributed to APMs and fee-for-service arrangements complicates providers' transition to new care delivery models.[88] First, the incentives under fee-for-service to increase the volume and intensity of care conflict with APM incentives to reduce costs, utilization, and care intensity.[89] For example, in health systems that own both hospitals and physician practices, APMs that reward physicians for lowering hospital admissions and emergency room visits can harm the financial well-being of the system's hospitals.[90] Second, APMs and fee-for-service arrangements encourage different clinical care practices. For example, the volume-driven incentives of fee-for-service encourage physicians to shorten the length of

[86] *See* Friedberg et al., *supra* note 36, at 63 ("[A] serious tension could also arise when practices participate in a mix of both FFS [(fee-for-service)] and risk-based contracts.").
[87] *APM Measurement Effort*, HEALTH CARE PAYMENT LEARNING & ACTION NETWORKS, (2022), https://hcp-lan.org/workproducts/apm-infographic-2022.pdf. Among payments made under APMs, less than 20 percent of providers' payments are made under more advanced risk-based contracts that shift insurance risk to providers, such as shared savings models with downside risk and population-based payments. *See id*.
[88] *See* ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, U.S. DEP'T OF HEALTH AND HUM. SERVS., ENVIRONMENTAL SCAN ON ISSUES RELATED TO THE DEVELOPMENT OF POPULATION-BASED TOTAL COST OF CARE (TCOC) MODELS IN THE BROADER CONTEXT OF ALTERNATIVE PAYMENT MODELS (APMS) AND PHYSICIAN-FOCUSED PAYMENT MODELS (PFPMS) (Mar. 3, 2022) (noting that it is difficult for providers to "strike a balance" between the incentives under fee-for-service arrangements and APMs that shift significant financial risk to providers, such as population-based payment models linked to the total cost of caring for a patient population) [hereinafter "ASPE Report"]; Friedberg et al., *supra* note 36, at 100 ("Some physicians face the 'two-canoe' problem of depending on FFS and accompanying incentives to a significant portion of their revenues while working to transition to alternative payment models with conflicting incentives.").
[89] *See* Friedberg et al., *supra* note 36, at 63 (explaining that when practices participate in both fee-for-service and risk-based contracts, they "faced fundamentally conflicting incentives to increase volume under the FFS contract while reducing costs under the risk-based contract"); *see also* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 11, at 298-299 (explaining that among practices' participating in patient-centered medial home arrangements, their "underlying focus on visit volume" under fee-for-service made it more difficult for them to shift their focus to reducing total spending).
[90] Friedberg et al., *supra* note 36, at 63 (explaining that the conflict between incentives to increase volume under fee-for-service and reduce costs under risk-based contracts "was especially acute for hospital-owned physician practices, in which reductions in hospital utilization, which are strongly incentivized under risk-based contracts, could undermine the financial well-being of the parent organization").

time spent with individual patients and treat as many patients as possible.[91] In contrast, APMs such as patient-centered medical homes require spending more time with each patient in order to both better understand their specific needs and provide effective patient education.[92] Third, fee-for-service dampens the financial incentives under APMs—rather than transform their practices to ensure financial success under APMs, providers can simply make-up lower APM revenue by increasing the volume or intensity of services provided to fee-for-service patients.[93]

C. Collective Action Challenges

As discussed above, to succeed under APMs, providers must shift to patient care models that improve patient outcomes while lowering costs. This transformation requires a significant investment in hiring and training personnel, upgrading data management capabilities, and designing and implementing new patient care processes.[94] Many providers, however, lack the skills and expertise to make this transformation on their own.[95] In addition, providers often struggle to adequately finance the necessary upfront costs,[96] particularly when financed by loans that cannot be repaid if APM

[91] Collin Couey, *Value-Based Care vs Fee-for-Service: The Ins and Outs You Need to Know*, SOFTWARE ADVICE (Aug. 1, 2022), https://www.softwareadvice.com/resources/value-based-care-vs-fee-for-service/.

[92] *See* Friedberg et al., *supra* note 36, at 28-30, 65-66 (quoting the leader of a primary care practice explaining the competing time pressures under FFS and patient-center medical home arrangements).

[93] Friedberg Follow-up Study, *supra* note 32, at 35-36 (quoting the leader of a primary care practice stating that "their financial reality is that they can make up for whatever negative impact there might be [under APM contracts] . . . by just seeing a few more patients").

[94] *See* Friedberg et al., *supra* note 36, at 41 ("The ability to manage effectively [under APMs] is often dependent on the ability to invest in people, in technology, and in designing and implementing care processes."); *see also* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 11, at 162-163 (stating that implementing integrated care delivery models involves "high start-up costs").

[95] *See* Friedberg Follow-up Study, *supra* note 32, at xiv (commenting that small and independent practices in their study "reported that they lacked the internal skills and experience necessary to perform well in APMs").

