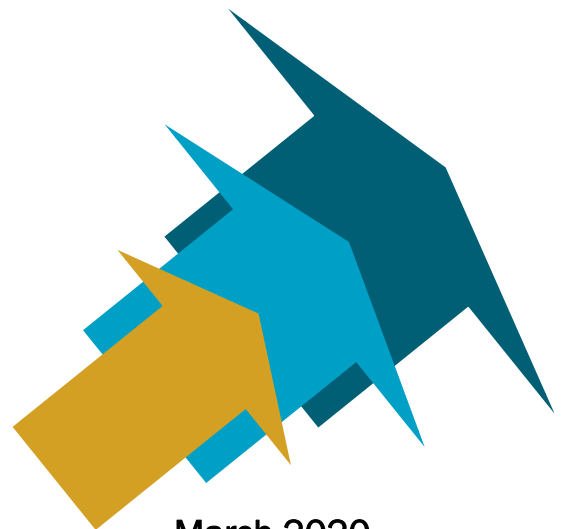


How to Create More Successful Alternative Payment Models in Medicare

*Accelerating Value-Based Payment and
Supporting Patient-Centered Care Through
More Efficient and Effective Innovation*

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HOW TO CREATE MORE SUCCESSFUL ALTERNATIVE PAYMENT MODELS IN MEDICARE EXECUTIVE SUMMARY

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 CMMI 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.

I. 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.¹

These problems led Congress to encourage the creation and use of Alternative Payment Models (APMs):

- In the Patient Protection and Affordable Care Act of 2010 (ACA), Congress created the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) and gave CMMI significant funding and regulatory flexibility to test Alternative Payment Models in Medicare.²
- Five years later, in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Congress added incentives for physicians to participate in APMs and it specifically encouraged the development of “physician-focused” APMs.³

Unfortunately, a decade after passage of the ACA and five years after passage of MACRA, CMS has failed to create APMs for most physicians, and most of the APMs it has created have failed to generate significant savings for Medicare or improvements in quality for patients.

A. CMS Has Not Created APMs For Most Medicare Beneficiaries or Physicians

As shown in Table 1, CMS has eleven active Alternative Payment Models in 2020 and it is expected to have ten APMs in operation during 2021. However, the majority of Medicare beneficiaries and their physicians and other healthcare providers are unable to participate in any of them. There are several reasons for this:

- **No Primary Care-Focused APM is available for most Medicare beneficiaries and their primary care providers.** There is virtually universal agreement that (a) strong primary care is an essential element of a high-value healthcare delivery system and (b) standard fee-for-service and pay-for-performance systems do not provide the financial support that primary care practices need. However, most of the primary care physicians and other primary care providers (PCPs) in the country are unable to participate in any of the CMS primary care-focused APMs, and there are no current plans to change that:

- ◆ **The Comprehensive Primary Care Plus (CPC+) APM is not available to PCPs in most of the country.** CPC+ is the largest primary care APM in the Medicare program, but participation is limited to primary care practices located in only 13 states and 5 metropolitan areas, and the APM has not been open to new participants even in those areas for nearly three years.⁴ The Maryland Primary Care Program, which is similar to CPC+, is only available in Maryland.⁵
- ◆ **The Primary Care First APM will not be available to PCPs in most of the country.** The newest primary care-focused APM created by CMS will not begin making payments until 2021. It will only include primary care practices in 9 more states than CPC+, so practices in the majority of states will still not be eligible. Moreover, even primary care practices in the included areas will not be able to participate if they did not apply by January 2020.⁶
- ◆ **The Independence at Home APM is not available to most primary care practices.** The Independence at Home APM has only 14 participating practices and has not been open to new practices since 2012.⁷
- **There are no Condition-Based APMs designed to support treatment and management of chronic conditions by specialists.** The majority of Medicare beneficiaries have one or more chronic conditions such as asthma, COPD, diabetes, heart disease, inflammatory bowel disease, or rheumatoid arthritis. Although most of these patients will need a specialist to treat and manage their condition in addition to primary care, CMS has not created any APMs designed to support this. (Although the Bundled Payments for Care Improvement APM includes patients with some chronic diseases, patients are only eligible if they have been hospitalized, and this conflicts with one of the principal goals of good chronic disease care, which is to *avoid* hospital admissions.⁸) As a result, physicians such as allergists, cardiologists, dermatologists, endocrinologists, gastroenterologists, neurologists, ophthalmologists, pulmonologists, rheumatologists, and urologists have little or no opportunity to participate in an APM.
- **There are no APMs designed for most patients receiving outpatient procedures.** CMS episode-based APMs have focused almost exclusively on inpatient procedures even though most procedures are performed in outpatient settings.⁹ The only exceptions are four outpatient procedures that are included in the Bundled Payments for Care Improvement - Advanced APM (back and neck procedures other than spinal fusion, cardiac defibrillator, lower joint replacements, and percutaneous coronary interventions), chemotherapy during cancer (in the Oncology Care Model), and dialysis for end-stage renal disease (in the Comprehensive ESRD Care APM). There are no APMs for the most-frequently performed procedures, such as cataract surgery, endoscopies, colonoscopies, spine and joint injections, and lesion removal. As a result, most dermatologists, gastroenterologists, cataract surgeons,

