Exploring features of Medicare's alternative payment models

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Roadmap for today's presentation

- Recap of June 2021 report recommendation
- Review four key features of Medicare APMs
- Questions for commissioners to consider

Note: Alternative payment models (APMs).

The Commission’s June 2021 report on APMs

- Identified several concerns with implementing many Medicare APMs concurrently
  - Providers participating in multiple models
  - Beneficiaries aligned to multiple models
  - Difficulty evaluating impact of models due to overlap
- Recommended that CMS implement a smaller number of APMs that are designed to work together

Exploring four features of APMs

- Are there opportunities to make model features more consistent?
  - ❶ How **spending benchmarks** are set
  - ❷ How benchmarks are **risk adjusted**
  - ❸ How much **financial risk** providers face
  - ❹ How provider participation is **incentivized or mandated**

Focusing primarily on Medicare's advanced APMs

Population-based	• Medicare Shared Savings Program (MSSP) • CHART Model's ACO Transformation Track (for MSSP ACOs) • Independence at Home • Global & Professional Direct Contracting • Comprehensive Kidney Care Contracting
Episode-based	• Comprehensive Care for Joint Replacement • Bundled Payments for Care Improvement Advanced • Oncology Care Model • Radiation Oncology
Advanced primary care	• Primary Care First • Kidney Care First

Note: Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), accountable care organization (ACO), Community Health Access and Rural Transformation (CHART). Vermont and Maryland offer their own adaptations of Medicare APMs, which are not included in this analysis.

❶ APMs' spending benchmarks

- Used in population-based and episode-based payment models
- Compared to actual spending to determine if a provider will receive shared savings or owe shared losses
- Customized for each participating provider
- Represent spending that would be expected to occur if historical treatment patterns continued into the current year

How APMs' spending benchmarks differ

- Models incorporate non-participating providers' historical spending at the county, hospital referral region, state, multi-state, or national level
- Models draw historical spending from either a fixed or a rolling baseline period
- Models trend forward historical spending to the current year using spending growth trends at the county, state, multi-state and/or national levels

Questions about benchmarks

- Should there be more consistency in:
  - The geographic area used to identify non-participating provider historical spending that is incorporated into a benchmark?
  - The baseline periods (fixed vs. rolling) used to identify historical spending?
  - The geographic area used to identify spending growth trend factors?

❷ APMs’ risk adjustment

- Spending benchmarks are risk-adjusted to reflect the expected spending of the patients attributed to each provider
- Models use variations on CMS’s HCC risk adjustment model, but they don’t always list all variables used
- Beneficiaries’ risk scores are primarily based on the diagnoses in their claims data
  - ↑ diagnoses = ↑ risk score = ↑ benchmark = ↑ shared savings

Note: Hierarchical condition categories (HCC).

How APMs' risk adjustment differs

- To minimize the effects of coding-induced risk score growth, APMs use a variety of approaches
  - e.g., limiting risk score growth over time, using only a beneficiary's main diagnoses, using broad risk tiers
- APMs use current-year or prior-year data
  - For niche patient populations with unpredictable spending: benchmarks are adjusted at the end of the year, using current-year data
  - For broad patient populations or patients with predictable spending: benchmarks are adjusted at the start of the year, using prior-year data

Questions about risk adjustment

- Should models continue to vary in:
  - The approaches used to minimize the effects of coding-induced risk score growth?
  - The use of current-year vs. prior-year data for risk adjustment (depending on whether accuracy or predictability is more important)?

❸ APMs’ financial risk arrangements

- Designed to give providers incentives to reduce spending and improve quality
- Vary across several dimensions:
  - Minimum savings & loss thresholds
  - Shared savings & loss rates
  - Limits on shared savings & losses
- In voluntary models, Medicare must balance financial risk with provider participation

How financial risk arrangements differ

- One-sided and two-sided risk
- Size of potential savings and losses varies across different models and tracks
  - Medicare has been trying to get providers to participate in two-sided models with higher levels of financial risk
- In some models, financial risk can vary depending on provider characteristics such as number of aligned beneficiaries or revenue

Questions about financial risk arrangements

- Should financial risk arrangements be made more consistent across models?
- Under what circumstances should providers participate in one-sided models and for how long?
- Should the size of financial risk be made larger to increase incentives to transform care?
- Should financial risk be tailored to provider characteristics (e.g., size, revenue, patient mix)?

❹ Incentivizing or mandating provider participation

- Robust participation is needed to minimize effects caused by random variation and ensure that models are scalable
- Medicare can induce participation by:
  - Setting attractive financial risk terms
  - Mandating provider participation
- MACRA provides 5% A-APM participation bonus through 2024 and differential updates starting in 2026

Note: Medicare Access & CHIP Reauthorization Act of 2015 (MACRA). Advanced alternative payment model (A-APM).

How APM provider participation policies differ

- Provider participation is voluntary in most models
  - Providers participate for different reasons
  - Can lead to problems with selection bias
- A few models have been mandatory
  - Used under certain circumstances
  - Stakeholder opposition is common
    - Critics claim that mandating two-sided risk could negatively affect beneficiary access

Questions about provider participation policies

- Should MACRA policies providing bonuses and higher payment updates to providers that participate in A-APMs be modified?
- Should traditional FFS be made less attractive for providers who do not participate in an APM?
- Should the amount of financial risk in APMs be used to incentivize participation in voluntary models?
- Should more models be mandatory? Under what circumstances?

Discussion

- Develop recommendations on any of the four model features?
- Other APM features commissioners would like to explore?
- Develop recommendations about how to reduce the number of APMs?
- Develop recommendations about model overlap rules?