[96] *See* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 11, at 163 (commenting on the challenges many providers face in paying for the transition to new care delivery models, such as team-based integrated care); *see also* Friedberg et al., *supra* note 36, at 42 (noting that many providers, particularly small, physician-owned practices, "reported that finding the capital to make vital investments in alternative payment models could be quite challenging"); *see also* U.S. GOV'T ACCOUNTABILITY OFF., MEDICARE INFORMATION ON THE TRANSITION TO ALTERNATIVE PAYMENT MODELS BY PROVIDERS IN RURAL, HEALTH PROFESSIONAL SHORTAGE, OR UNDERSERVED AREAS, GAO-22-104618, at i (2021) (reporting that providers in rural, shortage, or medically underserved areas "lack the capital to finance the upfront costs of transitioning to an APM") [hereinafter "GAO Report"].

bonuses fail to materialize, are smaller than expected,[97] or lag initial investments by several years.[98] These challenges have deterred some providers, particularly small or under-resourced practices, from participating in APMs.[99] And among providers participating in APMs, many experience difficulty in building the necessary infrastructure and internal expertise to succeed under APMs, achieving only negligible improvements in patient care outcomes and cost reductions.[100]

In recognition that APMs cannot achieve their goals unless providers receive external support, some payers have engaged in various provider capacity-building activities. For example, recent Medicare APM demonstrations have subsidized providers' upfront infrastructure investments.[101] CMS and some commercial payers also have helped physician practices improve their data infrastructure by offering guidance and training in data management,[102] with studies suggesting that this

[97] *See* Friedberg Follow-up Study, *supra* note 32, at 60 (explaining that providers' investment "when financed by loans, could create financial risk of bonuses failing to materialize when expected").

[98] Studies suggest that it takes years for providers to transform their practices and for improvements in patient care to lead to improved outcomes and savings. Consequently, there often is a lag time of several years before providers achieve financial rewards under APMs. *See* MedPAC, *supra* note 3, at 58 (discussing the lag time between providers' investments and generating savings for Medicare APMs); *see also* Werner, *supra* note 3, at 8 ("Successful value-based payment transitions take time; the savings and practice transformations from APMs take years of experience and investment to pay off."); *see also* Friedberg et al., *supra* note 36, at 45 (noting that additional payments under APMs often lagged providers' investments); *see also supra* text accompanying note 71 (describing time-related challenges faced in APMs).

[99] *See* MedPAC, *supra* note 3, at 58 (observing that some providers, particularly small or under-resourced providers, have not participated in APMs because they cannot make the infrastructure investments needed to succeed under APMs).

[100] *See* Friedberg Follow-up Study, *supra* note 32, at xiv (stating that many physician practices reported that they lacked the internal skills and experience necessary to perform well in APMs); *see also* Friedberg et al., *supra* note 36, at 58 (noting that some providers struggled with acquiring the necessary data management capabilities to operate under APMs and were hesitant to make the needed investments); *see also* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 11 at 300 (commenting that providers participating in Medicare primary care APM demonstrations often struggled to find the time and resources necessary to implement care delivery innovations); *see also supra* text accompanying note 71 (describing administrative challenges experienced by participants in APMs).

[101] *See* GAO Report, *supra* note 96, at i (commenting that Medicare APMs that offer upfront funding can help providers in rural, shortage, or underserved areas transition to APMs); *see also* Friedberg Follow-up Study, *supra* note 32, at 60 (discussing Medicare APMs such as the Comprehensive Primary Care Plus program).

[102] *See* Friedberg et al., *supra* note 36, at 102 (describing the existence of health plans that provide data-management training to physician practices); *see also Comprehensive Primary Care Plus*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Aug. 5, 2022),

assistance improves success under APMs.[103] Additional technical assistance can include payers educating providers about APMs, sharing "best practices" for improving patient care, and supporting peer-to-peer collaborations where providers can learn from one another's successes and failures.[104]

Unfortunately, because a single payer's provider capacity-building activities will benefit other payers, "free rider" concerns can deter any one payer from supporting providers' practice transformations.[105] As described in subpart B, providers generally treat all patients similarly. Consequently, any investments in new infrastructure, staff, or treatment protocols will transform care practices across the providers' entire patient panel. A payer's subsidies or technical assistance, therefore, not only benefit the patients insured by the financing payer, but also benefit other payers' beneficiaries. This condition gives rise to a classic free rider problem—because provider capacity-building activities benefit all payers, a single commercial insurer cannot gain a competitive advantage when helping a provider transform their practice. This in turn weakens the economic incentives for any single commercial payer to provide financial and technical assistance to providers.[106]

In theory, public payers such as Medicare and Medicaid may be more willing to support efforts that benefit the health system as a whole, including other payers' beneficiaries. However, in practice, whether public payers do so may depend on program economics, namely whether provider capacity-building activities generate net savings *for the public payer*. For example, CMS requires that any Medicare and Medicaid demonstration approved under section 1115 of the Social Security Act be "budget neutral," meaning

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https://innovation.cms.gov/innovation-models/comprehensive-primary-care-plus (describing the CPC+ Medicare demonstration and noting that CMS provided participating providers with "a robust learning system"); *see also Health IT Vendors in CPC+*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 17, 2019), https://innovation.cms.gov/files/x/cpcplus-hittracker.pdf (explaining that as part of the CPC+ Medicare demonstration, CMS contracted with certain health IT vendors to provide IT assistance to participating providers).

[103] *See* Milad, *supra* note 3, at 546 (noting that support for provides, in the form of technical assistance for the development of data infrastructure, promotes successful implementation of APMs).

