Advising the Congress on Medicare issues

CMMI's development and implementation of alternative payment models

Rachel Burton & Geoff Gerhardt

January 14, 2021

MEDPAC

Roadmap

- CMMI's authority to develop and implement models
- Goals and factors CMMI considers when selecting models
- Impacts of alternative payment models on spending and quality
- Barriers to models' success
- Three policy options re: how CMMI manages its portfolio
- Discussion

MEDPAC

Note: Center for Medicare and Medicaid Innovation (CMMI).

CMMI’s authority to develop and implement models

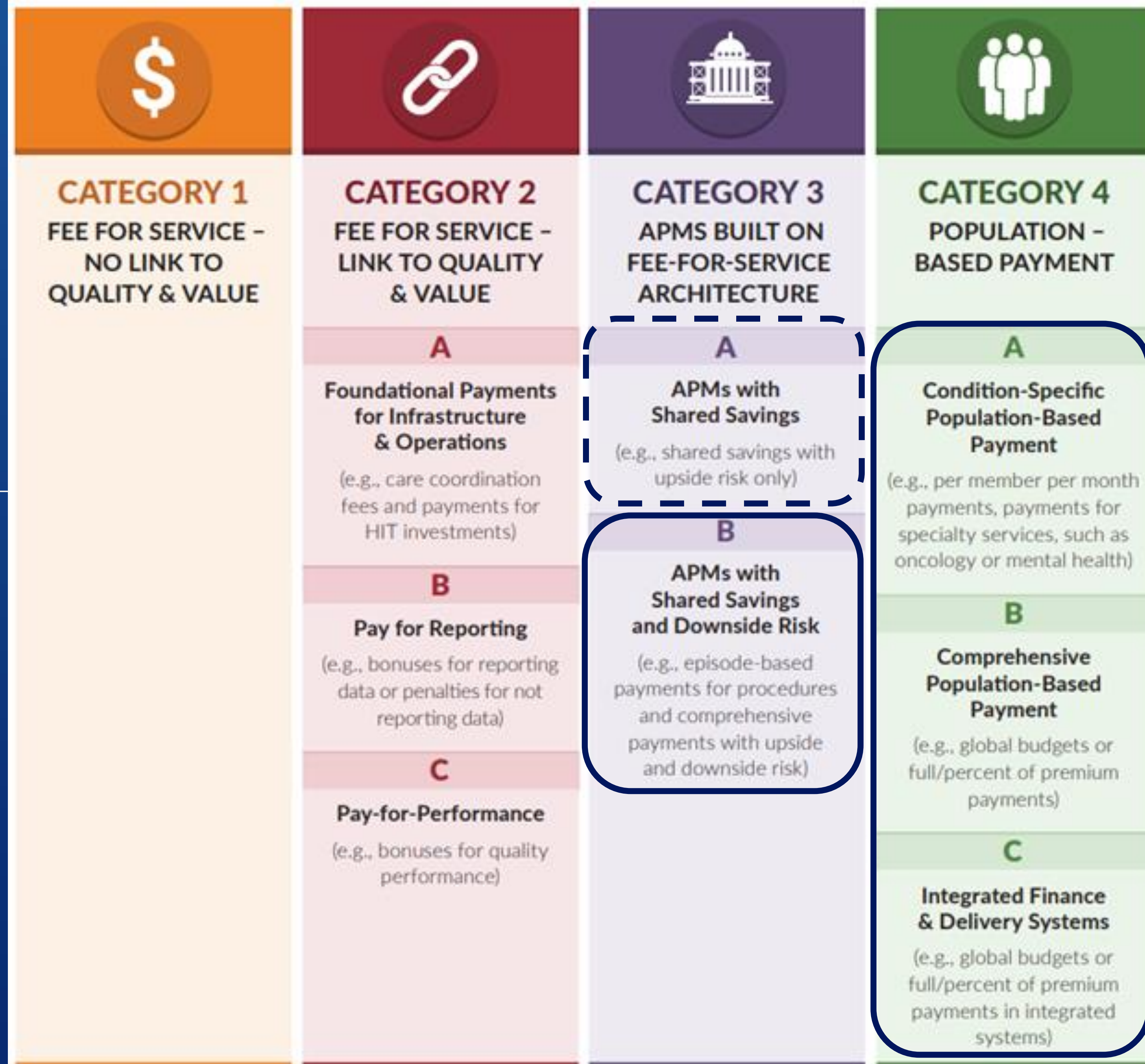
- Established by the Affordable Care Act of 2010
- Statutory goal: test innovative payment and delivery models that will reduce program spending and/or improve quality
- Congress suggested 27 potential models in CMMI’s statute
- Appropriated $10 billion every 10 years, in perpetuity
- Models typically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

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

- Created annual 5% bonus 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 the Merit-based Incentive Payment System (MIPS)
  - Require providers to use certified electronic health records
- Created the Physician-Focused Payment Model Technical Advisory Committee (PTAC)
  - Assesses models submitted by the public, recommends whether to implement them, but CMMI not bound by these recommendations

HHS has endorsed particular types of payment models through CMMI's LAN

- CMMI funds the Health Care Payment Learning & Action Network (the LAN), to encourage broad adoption of alternative payment models
- The LAN annually measures payers' adoption of its (HHS's) preferred payment models (circled)



Source: The LAN's APM framework.

