The evolution of Medicare’s advanced alternative payment models

Geoff Gerhardt and Rachel Burton
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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
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
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
### Population-based payment models

<table>
<thead>
<tr>
<th>Model name</th>
<th>Performance period</th>
<th>Participating providers</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Shared Savings Program (MSSP)</td>
<td>2012 – Present</td>
<td>462,902 clinicians, 1,431 hospitals, 4,422 other types of providers</td>
<td>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)</td>
</tr>
<tr>
<td>Comprehensive ESRD Care</td>
<td>2015 – 2021</td>
<td>685 dialysis facilities</td>
<td>Dialysis facilities and nephrologists can form ACO-style organizations for ESRD beneficiaries on dialysis</td>
</tr>
<tr>
<td>Next Generation ACO</td>
<td>2016 – 2021</td>
<td>28,215 clinicians</td>
<td>Two-sided model offers ACOs up to 100% shared savings (and losses)</td>
</tr>
<tr>
<td>Vermont All-Payer ACO</td>
<td>2017 – 2022</td>
<td>6 hospitals, 2 critical access hospitals, 1 federally qualified health center</td>
<td>Multi-payer version of Next Generation model available in Vermont</td>
</tr>
</tbody>
</table>

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
### Population-based payment models – *forthcoming*

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<tr>
<td>Direct Contracting</td>
<td>2021 – 2025</td>
<td>TBD</td>
<td>Two-sided model with differing levels of prospective capitated payments and either 50% or 100% shared savings/losses</td>
</tr>
<tr>
<td>Comprehensive Kidney Care Contracting</td>
<td>2021 – 2023</td>
<td>TBD</td>
<td>Based on Direct Contracting model, entities will receive 50% or 100% shared savings/losses for beneficiaries with chronic kidney disease</td>
</tr>
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<tr>
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</tr>
<tr>
<td>Comprehensive Care for Joint Replacement</td>
<td>2016 – 2020</td>
<td>472 hospitals</td>
<td>90-day retrospective episodes triggered by inpatient hip and knee replacement surgery</td>
</tr>
<tr>
<td>Oncology Care Model</td>
<td>2016 – 2021</td>
<td>175 oncology practices</td>
<td>Six-month retrospective episodes triggered by chemotherapy treatment</td>
</tr>
<tr>
<td>Bundled Payment for Care Improvement (BPCI) Advanced</td>
<td>2018 – 2023</td>
<td>1,295 physician group practices and hospitals</td>
<td>90-day retrospective episodes triggered by 31 inpatient stays and outpatient procedures</td>
</tr>
<tr>
<td>Radiation Oncology model</td>
<td>2021 – 2025</td>
<td>TBD</td>
<td>90-day prospective episodes triggered by radiation therapy treatment</td>
</tr>
</tbody>
</table>
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

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