



*Advising the Congress on Medicare issues*

# The evolution of Medicare's advanced alternative payment models

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# Roadmap

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- 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

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- 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

# Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

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- 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



# Overview of current and forthcoming A-APMs

# Three main types of advanced alternative payment models

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**Population-based payment models**

**Episode-based payment models**

**Advanced primary care models**

# Overview of A-APM evaluation findings

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- 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



# 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

# 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

# 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 <i>forthcoming</i>	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 <i>forthcoming</i>		Up to 3,000 practices	Higher care management fees PBPM, lower FFS payment rates, larger performance bonuses
Primary Care First – Seriously Ill Population <i>forthcoming</i>	2021 – 2026	(in CPC+ regions plus 8 additional states)	Larger payments PBPM than Primary Care First’s General option, to temporarily stabilize seriously ill patients who lack a PCP
Kidney Care First <i>forthcoming</i>	2021 – 2023 (or possibly until 2025)	Practices and their nephrologists	Nephrology practices paid performance-based capitated payments for managing beneficiaries with chronic kidney disease

# 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

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- 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

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- 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

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- 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)

# Discussion

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- 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?