HHS has three stated objectives for CMMI’s alternative payment models

- **Transparent** – empower consumers to drive value through choice
- **Simple** – focus on measuring factors that matter rather than “check the box” requirements
- **Accountable** – encourage risk and accountability to align incentives and drive behavior change

Note: Department of Health and Human Services (HHS).
Source: CMS. PTAC value considerations for model development and testing fact sheet. https://innovation.cms.gov/files/fact-sheet/ptac-value-fs.pdf.

Factors CMMI considers when selecting a model

- Potential for cost savings and quality improvement
- Strength of evidence base
- Extent of clinical transformation
- Overlap with current and anticipated models
- Operational feasibility for participants and CMS
- Evaluative feasibility
- Scalability

Note: * Light blue indicates factors CMMI would not expect stakeholders to describe in proposed models.
Source: CMMI's Alternative Payment Model Design Toolkit. https://aspe.hhs.gov/system/files/pdf/234386/CMMIAPMToolkit.pdf

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

- In 2020, CMMI was actively operating 24 payment and delivery models
  - Seven of these models were designated as A-APMs
- Four CMMI models have met the criteria for expansion
  - Only one A-APM has met the criteria: the Pioneer ACO model, which served as a model for one of the tracks in the Medicare Shared Savings Program (MSSP)
- The largest A-APM (MSSP) is a permanent program, not operated by CMMI

Note: Our count of "models" does not include CMMI efforts like the Health Care Innovation Awards, the Artificial Intelligence Health Outcomes Challenge, the Transforming Clinical Practice Initiative, and the Health Care Payment Learning and Action Network. In addition to the seven A-APMs noted on this slide, state-specific versions of some of these models have been designated as A-APMs in Maryland and Vermont.

Summary of model evaluation findings

- Reviewed evaluation reports for the 7 A-APMs and their predecessor models (totaling 15 models)
- 9 of these models generated gross savings for Medicare
  - 5 also generated net savings, after factoring in models' new payments to providers
- 7 models generated improvements on quality measures

Note: Advanced alternative payment model (A-APM)
Source: MedPAC analysis of data in the most recent report by CMMI-funded evaluators for each of the above models, plus analyses by J. Michael McWilliams of MSSP in various peer-reviewed journals and their blogs.

Potential barriers to APMs achieving greater improvement in spending and quality

- Providers in alternative payment models may continue to have incentives to maximize utilization
- Models’ incentives can be hard for providers to understand
- Clinicians’ employment arrangements may shield them from models’ incentives
- Lack of alignment and integration between models
- Voluntary models may be subject to selection bias
- Beneficiaries’ incentives may not align with models’ goals

Policy options related to portfolio of CMMI models

❶ Implement a smaller suite of coordinated models designed to support a clear set of strategic goals

❷ Only develop second-generation models when specified criteria demonstrating promise have been met

❸ Reduce or eliminate changes to models' features once they are in the field

❶ Implement a smaller suite of coordinated models designed to support a clear set of strategic goals

✓ Pros:

- Would encourage CMMI to create a system of models that actively support one another, instead of separate one-off models
- Could reduce unintended interactions between models

✗ Cons:

- Would decrease the diversity of models being tested (which could decrease the chances of finding one that works)
- Could constrain CMMI's ability to develop models tailored to subgroups of providers and beneficiaries

❷ Only develop second-generation models when specified criteria demonstrating promise have been met

✓ Pros

- Would make CMMI's decisions about model relaunches more transparent and objective
- Would discourage CMMI from relaunching versions of models that have consistently failed to meet performance criteria

✗ Cons

- Could create incentive for CMMI to focus on models that will meet continuation criteria and divert attention away from statutory criteria for expansion
- Might not provide CMMI with sufficient time or flexibility to fully test potentially promising approaches

❸ Reduce or eliminate changes to models' features once they are in the field

A) Completely freeze models' features once they are in the field

B) Only make minor technical fixes to models once they are in the field

C) Launch updated versions of models in subsequent provider cohorts

MEDPAC

❸ Reduce or eliminate changes to models' features once they are in the field

✓ Pros

- Would reduce provider administrative burden involved in keeping track of changes to models and adjusting plans accordingly
- Could encourage providers to make investments in care transformation infrastructure

✗ Cons

- More providers might exit models if flaws discovered during implementation are not fixed
- Might increase spending or other negative effects if problems with models cannot be addressed

Discussion

- Seeking input on policy options:

❶ Implement a smaller suite of coordinated models designed to support a clear set of strategic goals

❷ Only develop second-generation models when specified criteria demonstrating promise have been met

❸ Reduce or eliminate changes to models’ features once they are in the field

- Any policy options commissioners would like to pursue will be presented for further consideration this spring