[104] *See* GAO Report, *supra* note 96, at 23 (noting that CMS has supported providers by educating them about APMs); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., INNOVATION CENTER STRATEGY REFRESH 20, 22 (2021) (stating that technical assistance CMS could provide includes sharing of best practices, peer-to-peer learning collaboratives, and assistance with screening tools).

[105] *The Free Rider Problem*, STANFORD ENCYCLOPEDIA OF PHIL. (Oct. 13, 2020), https://plato.stanford.edu/entries/free-rider/.

[106] *See generally* Cavanaugh & Burke, *supra* note 4, at 6 (discussing the free rider problem among payers that subsidize providers' practice transformations).

that they cannot increase expenditures for either Medicare or Medicaid.[107] Similarly, under section 1115A of the Social Security Act, CMS cannot expand any Medicare or Medicaid payment demonstration on a nationwide basis unless the CMS actuary concludes that doing so will reduce Medicare or Medicaid spending without reducing the quality of care (or will improve the quality of care without increasing Medicare or Medicaid spending).[108] Any cost savings that accrues to other payers is ignored in these calculations.[109] Moreover, given public payers' limited resources, they likely cannot fund wide-spread provider capacity-building efforts, but instead will continue to limit these activities to payment demonstrations.[110]

In sum, a multi-payer system imposes significant administrative complexity on providers and dilutes the financial incentives under individual APM arrangements. Moreover, payers' support of provider capacity-building activities remains limited. Consequently, many providers have taken few, if any, meaningful steps toward adopting enhanced care delivery models. So, although payers have implemented a wide range of APMs designed to improve the quality and efficiency of the healthcare system, progress has been frustratingly slow and uneven. True change will occur only if payers replace the current heterogeneity in payment rules and incentives with greater alignment across payment models.[111]

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[107] *See* Cindy Mann et al., *CMS Updates Its Budget Neutrality Policy*, HEALTH AFFS. BLOG (Jan. 26, 2023), https://www.healthaffairs.org/content/forefront/cms-updates-its-budget-neutrality-policy (discussing the budget neutrality requirement for section 1115 demonstrations).

[108] Social Security Act § 1115A(c), 42 U.S.C. § 1315a(c) (2022).

[109] Showing that a demonstration generates cost savings for Medicare and Medicaid (or is budget neutral if improving quality) can be difficult given the evaluation challenge in isolating the demonstration's effects on spending from other policies and marketplace dynamics. As explained by Philip Rocco and Andrew Kelly:

> Evaluations of Medicare and Medicaid demonstration projects have long tacitly assumed that the effects of these interventions on spending and care quality can be clearly isolated and identified. Yet in practice these models are implemented in complex environments; multiple policy interventions and market dynamics may complicate the isolation of policy effects.

Rocco & Kelly, *supra* note 28, at 75. For example, an evaluation of a Medicare or Medicaid APM demonstration will underestimate program cost savings if the comparison group of patients also experienced improved care, either because of "spillover effects" (i.e., providers improving care for all patients and not simply patients treated under the Medicare or Medicaid demonstration) or from the positive effects of other APMs. *See id*.; *see also* Crook et al., *supra* note 3 (discussing the challenges of assessing the impact of a single payment reform).

[110] *Cf.* Rocco & Kelly, *supra* note 28, at 76 (commenting that CMS's Center for Medicare and Medicaid Innovation cannot provide "enough resources" to transform existing demonstration projects to permit scaling).

[111] *See* Werner et al., *supra* note 3, at 12 ("For APMs to be successful, they must be aligned

III. THE LIMITED PROMISE OF MULTI-PAYER ALIGNMENT INITIATIVES

To address payment misalignment, federal and state agencies have created various initiatives that support more consistent payment approaches across payers.[112] Specifically, these multi-payer alignment initiatives (MPAIs) bring together a consortium of payers seeking to align their APM requirements and incentives.[113] For example, participating payers can adopt a common set of performance measures and data reporting formats or standardize the operational requirements that providers must satisfy.[114] Payers also can agree to follow a similar methodology for payment, such as paying upfront population-based fees,[115] or address free-rider concerns by coordinating the resources they offer providers.[116]

By aligning multiple payers' payment methodologies, MPAIs can increase the percentage of patients covered by a common set of payment rules and

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and harmonized across payers, service lines, and health plans."); Anglin et al., *supra* note 45, at 603 ("Payers are increasingly recognizing that collective action can offer a more powerful, streamlined set of expectations and incentives for providers and potentially result in greater improvement in outcomes."); ASPE Report, *supra* note 88, at 44 ("Policy stakeholders have indicated that achieving multi-payer alignment is necessary to sustain provider engagement in value-based payment models across the payer systems in the United States.").

[112] *See* Stremikis, *supra* note 1, at 2 (discussing the SIM program which provides states with up to $100 million to develop models for multi-payer payment initiatives).