and other physicians who perform these procedures do not have any opportunity to participate in an APM.

- **Most physicians cannot participate in Accountable Care Organizations.** The largest Medicare APM is the Medicare Shared Savings Program (MSSP), but physicians can only participate in an ACO if their patients are attributed to the ACO, and in 2018, only 30% of Medicare fee-for-service beneficiaries were part of an Accountable Care Organization (ACO) in MSSP.¹⁰ An additional 4% of beneficiaries were part of the Next Generation ACO¹¹ and Vermont ACO programs, so in aggregate, only one-third of Medicare beneficiaries are part of an ACO.
- **As a result, the majority of physicians and other clinicians in the Medicare program have not been able to participate in a Medicare APM.** Because there are no APMs designed for most types of patient health conditions and procedures and because current APMs are limited either by geography or by the number or types of patients eligible to participate, fewer than half of the physicians and other clinicians who treat Medicare beneficiaries have participated in APMs to any significant extent. CMS reported that in 2018, of the 1.1 million clinicians participating in the CMS Quality Payment Program, only 16.7% (183,445) were “Qualifying APM Participants” (i.e., they participated in one of the “Advanced” APMs and had a high enough percentage of their total patients included in that APM), and only 30.5% (356,828) were part of a “MIPS APM” (i.e., they participated in an APM that was not “Advanced” or they did not have a sufficient number of patients in such an APM).¹²
- **Most healthcare providers, particularly small physician practices, cannot begin participating in the existing APMs now even if they want to.** As shown in Table 1, most CMS APMs are no longer accepting new participants. This includes some of the newest APMs CMMI created in 2019. The only APMs where CMS has committed to accept new applications in the future are the Medicare Shared Savings Program and the new ACO-like Direct Contracting APM.¹³ However, both MSSP ACOs and Direct Contracting Entities must serve a minimum of 5,000 Medicare beneficiaries, which makes it impossible for small physician practices and many rural providers to participate.

B. CMS APMs Have Failed to Produce Significant Savings or Improvements in Quality

The Affordable Care Act required that APMs created by the Center for Medicare and Medicaid Innovation (CMMI) must either (1) improve the quality of care for Medicare beneficiaries without increasing Medicare spending, (2) reduce Medicare spending without reducing the quality of care, or (3) improve the quality of care and reduce spending.¹⁴ The evaluations completed to date show that CMMI APMs have not met these requirements:

- **Most CMMI APMs have increased Medicare spending.** As shown in Table 2, the evaluations conducted to date have found that most of the APMs created by CMMI have not only failed to reduce Medicare spending, they have actually resulted in increases in Medi-

care spending. In most of the APMs, although there was a small reduction in the gross Medicare spending on services to the participating patients¹⁵, the shared savings or reconciliation payments (which are paid to the subset of participating providers that generated savings) more than offset the gross reductions in spending, so the net result was an increase in total Medicare spending. The only program that has generated a high percentage of net savings is the Independence at Home program, which was created by Congress, not CMMI, and it has only been available to a small number of physician practices, so its dollar impact has been small and uncertain.¹⁶

- **Most CMMI APMs have not resulted in significant improvements in the quality of care.** As shown in Table 2, the evaluations to date have not found any significant impacts on the quality of care. Although “no impact on quality” might be considered a positive result if the APMs had also reduced spending (since it would at least assure beneficiaries that they were not being harmed by the financial incentives in the APM), the failure to improve quality or reduce spending means that the APMs have not achieved either of the goals established by Congress.
- **No CMMI APMs have been expanded nationally.** After ten years of operation, only one CMMI project has been expanded nationally (the Medicare Diabetes Prevention Program), and this is not considered an Alternative Payment Model under CMS regulations.

