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

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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

<table>
<thead>
<tr>
<th>CMMI’s model categories</th>
<th>Example model</th>
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<tbody>
<tr>
<td>Accountable care</td>
<td>Next Generation ACO model</td>
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<tr>
<td>Episode-based payment initiatives</td>
<td>Bundled Payments for Care Improvement (BPCI) Advanced</td>
</tr>
<tr>
<td>Primary care transformation</td>
<td>Comprehensive Primary Care Plus (CPC+)</td>
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<td>Initiatives to accelerate the development &amp; testing</td>
<td>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)</td>
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<tr>
<td>of new models</td>
<td></td>
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<td>Initiatives focused on Medicaid &amp; CHIP populations</td>
<td>Strong Start for Mothers and Newborns initiative (enhanced prenatal &amp; maternity care models)</td>
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<td>Initiatives to speed the adoption of best practices</td>
<td>Partnership for Patients (technical assistance to reduce hospital-acquired conditions)</td>
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<td>Initiatives focused on dual enrollees</td>
<td>Financial Alignment Initiative for Medicare-Medicaid Enrollees (new health plans and care coordination programs)</td>
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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

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

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