The Failure to Create Successful APMs in Medicare

There is broad consensus that the fee-for-service payment systems used by Medicare and other payers are a major reason why healthcare spending continues to grow faster than inflation without any corresponding improvement in the quality of care or patient outcomes. Pay-for-performance programs (such as the Merit-Based Incentive Payment System (MIPS) and the Hospital Value-Based Purchasing program in Medicare) not only have failed to solve the problems with fee-for-service payments, but the high administrative burdens and problematic methods of measuring quality and spending in these programs threaten to reduce access to care for vulnerable patients.

In order to address these problems, Congress created the Center for Medicare and Medicaid Innovation (CMMI) in 2010 and provided CMMI with significant funding and regulatory flexibility to develop and test Alternative Payment Models (APMs). In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress created incentives for physicians to participate in CMS APMs and specifically encouraged the creation of more physician-focused APMs.

Unfortunately, a decade after creation of CMMI and five years after passage of MACRA:

- **CMS has not created APMs for most Medicare beneficiaries or physicians.** The majority of Medicare beneficiaries and the majority of physicians are unable to participate in any Medicare APMs. There is no Primary Care-Focused APM available for most Medicare beneficiaries and their primary care providers, there are no Condition-Based APMs designed to support better ambulatory care by specialists for patients with chronic conditions, and there are no APMs designed for most patients receiving outpatient procedures.

- **CMS APMs have failed to produce significant savings or improvements in quality.** To date, most CMMI APMs have actually increased Medicare spending and have not resulted in significant improvements in the quality of care. ACOs in both the Medicare Shared Savings Program and the Next Generation ACO program have failed to achieve significant savings.

The Problems With the CMS Approach to Creating APMs

There are four basic reasons why there are so few successful Alternative Payment Models in Medicare:

- **CMMI has used only a small portion of its funding from Congress for development and implementation of Alternative Payment Models.** Over the past decade, less than half of CMMI’s total spending, and less than 15% of the funds Congress appropriated for CMMI projects, was used to develop and implement APMs in which physicians could participate under MACRA. Moreover, nearly one-third of the funds spent to develop APMs were used to create variations on ACOs, rather than to create completely different types of APMs in which specialists and small and rural physician practices could successfully participate.

- **CMS uses a slow, expensive process to design and implement APMs.** The steps that CMMI follows in choosing, designing, implementing, and evaluating APMs require 7-9 years or more to complete, and CMS has spent $75 million or more solely on model design and evaluation contracts for each one of the APMs it has developed. The cost and time involved in this process makes CMS less likely to test multiple APMs, causes unsuccessful APMs to continue operating for too long, and prevents successful APMs from being created and expanded more quickly.

- **The APMs that CMS has developed fail to solve the problems with current payment systems.** Most of the APMs created by CMS are merely pay-for-performance programs: no changes are made in current fee-for-service payments, and providers receive bonuses or penalties based on whether spending is less than CMS projections. These types of APMs have not given providers the resources or flexibility they need to deliver high-value services to patients that could reduce spending and improve quality. Moreover, these APMs can penalize providers for things they cannot control and reward them for failing to deliver services patients need. Simply increasing the amount of downside risk in APMs will not produce greater savings.

- **CMMI has refused to implement additional or different APMs.** More than 30 proposals for Alternative Payment Models have been developed by physicians, medical specialty societies, health systems, and other individuals and organizations and submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) created by Congress. PTAC has recommended that 16 of these proposals be implemented or tested, but CMS has not implemented or tested any of them and has no plans to do so.
How to Create More Successful APMs in Medicare More Quickly

Clearly, a different approach to creating APMs in Medicare is urgently needed. There are three things that CMS can and should do to accelerate the implementation of more APMs that will achieve much greater savings for the Medicare program and improve the quality of care for many more Medicare beneficiaries:

- **Design and Implement Patient-Centered Alternative Payment Models.** Rather than continuing to add more “incentives” and “risk” on top of current fee-for-service payment systems, CMS needs to take a patient-centered approach to designing APMs. A four-step process should be used for designing a Patient-Centered Alternative Payment Model:
  
  **Step 1:** Identify one or more specific opportunities for reducing spending and/or improving the quality of care for Medicare beneficiaries;
  
  **Step 2:** Identify the changes in care delivery that will reduce spending or improve quality in those opportunity areas;
  
  **Step 3:** Identify the barriers in the current payment system that prevent or impede implementing the improved approach to care delivery;
  
  **Step 4:** Design the Alternative Payment Model so that it removes the barriers in the current payment system and assures the delivery of higher-value care.

A Patient-Centered Alternative Payment Model developed through this process should have four key components:

- **Component #1** removes the barriers in the current payment system that prevent providers from delivering higher-value care.

- **Component #2** requires accountability from participating providers for reducing aspects of spending that they have the ability to control.

- **Component #3** requires accountability from participating providers for maintaining or improving aspects of care quality and outcomes they can control.

- **Component #4** defines the patients who are appropriate for the services supported by the APM and ensures they are willing to participate before services begin.

There is no single Alternative Payment Model with these characteristics that will work for all types of patients and all types of healthcare providers. Multiple APMs will be needed to successfully reduce spending.

- **Use a “bottom-up” instead of a “top-down” approach to creating APMs.** Physicians and other healthcare providers are in the best position to identify specific opportunities to reduce spending and improve quality for patients and to know what changes are needed in current payment systems to support higher-value care. CMS should encourage a greater role for healthcare providers in the development of APMs through the following actions:
  
  - **Send a clear signal that well-designed APMs developed by physicians and other stakeholders will be tested by CMS.** One obvious way to do this would be to implement at least a subset of the 16 APMs that have been recommended by the Physician-Focused Payment Model Technical Advisory Committee (PTAC) that was created by Congress.
  
  - **Provide data and technical assistance to help physicians and other stakeholders develop good APMs.** HHS should either permit PTAC to provide data and technical assistance to APM developers or create a separate mechanism for doing so.
  
  - **Work collaboratively with providers to refine the details of APMs and encourage participation.**
  
  - **Use a more efficient and effective approach for testing APMs.** Similar to the approaches used to encourage innovations in other industries, CMS should select multiple APMs for “beta testing” in order to refine the APMs and determine if they are likely to work before inviting large numbers of providers to participate and committing large amounts of money to extensive evaluations. This would enable design and testing of an APM to be completed within a 4-5 year period rather than the 7-9 years required under the current approach, and it would provide a much higher return on the investment of the funding Congress has made available.

**Two modifications to this process are needed to support successful primary care payment reform:**

- Testing of additional primary care APMs should be designed so that every Medicare beneficiary in the country has an opportunity to participate in a patient-centered primary care APM that provides adequate, flexible payments to support high-quality services.

- Because the biggest benefits of improved primary care will occur beyond the time periods typically used for evaluation, and the short-term savings for Medicare may not offset the higher payments needed to support good primary care, Congress will need to change the law so CMMI can continue primary care APMs that improve the quality of care even if they do not reduce short-term spending.