In contrast to the goals established for CMMI, Congress did not establish any specific quality or spending goals for the Medicare Shared Savings Program (MSSP), nor did it require that the program be evaluated to determine whether it was effective in reducing spending or improving the quality of care. However, every year, CMS has released basic data about spending and shared savings payments in the program that are used to measure its impact on Medicare spending. In addition, CMS has tested different ACO models through CMMI, and some of these models have been evaluated. These data and evaluations show that:

- **The Medicare Shared Savings Program has failed to achieve significant savings.** As shown in Table 2, CMS data show a net increase in Medicare spending during the first four years of MSSP, and only a very small amount of savings (less than 1%) in 2017 and 2018.¹⁷ Although advocates for the program have asserted that measuring spending relative to CMS-defined benchmarks underestimates the true amount of savings, the most recent study conducted using a comparison group methodology concluded that the amount of net savings in 2017 was only half as much as the amount reported by CMS (0.16% vs. 0.33%).¹⁸
- **The Next Generation ACO program has failed to achieve significant savings.** The Next Generation ACO program developed by CMMI was supposed to be the most advanced version of the program, and participating ACOs are required to accept significant downside risk in order to participate. The most recent evaluation of the Next Generation ACO Program found that Medicare spending increased during the first two years and there was no improvement in quality.¹⁹

**TABLE 1
MEDICARE ALTERNATIVE PAYMENT MODELS IN 2020 AND 2021**

2020	2021	Alternative Payment Model	Qualifies as “Advanced APM?”	Types of Providers Eligible	Geographic Areas Eligible	Most Recent Application Deadline	Accepting New Applications?
PRIMARY CARE							
1		Independence at Home	No	Primary care practices	National, but limited in number	February 2012	No
2	1	Comprehensive Primary Care Plus (CPC+)	Yes	Primary care practices	Only in 13 states & 5 metro areas	July 2017	No
3	2	Maryland Primary Care Program	Yes	Primary care practices	Only in Maryland	June 2019	No
	3	Primary Care First	Yes	Primary care practices	Only in 22 states & 5 metro areas	January 2020	No
HOSPITALIZED PATIENTS							
4	4	Bundled Payments for Care Improvement Advanced (BPCI-A)	Yes	Hospitals, Physician groups	National	June 2019	No
5		Comprehensive Care for Joint Replacement (CJR)	Track 1	Large hospitals	Only in 67 metro areas	January 2018	No
NEPHROLOGY/DIALYSIS							
6		Comprehensive ESRD Care (CEC)	Yes	Dialysis providers	National	July 2016	No
	5	Kidney Care First	Yes	Nephrology practices	National	January 2020	Possible
	6	Comprehensive Kidney Care Contracting	Yes	Nephrology practices + transplant providers	National	January 2020	Possible
ONCOLOGY							
7		Oncology Care Model (OCM)	Two-Sided Risk Track	Oncology practices	National	June 2015	No
ACCOUNTABLE CARE ORGANIZATIONS							
8	7	Medicare Shared Savings Program (MSSP)	All But Track 1 & BASIC A,B	ACOs with at least 5,000 beneficiaries	National	June 2019	Yes
9		Next Generation ACO	Yes	ACOs	National	May 2016	No
10	8	Vermont Medicare ACO	Yes	ACOs	Only in Vermont	2016	No
	9	Direct Contracting	Yes	Physicians, Hospitals, Clinics, ACOs	National	February 2020	Yes
OTHER							
11	10	Maryland Care Redesign Program	Yes	Hospitals	National	N/A	No

TABLE 2
IMPACT OF MEDICARE ALTERNATIVE PAYMENT MODELS ON SPENDING AND QUALITY

Alternative Payment Model	Most Recent Evaluation Year	Net Impact on Medicare Spending	Impact on Quality of Care
Independence at Home ²⁰	Year 5 (2016–2017)	6.7% savings	No negative impacts
Comprehensive Primary Care Initiative ²¹	Final (2012-2016)	1% higher spending	No significant impact
Comprehensive Primary Care Plus ²²	Year 1 (2017)	2.6% higher spending	Small improvement in diabetes management and cancer screening measures
Bundled Payments for Care Improvement ²³	Years 1-3 (2013-2016)	1.0% higher spending	Non-significant positive and negative impacts
Comprehensive Care for Joint Replacement ²⁴	Years 1-2 (2016-2017)	0.5% savings	No significant impact
Comprehensive ESRD Care ²⁵	Years 1-2 (2015-2017)	1.2% higher spending	Reductions in hospitalizations due to complications of dialysis
Oncology Care Model ²⁶	Year 1 (2016)	2.9% higher spending	No significant impact
Next Generation ACO ²⁷	Years 1-2 (2016-2017)	0.4% higher spending	No significant impact
Medicare Shared Savings Program ²⁸	Year 1 (2013)	0.18% higher spending	Not evaluated
	Year 2 (2014)	0.09% higher spending	
	Year 3 (2015)	0.30% higher spending	
	Year 4 (2016)	0.05% higher spending	
	Year 5 (2017)	0.33% savings	
	Year 6 (2018)	0.67% savings	

II.