[113] *See* Stremikis, *supra* note 1, at 3 ("Multipayer initiatives involve collaboration among public (e.g., Medicaid) and private (e.g., commercial insurance) payers participating in value-based payment and delivery system reforms...."). While MPAIs do not necessarily need to be convened by a government agency, collaborations among private payers only risks running afoul of antitrust laws prohibiting coordinated action among payers. In contrast, government-led MPAIs can invoke the state action doctrine, which provides immunity to actions that would otherwise be considered anticompetitive when taken pursuant to a clearly articulated state policy and under state supervision. *See* Barbara Wirth et al., *State Strategies to Avoid Antitrust Concerns in Multipayer Medical Home Initiatives*, COMMONWEALTH FUND (July 16, 2013), https://www.commonwealthfund.org/publications/issue-briefs/2013/jul/state-strategies-avoid-antitrust-concerns-multipayer-medical (discussing antitrust concerns for MPAIs).

[114] *See generally* Anglin et al., *supra* note 45, at 606 (discussing ways in which payers participating in Medicare's Comprehensive Primary Care (CPC) Initiative aligned performance measures and requirements).

[115] *Cf.* Stowe et al., *supra* note 37, at 8 (suggesting that multiple payers pay upfront population-based fees in a similar fashion).

[116] *See* CTR. FOR HEALTH CARE STRATEGIES, MULTI-PAYER INVESTMENTS IN PRIMARY CARE: POLICY AND MEASUREMENT STRATEGIES 3 (2014) (stating that one benefit of multipayer coordination is "[a]voiding the economic "free rider" problem of some entities benefiting from others' investments"); Cavanaugh & Burke, *supra* note 4, at 6 ("[P]ayers may look to collaborate to reduce or eliminate free riders."). For example, CMS required payers participating in their Comprehensive Primary Care (CPC) Initiative to contribute adequate resources to providers, such as agreeing to raise their care management fees. *See* Anglin, et al. *supra* note 45, at 616.

incentives;[117] offer providers more predictable and sustainable financing;[118] and boost the financial and technical assistance available to providers.[119] This in turn reduces the administrative burden for providers participating in APMs and improves the business case for investing in meaningful redesign of patient care practices.[120] MPAIs therefore have the potential to amplify payers individual efforts and achieve broad scale improvement of the healthcare delivery system.[121] Unfortunately, for the reasons discussed below, MPAIs face a range of challenges that limit their potential to achieve these goals.

Numerous obstacles stand in the way of multi-payer coordination.[122] For commercial insurers who have a long history of competing with one another, shifting to a culture of cooperation can prove challenging. Competing insurers seeking to gain a market advantage through product differentiation have little incentive to work together to make their payment methodologies more uniform.[123] Relatedly, payers may hold different priorities or disagree on the merits of alternative performance measures or payment

[117] *See* ASPE Report, *supra* note 88, at 118 ("A key goal of multi-payer or all-payer models is to bring as many of a provider's patient panel under one set of common initiatives as possible . . . .").

[118] *Cf.* Stowe et al., *supra* note 37, at 8 (stating that when multiple payers agree to pay upfront population-based fees in a similar fashion, this allows providers to create and sustain care improvements, such as dedicated care managers and telehealth).

[119] *See* Anglin et al., *supra* note 45, at 603 (explaining that collective action by a group payers can include significant additional funding to providers, thereby giving them the financial resources for providers to improve care delivery).

[120] *See* ASPE Report, *supra* note 88, at 12 (noting that MPAIs can simplify administrative and financial planning for provider organizations and increase providers engagement with APMs); Stremikis, *supra* note 1, at 3 ("Successful multi-payer alignment can amplify the impact of payment and delivery reforms by sending consistent incentives to health care providers and aligning performance measurement."); McGinnis, *supra* note 52, at 2 ("When multiple payers and plans align their measurement and quality improvement goals, they send a stronger message to providers about what needs to be done, and make it easier for providers to focus improvement efforts and target staff resources effectively.").

[121] *See* ASPE Report, *supra* note 88, at 44 (stating that some experts believe MPAIs "are much more likely to generate system-wide impacts than are similar models that are limited to one single payer.").

[122] *See generally* Anglin et al., *supra* note 45, at 602 ("[S]ustaining engagement and achieving coordination among payers can be challenging."); Cavanaugh & Burke, *supra* note 4, at 14 ("[W]hile multi-payer collaboratives are necessary to effective health system redesign and improvement, they are quite difficult to achieve.").

[123] *See* NAT'L ACAD. OF SCI., ENG'G, & MED., *supra* note 11 at 311 ("[T]he [primary care] office operates in a sea of confusing financial incentives from insurers that not only have no incentive to coordinate payment terms but often see [them] as a source of competitive differentiation."); Cavanaugh & Burke, *supra* note 4, at 6 ("Generally, competing firms seek to differentiate their products from their competitors, rather than make them more similar. . . In this context, it is understandable that any payer would not seek out opportunities to collaborate with other payers.").

methodologies.[124] They therefore may become frustrated with MPAIs if reaching consensus limits a payer's ability to pursue an innovative approach or its own priorities.[125] Moreover, payers that compete with one another may have difficulty building the foundation of trust necessary for reaching consensus on payment approaches.[126] For example, a study of the CMS-led Comprehensive Primary Care (CPC) Initiative reported that in some regions, a lack of trust among payers complicated negotiations, with discussions "often becoming heated."[127]

