Advising the Congress on Medicare issues

The evolution of Medicare's advanced alternative payment models

Geoff Gerhardt and Rachel Burton

October 2, 2020

MEDPAC

Roadmap

- Background on advanced alternative payment models (A-APMs)
- Overview of current and forthcoming A-APMs
  - Population-based payment models
  - Episode-based payment models
  - Advanced primary care models
- Potential improvements to A-APMs

Background on advanced alternative payment models (A-APMs)

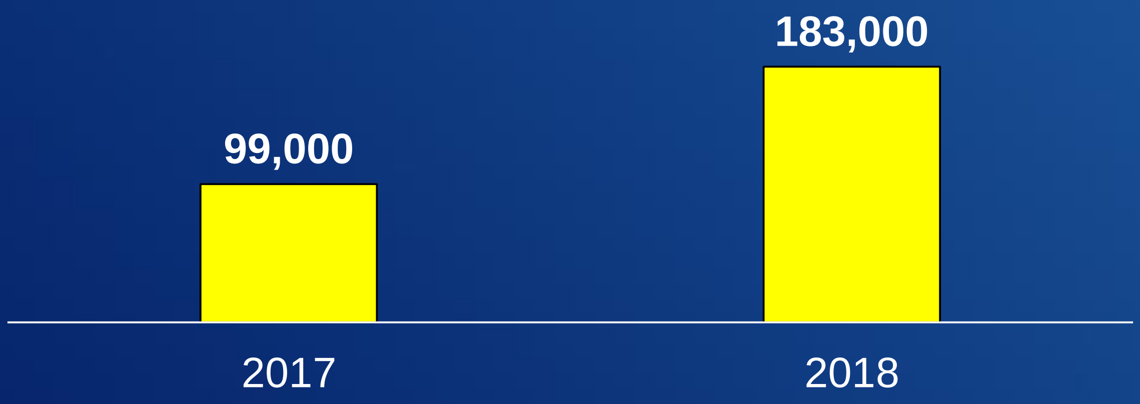
Affordable Care Act of 2010

- Created permanent accountable care organization (ACO) program: the Medicare Shared Savings Program
- Created the Center for Medicare and Medicaid Innovation (CMMI) within CMS to test additional APMs
  - CMMI receives $10 billion in funding every 10 years
  - Models that reduce spending without decreasing quality or improve quality without increasing spending can be expanded in scope and duration

APM (alternative payment model).

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Created 5% bonuses for clinicians who participate in *advanced* APMs (A-APMs)
  - Waives MIPS reporting for these clinicians
- The number of clinicians qualifying for the A-APM bonus has doubled in the first two years of its availability



Source: CMS's publicly reported information on Quality Payment Program participation.
Data are preliminary and subject to change. APM (alternative payment model), MIPS (Merit-based Incentive Payment System).

Overview of current and forthcoming A-APMs

Three main types of advanced alternative payment models

Population-based payment models

Episode-based payment models

Advanced primary care models

MEDPAC

Overview of A-APM evaluation findings

- Quality has generally been maintained and some measures have improved
- Utilization patterns were detected in some models
  - e.g., reductions in ED use, hospitalizations, institutional PAC
- Some models had reductions in per-beneficiary Medicare spending, before performance payments were factored in
- Once performance payments were included, no net savings for Medicare in most models

ED (emergency department), PAC (post-acute care).

Population-based payment models

Model name	Performance period	Participating providers	Summary
Medicare Shared Savings Program (MSSP)	2012 – Present	462,902 clinicians, 1,431 hospitals, 4,422 other types of providers	Groups of providers can receive a share of their savings (or owe a share of their cost overruns) if assigned beneficiaries' spending is below (or over) their benchmark; quality results adjust the size of these bonuses (or penalties)
Comprehensive ESRD Care	2015 – 2021	685 dialysis facilities	Dialysis facilities and nephrologists can form ACO-style organizations for ESRD beneficiaries on dialysis
Next Generation ACO	2016 – 2021	28,215 clinicians	Two-sided model offers ACOs up to 100% shared savings (and losses)
Vermont All-Payer ACO	2017 – 2022	6 hospitals, 2 critical access hospitals, 1 federally qualified health center	Multi-payer version of Next Generation model available in Vermont

MEDPAC

ACO (accountable care organization), ESRD (end-stage renal disease).

