Advising the Congress on Medicare issues

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

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April 1, 2021

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Roadmap

- Background on CMS's alternative payment models
- The promise of Medicare alternative payment models
- Unintended consequences of model overlap
- Draft recommendation
- Implications of recommendation

Background on CMS's alternative payment models

- CMS tests alternative payment models (APMs) through CMMI
  - CMMI was established in the Affordable Care Act (ACA) in 2010
  - CMMI was given broad flexibility and resources to test payment and care delivery models
  - Models that save money or improve quality can be expanded and made permanent administratively
- CMS also operates a permanent, nationwide APM (also created by the ACA): the Medicare Shared Savings Program (MSSP)
- MACRA created incentives for clinicians to participate in APMs
- In 2021, CMS will operate 12 APMs with a total of 25 tracks

Note: Center for Medicare and Medicaid Innovation (CMMI); Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).

The promise of Medicare APMs

- Observers have theorized that APMs may:
  - Motivate providers to furnish care more efficiently and improve patients' health outcomes
  - Cause positive spillover effects on a provider's non-APM patients
  - Lower health care spending in Medicare Advantage (MA) (because MA payments are tied to FFS spending)
  - Lower national health care spending (because of payers' and providers' widespread pursuit of APMs)

Note: fee-for-service (FFS).

CMMI should adjust its approach to testing APMs

- It made sense for CMMI to test many models in its first decade, to build up the evidence base on APMs
- Of the 54 models tested, only 4 have met the criteria to be expanded into permanent, nationwide programs
- Evaluations of models often find promising impacts (e.g., gross savings before model payments are included), but APMs aren't reaching their full potential

Models' incentives can be diluted when clinicians participate in multiple APMs concurrently

- A substantial share of clinicians are in multiple APMs
  - 580,000 clinicians participated in APMs in 2019
  - 20% of these clinicians were in multiple APMs, or multiple tracks of an APM
- Clinicians in multiple APMs face different incentives for different subsets of their patients

Source: MedPAC analysis of data provided by CMS.
Note: Data are preliminary and subject to change.

Models' incentives can also be diluted when beneficiaries are attributed to multiple APMs

- The percent of beneficiaries attributed to multiple APMs is likely to be substantial
- CMS's model overlap policies can result in:
  - One model's providers receiving a bonus, and another model's providers receiving no model payments for the same beneficiary
  - Bonuses paid to providers in one model being counted as spending for another model's providers
- The number of APMs currently operating increases the likelihood of model overlap policies being triggered

The crowded APM landscape may hinder evaluators' ability to assess models' impacts

- Evaluators measure a model's impact relative to a comparison group of providers that are ideally not in any APMs
- Contaminated comparison groups may reduce evaluators' likelihood of finding impacts from models
- Reducing the number of APMs that Medicare (and other payers) operate may lessen the contamination of comparison groups