A power imbalance among participating entities and protracted negotiations also can limit payers' enthusiasm for MPAIs. Given the size of the Medicare and Medicaid programs, CMS or the state Medicaid agency often wield considerable influence over the MPAIs in which they participate.[128] For example, private payers participating in a CMS-led MPAI reported "frustration about the extent to which they could drive the initiative's direction" because "CMS dictated the terms of participation prior to the start of [the MPAI] instead of negotiating on equal footing with other payers."[129] A similar imbalance can arise when a commercial payer has a large share of the relevant regional market and therefore drives the MPAI decision-making process,[130] leaving smaller payers feeling marginalized and less engaged.[131] Building consensus across payers also is time and resource-intensive, and the slow pace of doing so can dampen participants'

[124] *See* Anglin et al., *supra* note 45, at 622 (noting that in some regional MPAIs, differing priorities among participating payers "sometimes hindered collaboration"); Cavanaugh & Burke, *supra* note 4, at 6 (explaining that a payer's willingness to participate in an MPAI may be influenced by the fact that "[p]ayers differ in their outlook on different models of service delivery reform").

[125] *See* Anglin et al., *supra* note 45, at 630 (explaining that payers competing with one another may have different priorities, and that this can make it more challenging to build trust and a common purpose); Cavanaugh & Burke, *supra* note 4, at 9 ("A health plan with an idea for an innovative payment system can pursue its own vision most easily by working alone; working with other plans, the plan might need to accommodate its partners' differing visions.").

[126] *See* Anglin et al., *supra* note 45, at 604 ("A challenge for initiatives bringing together payers is learning how to foster relationships among competing–and sometimes adversarial–organizations in ways that maximize an initiative's impact.").

[127] *Id.* at 623.

[128] *Id.* at 605 (commenting that government agencies such as CMS "can be expected to exercise greater influence in shaping an [MPAI] initiative").

[129] *Id.* at 617.

[130] *See generally* Cavanaugh & Burke, *supra* note 4, at 8 ("This [MPAI] decision-making process also needs to be able to deal with imbalances in size or market position, as payers with a large market share may believe they deserve a larger voice in the design of the multipayer collaborative.").

[131] *See*, *e.g.*, Anglin et al., *supra* note 45, at 623 (describing how smaller payers' engagement in a MPAI decreased over time when a dominant payer drove the initiative's decision-making).

commitment to a MPAI, especially for payers seeking to quickly test new ideas or payment approaches.[132]

For some payers, internal operational considerations also may limit their willingness to participate in a MPAI or conform to the collaboration's new payment rules and requirements.[133] Payers who have devoted significant time and resources to developing their own payment methodologies may be unwilling to modify their approach if doing so would render their prior investment moot. For example, payers in Maine rejected a common set of performance measures developed by the state because each had already invested in their own, unique set of measures.[134] Similarly, some national and multi-regional payers prefer to standardize their payment operations across their geographic service areas, rather than conform to the disparate standards of multiple national and regional MPAIs.[135] Finally, a payer may lack the capacity to support the payment methodology adopted by a MPAI, such as the necessary claims processing functionality.[136]

Differences in plans' covered patient populations and benefits also can impede efforts to align payment methodologies across payers. Because patient populations vary in their characteristics and needs, payers serving different populations often have divergent interests and priorities.[137] For example, given the prevalence of serious chronic conditions among the Medicare population, CMS-sponsored MPAIs often emphasize payment methodologies that support coordinated, team-based care, such as per-member-per-month management fees.[138] In contrast, commercial insurers

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[132] *See* Cavanaugh & Burke, *supra* note 4, at 9 (commenting that participants in an Adirondack region MPAI identified the slow pace of collaboration "as a significant drawback," and that "[a] payer hoping to implement or test a new idea quickly may prefer to move ahead by itself").

[133] *See*, *e.g.*, Kissam, *supra* note 49, at 532.

[134] *See id.*

[135] *See*, *e.g.*, Anglin et al., *supra* note 45, at 622 (stating that some national payers were hesitant to participate in multiple CMS-sponsored regional MPAIs because they desired to maintain approaches "that were standardized across regions within their own organizations").

[136] *See*, *e.g.*, Cavanaugh & Burke, *supra* note 4, at 9-10 (describing how an Adirondacks-based MPAI required payers to pay providers a monthly care management fee, but several payers had claims processing systems that were unable to generate this monthly fee).

[137] *See generally* Anglin et al., *supra* note 45 at 606 ("[D]ifferences in covered populations might lead to a divergence of interests and impediments to collaboration."); *see also* ASPE Report, *supra* note 88, at 120 (noting that some state Medicaid programs cite differences in their beneficiary populations as a challenge to their participating in MPAIs).