Changes to Medicare Shared Savings Program

- 2018 “Pathways to Success” redesign to MSSP
- Requires that ACOs take on more risk more quickly
- Longer 5-year contracts
- Can choose between retrospective and prospective beneficiary assignment each year
- Changes to benchmarks
  - Based on a blend of ACO’s prior spending and regional spending
  - Risk scores can increase benchmarks by 3 percent

MEDPAC

MSSP (Medicare Shared Savings Program), ACO (accountable care organization).

Population-based payment models – *forthcoming*

Model name	Performance period	Participating providers	Summary
Direct Contracting	2021 – 2025	TBD	Two-sided model with differing levels of prospective capitated payments and either 50% or 100% shared savings/losses
Comprehensive Kidney Care Contracting	2021 – 2023	TBD	Based on Direct Contracting model, entities will receive 50% or 100% shared savings/losses for beneficiaries with chronic kidney disease

Episode-based payment models

Model name	Performance period	Participating providers	Summary
Comprehensive Care for Joint Replacement	2016 – 2020	472 hospitals	90-day retrospective episodes triggered by inpatient hip and knee replacement surgery
Oncology Care Model	2016 – 2021	175 oncology practices	Six-month retrospective episodes triggered by chemotherapy treatment
Bundled Payment for Care Improvement (BPCI) Advanced	2018 – 2023	1,295 physician group practices and hospitals	90-day retrospective episodes triggered by 31 inpatient stays and outpatient procedures
Radiation Oncology model *forthcoming*	2021 – 2025	TBD	90-day prospective episodes triggered by radiation therapy treatment

Changes to episode-based payment models

- Most models use retrospective reconciliation, but new Radiation Oncology model will use prospective payments
- Despite some attempts at mandatory models, most are voluntary
- Expansion from hospital-centric episodes to include more outpatient episodes
- Target prices now include more provider-specific factors

Advanced primary care models

Model name	Performance period	Participating providers	Summary
Comprehensive Primary Care Plus (CPC+)	2017 – 2022	2,683 primary care practices in 14 states and 5 cities	Supplemental PBPM care management fees, with an option to convert some FFS payments to capitated payments
Primary Care First – General *forthcoming*	2021 – 2026	Up to 3,000 practices (in CPC+ regions plus 8 additional states)	Higher care management fees PBPM, lower FFS payment rates, larger performance bonuses
Primary Care First – Seriously Ill Population *forthcoming*			Larger payments PBPM than Primary Care First's General option, to temporarily stabilize seriously ill patients who lack a PCP
Kidney Care First *forthcoming*	2021 – 2023 (or possibly until 2025)	Practices and their nephrologists	Nephrology practices paid performance-based capitated payments for managing beneficiaries with chronic kidney disease

PBPM (per beneficiary per month), FFS (fee-for-service), PCP (primary care provider).

Changes to advanced primary care models

- Larger performance bonuses, tied mainly to one measure
- Larger payments per beneficiary per month
- Lower fee-for-service payment rates for model participants
- Increasing geographic reach of models
- Launching model tailored to beneficiaries with chronic kidney disease

Potential improvements to A-APMs

Strengthen incentives for providers and more actively engage beneficiaries

- Strengthen financial incentives
  - Increase shared savings/loss percentages
  - Set benchmarks lower, or have them grow more slowly
  - Limit degree to which risk score increases can raise benchmarks
  - Increase episode target prices’ discounts and withholds
- Make greater use of *mandatory* participation in models
- More actively engage beneficiaries in choosing providers
  - Give beneficiaries information on high-value providers

Improve the evaluability of models

- Test fewer models that include more providers
- Randomly assign providers to treatment and control groups
- Test models over longer periods of time
- Freeze models' features during testing, instead of making annual adjustments

Test new types of models

- Develop models focused on managing specific high-cost conditions (e.g., COPD)
- Offer simplified APMs to independent practices
- Test utilization management tools more widely (e.g., prior authorization, preferred provider networks)

COPD (chronic obstructive pulmonary disease).

Discussion

- Fewer models?
- Prioritize or deprioritize certain types of models?
- Change or expand specific features of models?
- Randomize providers into treatment and control groups?
- Lengthen models' testing periods, with fewer changes mid-way through the testing period?
- Make greater use of mandatory participation in models?
- Develop models focused on managing high-cost conditions?