

The Failure of Current Alternative Payment Models

Despite high hopes that Alternative Payment Models (APMs) would achieve significant savings for payers and better quality care for patients, most of the APMs implemented to date have had disappointing results.

The largest APM in the nation is the Medicare Shared Savings Program (MSSP). Debates among statisticians about how much savings have been achieved by Accountable Care Organizations in the MSSP have obscured the fact that even the most optimistic analyses show net savings of only \$29 per beneficiary per year (one-quarter of one percent) during the first four years of the program (2013-16), and savings in 2017 were only slightly higher.

The poor performance of current APMs is not surprising because they do not actually change the fee-for-service payment system; they merely pay bonuses if providers can reduce spending and/or impose penalties if spending increases. However, because there are no changes in the way physicians, hospitals, and other providers are paid, they cannot deliver many kinds of high-value services that could reduce spending without harming patients. Moreover, most APMs require that individual providers reduce *total* spending on their patients, even though no individual provider can control all of the services a patient receives or all of the factors affecting the costs of those services.

The Move to Higher-Risk APMs

Unfortunately, rather than creating better APMs, the Centers for Medicare and Medicaid Services (CMS) and other payers claim that the solutions are to continue using the same approaches, but with higher levels of financial risk for providers, or to create “population-based payments” in which healthcare providers would be expected to deliver all of the services a patient needs for a fixed monthly or annual payment. CMS has already announced plans to phase out the “upside only” Medicare Shared Savings Program, and the Center for Medicare and Medicaid Innovation (CMMI) has indicated that most new APMs it tests will require high levels of financial risk.

Because of the problematic way that most APMs have been structured, many providers have been unwilling to participate. Increasing the level of risk in APMs could result in even fewer providers participating, which in turn would reduce the total savings that can be achieved. In addition, because participation in APMs has been voluntary, evaluations of the APMs will be biased if the initial participants are not representative of all providers who would ultimately participate.

Concerns about these issues have led to calls for CMS to create “mandatory” payment models.

What is a “Mandatory” Payment Model?

The term “mandatory payment model” is misleading because the intention is typically *not* to require every provider in the country to participate in a particular alternative payment model. Instead, the goal is to make participation in an APM mandatory for *some* providers in order to “test” the APM, i.e. to evaluate its effectiveness in reducing spending and/or improving quality.

In an effort to mimic a randomized controlled trial, a randomly-chosen subset of providers would be paid under the APM (whether they want to participate or not), while other providers (or a random subset of other providers) would be prohibited from participating in the APM (even if they would like to be paid under the APM). CMS is using one version of this approach in the Comprehensive Care for Joint Replacement (CJR) APM. CMS selected 196 of the 380 metropolitan statistical areas (MSAs) in the country, randomly chose 75 of those MSAs, and required all hospitals in 67 of the MSAs to participate in the CJR APM for two years. Hospitals in the rest of the country were not permitted to participate in the CJR APM. After the first two years of the program, the mandate was removed entirely in 34 of the MSAs and for small and rural hospitals in all 67, but about one-fourth of those hospitals elected to continue participating voluntarily.

The Problems with Mandatory APMs

There are a number of serious problems with the “mandatory model” approach to APM testing:

- There is no guarantee that the APM will achieve the desired results or that it will have no undesirable impacts, otherwise there would be no need to test it. APMs designed to reduce spending, particularly those involving significant financial risk, have the potential to harm patients as well as providers. It is inappropriate to require providers and their patients to participate in an APM that could be harmful before any testing or evaluation has been completed.
- Conversely, if the potential benefits of the APM are sufficiently great to justify requiring some providers to participate, it is inappropriate to prevent other providers from voluntarily participating, particularly if their patients could benefit from the type of care that could be delivered with support from the APM.
- It is well-known that there are significant differences in the health status of patients across the country and significant differences in practice patterns of providers both across and within geographic regions. Randomization only by region without randomization of providers or patients within regions would only have a limited ability to separate the effects of the APM from the influence of inter-regional and intra-regional differences in spending and quality.