[138] Telephone Interview with David Muhlestein, Chief Rsch. and Innovation Officer, Health Mgmt. Associates (Nov. 01, 2022) (notes on file with author); *see generally* Anglin et al., *supra* note 45, at 605 (explaining that the characteristics and needs of Medicare patients differ from those of commercial payers focused on working-age populations and Medicaid managed care plans focused on low-income and pediatric populations).

and Medicaid managed care plans serving healthier, working-age and pediatric populations may see little value in these approaches.[139] Moreover, because Medicare covers individuals for the remainder of their lives, it stands to reap the benefits of payment approaches that yield longer-term outcomes, whereas Medicaid and commercial payers often experience churn in enrollment and may prefer short-term gains.[140] Differences in covered benefits also can frustrate MPAI collaborations. For example, when participants in an Adirondack-based MPAI agreed to pay certain providers a monthly care management fee, this created challenges for payers whose insurance products did not include care management as a covered benefit.[141]

State and regional MPAIs face additional obstacles that can limit their success. Government agencies that convene MPAIs must dedicate significant resources to the initiative.[142] Some states, however, lack the necessary personnel, expertise, and funding, especially if they wish to sponsor multiple MPAIs across the state.[143] In addition, when regional MPAIs cover the same geographic area as national MPAIs sponsored by CMS, the MPAIs may have competing priorities and adopt different payment rules.[144] This in turn can undermine MPAI efforts to bring greater uniformity to a region's payment methodologies and tailor them to local needs and circumstances. For example, payers participating in both the CMS-led CPC initiative and regional MPAIs expressed frustration with the lack of regional alignment, leading to waning interest in continued collaboration.[145]

Finally, regional MPAI may have limited impact when the participating payers cover too small a percentage of providers' patient panels. Medicare often does not participate in state-sponsored MPAIs, which given the size of the Medicare program can significantly undermine states' efforts to align payment requirements and incentives.[146] National and multiregional health plans also may be disinclined to participate in a regional MPAI that covers a

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[139] *Id.*

[140] *See* Anglin et al., *supra* note 45, at 605 ("[S]ince Medicare generally covers these patients later in life, when serious health conditions become more prevalent, and is responsible for covering them for the remainder of their lives, it may be more interested in affecting longer-term outcomes than other insurers.").

[141] *See* Cavanaugh & Burke, *supra* note 4, at 9.

[142] *See id.* at 13 (noting that New York officials reported that serving as the convenor of an MPAI required "significant ongoing resource support").

[143] *See id.* at 13 (discussing that New York officials reported that they would have difficulty convening multiple MPAIs across the state at the same time without additional or redirected resources).

[144] Cavanaugh & Burke, *supra* note 4, at 6.

[145] *See* Anglin et al., *supra* note 45, at 618, 622 (discussing how competing initiatives and priorities across CPC and regional MPAIs frustrated payers).

[146] *See generally* Kissam, *supra* note 50, at 531 (stating that Medicare's lack of participation in regional MPAIs contributes to challenges in multipayer alignment).

small share of their overall business.[147] A reluctance to participate in MPAIs on the part of self-insured employers, representing almost two-thirds of insured workers,[148] similarly diminishes a regional MPAI's impact.[149]

Given the obstacles to successful collaboration across payers, the U.S. multi-payer system is unlikely to achieve broad-scale payment alignment. Unfortunately, then, payers' efforts to prod providers to more effective patient care models through APMs will continue to face a healthcare delivery system resistant to change. But is there another way for the U.S. to realize its goal of fundamentally transforming patient care practices? Part IV answers this question in the affirmative and explains how a single-payer healthcare system can achieve this aim.

IV. ALIGNING PAYMENT RULES AND INCENTIVES THROUGH SINGLE-PAYER

The debate over the merits of single-payer healthcare systems has primarily focused on healthcare access, costs, quality, and equity concerns, as well as patient autonomy and political considerations.[150] Largely overlooked, however, is whether APMs under a single-payer system would encourage providers to improve the delivery of patient care. This Part argues

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[147] *See* Stremikis, *supra* note 1, at 4; Takach, *supra* note 81, at 666.

[148] *See* Kaiser Family Foundation, *2022 Employer Health Benefits Survey* (Oct. 27, 2022), https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding.

[149] Stremikis, *supra* note 1, at 4 (discussing the lack of participation in MPAIs by self-insured employers). Many self-insured employers are hesitant to participate in MPAIs given their confusion or lack of knowledge about them and the absence of clear evidence that MPAIs will generate a return on investment for the employer. *See* Anglin et al., *supra* note 45, at 607; Stremikis, *supra* note 1, at 6-7 (citing employer's confusion about or unfamiliarity with MPAIs as reasons for their lack of participation in MPAIs). In addition, states cannot mandate that self-insured employers participate in MPAIs, as any such mandate would be pre-empted by ERISA. *Cf.* CTR. FOR HEALTH CARE STRATEGIES, *supra* note 116 at 3, 8 (discussing a limitation of state initiatives that relied on legislation to secure payers' participation in primary care MPAIs was that state legislation cannot reach self-insured employers due to ERISA preemption).