THE PROBLEMS WITH THE CMS APPROACH TO CREATING APMs

There are four primary reasons why there have been so few successful Alternative Payment Models in Medicare:

1. CMMI has used only a small portion of the funding available to it for development and implementation of Alternative Payment Models;
2. The process CMMI has used to design and implement APMs is unnecessarily expensive and slow;
3. The APMs that CMS has developed fail to solve the problems with current payment systems;
4. CMS has refused to implement physician-designed APMs that focus on known opportunities to reduce spending and improve the quality of care.

A. CMMI Has Used Only a Small Portion of Its Funding to Develop APMs

Congress appropriated \$10 billion to support the work of the Center for Medicare and Medicaid Innovation during fiscal years 2011 through 2019. However, as of the end of federal fiscal year 2018, CMMI reported that it had only spent or obligated \$5.8 billion of this appropriation on its initiatives.²⁹ Moreover, as shown in Table 3, only \$1.4 billion from the appropriation was used for development and implementation of the APMs described in the previous section. In other words, **over the past decade, CMMI spent less than 15% of the total funds that were appropriated to it by Congress on projects 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 and the Medicare Shared Savings Program, rather than to create completely different types of APMs in which specialists and small and rural physician practices could participate.**

The vast majority of the funds from CMMI's appropriation were used for more than two dozen other projects that would not qualify as APMs under MACRA. CMMI spent as much or more on some of these other projects than it spent on any of the APMs. Most of these other projects were intended to improve the delivery of healthcare services, but the evaluations of several of the projects have shown little or no impact. Moreover, although the amounts of funding allocated to these projects did not directly preclude CMMI from funding more APM projects (since the total spending was still well below the total appropriation available), **administering all of these other projects appears to make it more difficult for CMMI to devote adequate time to designing and implementing additional APMs.**

In addition to the funds spent from the \$10 billion that Congress specifically appropriated to support CMMI's projects, Table 3 shows that CMMI also spent or obligated more than \$2 billion from the Medicare Trust Fund and Medicaid appropriations.³⁰ However, even though

almost all of these other funds were spent as part of APMs, less than half of CMMI's total spending was used for the design and testing of APMs. Moreover, **using so much funding from the Medicare Trust Fund for APMs has likely made the Office of Management and Budget (OMB) less willing to allow CMS to test innovative approaches in those APMs.** There was no need to utilize monies from the Medicare Trust Fund for these APMs when there was more than enough funding available in the CMMI appropriation to cover the entire costs of those APMs as well as additional APMs, particularly when projections show that the Medicare Trust Fund could run out of money within the next decade.³¹

B. CMMI Uses a Slow, Expensive Process to Design and Implement APMs

CMMI uses a long, slow process to choose, design, implement, and evaluate an Alternative Payment Model that requires a total of 7-9 years to complete. The key steps in this process are:

- **1-2 years to choose and design new APMs.** Before deciding to implement an APM, CMMI develops a detailed Innovation Center Investment Plan (ICIP) that contains a design for the APM and an assessment of its likely benefits and costs. It has taken a year or even more for this process to be completed. For example, an environmental scan of oncology payment reform opportunities was completed for CMMI in July 2013³², and input on how to design an alternative payment model for oncology was included in a report from a Technical Expert Panel completed in December 2013³³, but the ICIP for the Oncology Care Model was not completed until the beginning of 2015.
- **1-2 additional years to get a new APM underway.** Once CMS announces a new APM, it has typically taken 18-24 months or more until healthcare providers can actually begin to participate and receive different payments. For example, although CMS announced its new Primary Care First APM in April 2019, primary practices will not know whether they can participate until the middle of 2020 and they will not be able to receive different payments until January 2021 at the earliest.
- **1.5-2 years to release the initial results of a new APM.** Although CMMI has stated that it uses "rapid-cycle evaluation" to develop and assess APMs³⁴, in most cases, there has been a long delay in releasing the initial results of APMs. For example, as of the beginning of 2020, the only evaluation results from the Oncology Care Model that have been released are for cancer patients whose treatment began in the first six months of the program (July 1, 2016 to January 1, 2017)³⁵, and the evaluation results for

