Streamlining CMS's portfolio of alternative payment models (APMs)

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MEDPAC

Roadmap

- Background on CMMI and APMs
- Impacts of APMs on spending and quality
- Barriers to APMs realizing larger impacts
- Unintended consequences of CMS implementing multiple concurrent APMs
- Chair's draft recommendation

Note: Center for Medicare and Medicaid Innovation (CMMI), alternative payment models (APMs).

Background on CMMI

- Established by the Affordable Care Act in 2010
- CMMI tests innovative payment and care delivery models
- Congress suggested 27 potential models in CMMI's statute
- Appropriated $10 billion every 10 years, in perpetuity
- Models typically run 3-5 years, but may be expanded if:
  - Model is expected to decrease spending without decreasing quality; or
  - Model is expected to increase quality without increasing spending

Only some of CMMI's models are APMs

	CMMI's model categories	Example model
APMs	**Accountable care**	Next Generation ACO model
APMs	**Episode-based payment initiatives**	Bundled Payments for Care Improvement (BPCI) Advanced
APMs	**Primary care transformation**	Comprehensive Primary Care Plus (CPC+)
	Initiatives to accelerate the development & testing of new models	Emergency Triage, Treat, and Transport (ET3) model (allows ambulances to bill for treatment-in-place by a telehealth provider or transport to low-acuity settings)
	Initiatives focused on Medicaid & CHIP populations	Strong Start for Mothers and Newborns initiative (enhanced prenatal & maternity care models)
	Initiatives to speed the adoption of best practices	Partnership for Patients (technical assistance to reduce hospital-acquired conditions)
	Initiatives focused on dual enrollees	Financial Alignment Initiative for Medicare-Medicaid Enrollees (new health plans and care coordination programs)

Note: accountable care organization (ACO), Children's Health Insurance Program (CHIP).

MACRA included new incentives for clinicians to adopt advanced APMs

- Created annual 5% bonus from 2019-2024 for clinicians in advanced alternative payment models (A-APMs) that:
  - Require "more than nominal" financial risk for providers
  - Use quality measures comparable to those used in MIPS
  - Require providers to use certified electronic health records
- Starting in 2026, clinicians in A-APMs will get higher annual updates to their Medicare physician fee schedule payments
  - +0.75%/year for clinicians in A-APMs
  - +0.25%/year for clinicians in MIPS

Note: Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Merit-based Incentive Payment System (MIPS).

Many models have been implemented, but few have met the criteria to be expanded

- CMMI has implemented 54 models over its 10-year history
- 4 CMMI models have met the criteria for expansion
  - 1 was an A-APM: the Pioneer ACO model
- The largest APM is the Medicare Shared Savings Program (MSSP), a permanent program not operated by CMMI
- CMS is expected to offer 13 APMs in 2021, involving 30+ tracks for providers to choose from
  - Each track uses a different payment model for providers

Our review of the literature finds few impacts of APMs on spending and quality

Model category	Gross savings?	Net savings?	Quality gains?
ACOs **(and other population-based payment models)**	Often, but small	Sometimes, but small (<1%)	Inconsistent and small improvements (e.g., fewer ED visits, more delivery of preventive services)
Episode-based payment models	Often	Rarely (2% for hip and knee replacements at hospitals mandated to participate)	Little to no impacts, but improvements seen at mandatory hospitals (e.g., fewer readmissions, complications)
Primary care transformation models	Mixed findings	Usually not measured	Inconsistent and small improvements (e.g., fewer ED visits, more delivery of preventive services)

Note: emergency department (ED).

Could APMs have other positive impacts?

- Evidence is limited, but some observers theorize:
  - Positive spillover effects on a provider's non-APM patients
  - Lower health care spending in Medicare Advantage (because MA payments are tied to FFS spending)
  - Raising clinicians' awareness of the need to:
    - think about costs
    - change care patterns
  - Lower national health care spending (because of more widespread pursuit of APMs)

Potential barriers to APMs achieving greater improvement in spending and quality

- Providers in APMs may continue to have incentives to maximize utilization
- Models' incentives can be hard for providers to understand
- Clinicians' compensation arrangements may shield them from models' incentives
- Voluntary models likely subject to selection bias
- Infrastructure improvements can be seen as too costly
- Beneficiaries' incentives may not align with models' goals

Unintended consequences of operating multiple concurrent APMs

- Providers participating in multiple APMs can dilute each model's incentives
  - Each model may present providers with differing financial incentives and operational requirements
  - Performance payments from one model may increase total spending in another model, making it more difficult to achieve savings relative to a spending target

Unintended consequences of operating multiple concurrent APMs (cont'd.)

- Beneficiaries attributed to multiple APMs can weaken incentives
  - Spending for beneficiaries aligned to multiple APMs may be attributed to only one of the models or split in unanticipated ways between several models
- Contaminated comparison groups may reduce likelihood of isolating impact of each model
  - Can be difficult to accurately assess impact of a given APM on spending and quality if providers are in multiple models or if comparison group is participating in other similar models