[150] *See, e.g.,* Ben King et al., *The American Public Health Association Endorses Single-Payer Health System Reform*, 60 MEDICAL CARE 397 (2022) (endorsing a single-payer healthcare system); Adam Oliver, *The Single-Payer Option: A Reconsideration*, 34 J. OF HEALTH POL., POL'Y & L. 509 (2009) (evaluating arguments for and against single-payer); Victor R. Fuchs, *Is Single Payer the Answer for the US Healthcare System?*, 319 JAMA 15 (2018) (examining whether single-payer would better address the uninsured, poor health outcomes, and high costs); Jonathan Oberlander, *The Virtues and Vices of Single-Payer Health Care*, 37 NEW ENG. J. MED. 1401 (2016) (considering the pros and cons of single-payer health care); Linda J. Blumberg & John Holahan, *The Pros and Cons of Single-Payer Health Plans* (2019), https://www.urban.org/sites/default/files/publication/99918/pros_and_cons_of_a_single-payer_plan.pdf.

that a single-payer system would indeed drive providers to more effective patient care models by minimizing the obstacles to change that plague our multi-payer system. It begins with a brief description of single-payer healthcare systems.

A. Direct Public Financing of Health Care

The term "single-payer" has been used broadly to describe a range of government-financed healthcare systems, including healthcare systems with a single government health insurer, systems where the government both finances and delivers care through government-owned facilities, and even systems where citizens receiving government subsidies choose among multiple, highly regulated insurance plans.[151] As used in this Article, single-payer narrowly refers to healthcare system with a government insurance plan that covers the entire population and reimburses providers directly for covered health services. The government insurance plan could be a single national plan operated by the federal government or a regional plan operated by a state or regional entity.[152] In this scheme, private insurance would be prohibited in order to ensure that individual providers are paid solely by a single payer, thereby ensuring uniform payment rules and processes across a provider's patient panel.[153] The delivery of health care services, though,

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[151] There is no consensus on the definition of the term "single-payer." *See* Scott L. Greer et al., *Lessons for the United States From Single-Payer Systems*, 109 AM. J. PUB. HEALTH 1493, 1493 (2019) (noting that there is confusion over what is and what is not a single-payer system); Jodi L. Liu & Robert H. Brook, *What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.*, 32 J. GEN. INTERN MED. 822, 822-23 (2017) ("[T]here is no consensus on the definition of single-payer. . . . [and] the term is used with different meanings."). Sometimes the term refers to a healthcare system where the government alone acts as the payer of covered services (e.g., Canada, Taiwan), but other times the term includes healthcare systems that permit citizens to choose among highly regulated private insurance plans (e.g., Germany, the Netherlands, and Switzerland) or substitute private insurance for the government plan. *See* Liu, *supra* note 150 (discussing the uses of the term "single-payer"); Greer, *supra* note 150. The term also is sometimes used to include healthcare systems where the government not only finances health care, but also owns the healthcare delivery system and employs health care professionals (e.g., the United Kingdom's National Health Service (NHS)). *See* Oberlander, *supra* note 150, at 1401.

[152] For example, Canadian citizens receive coverage from government plans operated by each province/territory. *See* Liu, *supra* note 151, at 824.

[153] *See id.* at 830 (stating that some single-payer proposals ban insurance that duplicates the coverage under the government insurance plan); Liz Seegert, *What Single-Payer Healthcare Would Mean to Doctors*, MED ECON. 54, 55 (2016) (describing single-payer as consisting of government-designed and run insurance plan that enrolls all members of the population, and that in its purest form excludes other insurers). Some single-payers systems, however, permit private insurers to offer complementary insurance that covers services not covered by the government insurance plan. *See* Liu, *supra* note 151, at 830 (explaining complementary

would remain private, with the government's responsibility limited to a financing role.[154]

Although some single-payer proposals call for specific payment methodologies,[155] the author envisions a government insurance plan with the flexibility to pay providers based on their individual capacity to assume financial risk. For example, providers lacking the experience to assume significant financial risk could be paid fee-for-service rates, with adjustments made based on their performance on selected measures. Providers ready to assume financial risk could participate in shared savings or bundled payment arrangements or elect advanced population-based payment models such as full or partial capitation. Importantly, an individual provider would be paid in the same manner across their entire patient panel. This flexibility would allow individual providers to assume greater financial risk and transition to more integrated care delivery models at a pace that fits their specific circumstances.

B. Addressing Misaligned Payment Rules and Incentives

A single-payer system would overcome the challenges under a multi-payer system that deter providers from entering APM arrangements and transforming their clinical and operational practices. Specifically, single-payer would lower the administrative burden to providers of participating in APMs, give providers consistent incentives across their entire patient panel, and support more expansive provider capacity-building activities.

Many commentators have argued that a single-payer healthcare system would reduce administrative costs and complexity for providers.[156] Less appreciated, however, is that a single-payer system would minimize the administrative challenges that dissuade providers from participating in APMs or complicate their efforts to transform their practices.[157] As discussed in

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coverage); King, *supra* note 150, at 398 (explaining that Canada allows private plans to cover complementary services).

[154] *See* Seegert, *supra* note 153, at 3.

[155] *See generally* Liu, *supra* note 151, at 828 (discussing single-payer proposals and noting that some include fee-for-service, global budges, or population-based payments).

[156] *See*, *e.g.*, Oberlander, *supra* note 150, at 1402 ("Having a single-government operated insurance plan greatly reduces administrative costs and complexity."); King, *supra* note 150, at 398-99 (arguing that single-payer would lower administrative costs associated with a system with multiple different insurance companies); Fuchs, *supra* note 150, at 15 ("A single-payer system would undoubtedly lower administrative expenses.").