- Requiring every provider in a geographic region to participate in a payment model does not preclude patients from traveling to a different region for services, either to avoid the effects of the APM in their home region or to obtain whatever benefits are expected under the APM from a provider in a participating region. For example, there is anecdotal evidence that in regions where CJR is mandatory, higher-risk patients are being forced to travel to non-participating regions in order to receive hip or knee surgery. This “cherry-picking” and “lemon-dropping” could reduce the reliability of any evaluation results.
- Because the mandate may only last until the evaluation is completed, providers who would be unwilling to participate voluntarily may also be unwilling to make the changes in care delivery necessary to achieve success while the test is underway. Consequently, the evaluation of a *temporary* mandatory test would not necessarily show what the impacts of a *permanent* mandatory program would be. Indeed, if a subset of providers did not want the APM to be universally mandated, they would have an incentive *not* to produce successful results during the demonstration.

A Better Approach: Well-Designed APMs That Attract Patients and Providers

Support for mandatory models rests heavily on three false premises. False Premise #1 is that a voluntary approach will not provide an accurate indication of the true impact of an APM. However, there is no evidence for this; in fact, the evaluations of the mandatory CJR APM and the voluntary Bundled Payments for Care Improvement (BPCI) APM found similar impacts on savings and quality for hip and knee replacement surgeries.

False Premise #2 is that when providers are unwilling to participate in an APM, the only way to overcome that is to *require* them to participate. However, there is a better alternative — *redesigning* the APM so that providers and patients will *want* to participate.

Randomized controlled trials (RCTs) for drugs, medical devices, and procedures do not *mandate* that either patients or providers participate. RCTs *recruit volunteers* based on the potential benefits of a new therapy or the opportunity to achieve similar outcomes at lower cost.

The reason providers have refused to participate in CMS APMs is the poor design of those APMs, not unwillingness to move away from fee-for-service payment. The best evidence of this is the dozens of APM proposals that physicians have submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC). Over the past two years, PTAC has recommended 14 APMs that physicians *want* to participate in. But CMS has refused to implement any of them.

Instead, CMS continues to design APMs that place providers at financial risk for aspects of spending and quality they cannot control, while failing to give providers the resources they need to improve patient outcomes and reduce Medicare spending. There is no evidence that simply increasing the financial risk in CMS APMs would result in greater savings. Moreover, transferring significant financial risk to providers can have undesirable

results, including loss of access to services for higher-need patients, higher prices due to consolidation of providers, and lower quality of care.

A Better Approach: Limited Scale Testing Followed by Phased Expansion

False Premise #3 is that a new APM must be immediately tested with a large number of providers in order to determine whether it works. Yet this is the exact opposite of the approach used for clinical trials. Large, randomized trials are Phase III, not Phase I. The drug, device, or procedure is first tested with a small number of volunteers to ensure it is safe, then it is tested with a larger group of volunteers to make a preliminary assessment of its efficacy, and only then is a large scale trial contemplated. Positive results from the initial phases encourage patients and healthcare providers to voluntarily participate in the larger-scale tests.

The mandatory APM approach is also the exact opposite of how every other industry develops new products and services. New products do not immediately jump from the design table to large-scale production. Businesses create one or more prototypes and then test them on a limited scale to identify problems and opportunities for improvement. The design is then revised before broader production begins. In addition, product designs continue to be refined and new versions of products are created whenever the benefits for consumers are expected to outweigh the costs of making the changes.

A similar “beta testing” process is needed for APMs. The more innovative the APM – i.e., the more that it differs from the current payment system – the more likely there will be a need for initial beta testing and potentially for additional rounds of refinement after the APM is implemented more widely. Positive results from the beta testing phase will encourage more patients and providers to participate in larger tests, and if results continue to be positive, they will pave the way for broad implementation. This is why PTAC has recommended beginning with limited-scale testing for most of the APMs it has favorably reviewed.

Should Successful APMs Be Mandated?

If testing of an APM is successful, it will likely be appropriate to make it permanent. However, participation can still be voluntary. Successful APMs will not achieve savings simply because they pay in a different way or because they create an “incentive” to spend less; they will achieve savings by removing specific payment-related barriers to changing care delivery that will impact specific opportunities for improvement. Both the opportunities to achieve savings and the barriers to pursuing those opportunities will differ from community to community. This means that “one size fits all” APMs will be less likely to achieve the full amount of savings that are possible nationally or to provide better care to patients in all parts of the country than a more customized approach. Mandating a single approach may lower administrative costs for Medicare and other payers, but it will also likely reduce the amount of savings even more. Multiple, voluntary APMs will allow the fastest progress toward higher quality, more affordable healthcare.