[157] Although some commentators acknowledge that a single-payer system would lower providers' costs of managing multiple payer contracts, to the author's knowledge, no commentators have argued that this in turn could increase providers' participation in APMs and investment in practice transformation. *See* David Scheinker et al., *Reducing*

Part II.A, when providers contract with multiple payers, they must manage disparate performance measures, reporting rules, and other payment-related requirements. Some providers lack the time, resources, and expertise to effectively do so, while for other providers the associated administrative expense outweighs the financial rewards offered by APMs. In contrast, when a provider's entire patient panel is under one payment methodology, the provider need only understand and comply with a single set of performance measures and payment rules. Single-payer thereby greatly simplifies the process of providers collecting and analyzing data and developing coherent strategies for success under the relevant payment incentives.

A single-payer system also strengthens a payment model's financial incentives. When a single reward structure applies to a provider's entire patient population, the provider receives uniform signals regarding how quality and efficiency improvements will be rewarded. A provider therefore would no longer worry that clinical and operational processes that promote success under one payment model would hurt their performance under other payment models. In addition, because they are aggregated across a provider's entire patient panel, the financial rewards under a single-payer system could be sufficiently large and predictable to justify a providers' investment in new infrastructure, staff, and operations.

A single-payer system also avoids the collective action problem that currently deters payers from broadly engaging in provider capacity-building activities. As noted above, in a single-payer system a government insurer would cover the entire patient population. Consequently, it alone would capture the cost savings generated by providers who successfully transform their practices, savings that under the current U.S. system are spread across multiple payers. Moreover, because a government insurer would cover citizens for their entire lives, it can take a long-term budgetary view, investing in provider capacity-building even if doing so takes several years to yield improved patient outcomes and savings.[158] These considerations in

Administrative Costs in US Health Care: Assessing Single Payer and Its Alternatives, 56 HEALTH SERVS. RES. 615, 617 (2021) (narrowly arguing that a single-payer system would reduce providers' costs of simultaneously administering multiple payer contracts); Seegert, *supra* note 153, at 56 ("Single payer could allow physicians to spend less time on administrative tasks and devote that time to actual patient care."); Blumberg, *supra* note 150, at 4-5 (discussing how single-payer would generate administrative savings for providers); Steffie Woolhandler & David U. Himmelstein, *Single-Payer Reform-"Medicare for All,"* 321 JAMA 2399, 2399 (2019) (stating that the current multi-payer system "entails complexity that adds no value," as providers must navigate contracting with multiple plans, and contend with numerous payment rates, restrictions, and quality metrics, among other different processes).

[158] Because it typically takes years for providers to transform their practices, there is a lag time between upfront investments in provider capacity-building activities and savings for

turn strengthen the economic case for using public funds for more expansive provider capacity-building activities.

Importantly, a single-payer system would circumvent the many challenges that undermine MPAIs' alignment efforts. Specifically, single-payer would avoid the competitive dynamics, power imbalances, protracted negotiations, and incomplete payer participation that often frustrate multi-payer collaborations. Moreover, because a government insurer would cover the entire population, single-payer avoids the problem of conflicting priorities among payers covering different subpopulations. A single government payer also can take a wholistic view of the healthcare delivery system and promote payment models that best meet our collective health care needs, including the needs of underserved populations.

Accordingly, a single-payer healthcare system would have greater success than our current multi-payer system in advancing healthcare delivery transformation on a broad scale. However, despite decades of debate over single-payer, its proponents have overlooked the benefits of eliminating the current misalignment of payment rules and incentives.[159] Commentators and policymakers should consider this important rationale for single-payer during their future health reform debates.

V. CONCLUSION

Much has been written about the merits of a single-payer healthcare system relative to a multi-payer system, which raises the question: is there anything new to say about this issue? This Article has shown that the U.S. health reform debate has indeed overlooked a fundamental argument for single-payer — a single government payer could exert greater leverage to bring about transformative change to the healthcare delivery system.

The past decade has seen Medicare, Medicaid, and commercial insurers experiment with a variety of approaches for paying healthcare providers. These alternative payment models incentivize providers to find innovative ways to improve patient outcomes while lowering healthcare costs. Yet whether in practice the new payment models ultimately improve the delivery of healthcare depends on how providers respond to them. Unfortunately, few providers have meaningfully altered how they care for patients.

A key reason for these disappointing results is the multi-payer system itself— when providers contract with a mix of payers, they face an array of conflicting, muddled payment rules and diluted incentives. This, in turn, complicated providers' practice transformation efforts. Moreover, attempts

payers. *Cf. supra* note 98 (discussing the lag time between investing in practice transformation and providers' achieving financial rewards under APMs).

[159] *See* King, *supra* note 150; *see* Scheinker et al., *supra* note 157.

to coordinate payment incentives and rules across payers face substantial obstacles and are unlikely to achieve their alignment aims.

A single-payer healthcare system can, however, succeed where a multi-payer system has failed. Specifically, a single government insurer would apply a common set of payment rules and incentives to a provider's entire patient panel. When combined with financial and technical support for under-resourced providers, this would give providers the necessary tools and motivation to reorient the U.S. healthcare delivery system toward more effective and efficient ways of caring for patients.