**TABLE 3
CMMI SPENDING IN FISCAL YEARS 2010-2018**

	Model Design & Evaluation	Payments to Participants from CMMI Appropriation	Total Spending from CMMI Appropriation	Payments to Participants from Medicare or Medicaid \$	Total Spending by CMMI
ACO APMs					
ACO Track 1+	\$13,523,781	\$0	\$13,523,781	\$0	\$13,523,781
ACO Investment Model	\$13,766,305	\$96,694,886	\$110,461,191	\$45,819,946	\$156,281,137
Advance Payment ACO Model	\$5,885,707	\$67,801,572	\$73,687,279	\$181,166,101	\$254,853,380
Next Generation ACO	\$77,718,951	\$15,343,025	\$93,061,976	\$434,619,080	\$527,681,056
Pioneer ACO	\$114,167,715	\$13,181	\$114,180,896	\$319,090,315	\$433,271,211
Vermont All-Payer ACO	\$7,363,551	\$9,499,549	\$16,863,100	\$5,832,570	\$22,695,670
Maryland Total Cost of Care Model	\$2,956,277	\$0	\$2,956,277	\$0	\$2,956,277
Subtotal	\$235,382,287	\$189,352,213	\$424,734,500	\$986,528,012	\$1,411,262,512
Non-ACO APMs					
Comprehensive Primary Care Initiative	\$99,848,518	\$294,969,491	\$394,818,009	\$23,815,990	\$418,633,999
Comprehensive Primary Care Plus	\$209,842,914	\$0	\$209,842,914	\$978,690,092	\$1,188,533,006
Bundled Pmts for Care Improvement	\$102,684,908	\$0	\$102,684,908	\$0	\$102,684,908
BPCI Advanced	\$13,532,895	\$0	\$13,532,895	\$0	\$13,532,895
Comp. Care for Joint Replacement	\$33,939,402	\$19,047	\$33,958,449	\$37,470,378	\$71,428,827
Comprehensive ESRD Care	\$90,161,926	\$0	\$90,161,926	\$51,151,304	\$141,313,230
Oncology Care Model	\$87,421,981	\$0	\$87,421,981	\$13,319,081	\$100,741,062
Subtotal	\$637,432,544	\$294,988,538	\$932,421,082	\$1,104,446,845	\$2,036,867,927
APMs Designed But Not Implemented	\$17,722,849	\$0	\$17,722,849	\$0	\$17,722,849
Total MACRA APM Projects	\$890,537,680	\$484,340,751	\$1,374,878,431	\$2,090,974,857	\$3,465,853,288
% of Total CMMI Spending			24%		43%
Other Payment & Benefit Design Projects					
Medicare-Medicaid Fin. Alignment	\$184,652,471	\$90,875,280	\$275,527,751	\$36,500,000	\$312,027,751
SNF Hospitalization Reduction	\$35,373,451	\$158,203,144	\$193,576,595	\$13,220,144	\$206,796,739
13 Other Projects	\$257,155,952	\$149,156,673	\$406,312,625	\$117,214,414	\$523,527,039
Subtotal	\$477,181,874	\$398,235,097	\$875,416,971	\$166,934,558	\$1,042,351,529
Grants and Technical Assistance					
Health Care Innovation Awards	\$150,620,191	\$1,158,907,659	\$1,309,527,850	\$0	\$1,309,527,850
State Innovation Models	\$93,790,262	\$868,350,219	\$962,140,481	\$0	\$962,140,481
Partnership for Patients	\$110,763,842	\$460,059,702	\$570,823,544	\$0	\$570,823,544
TCPI	\$65,648,733	\$572,667,114	\$638,315,847	\$0	\$638,315,847
HCP-LAN	\$23,227,056	\$0	\$23,227,056	\$0	\$23,227,056
Medicaid Innovation Accelerator	\$81,874,587	\$0	\$81,874,587	\$0	\$81,874,587
Subtotal	\$281,514,218	\$1,032,726,816	\$1,314,241,034	\$0	\$1,314,241,034
Grand Total	\$1,893,644,225	\$3,942,560,542	\$5,836,204,767	\$2,257,909,415	\$8,094,114,182

the Next Generation ACO APM for the 2017 Performance Year were not released until January 2020, two years after the services were delivered.³⁶

- **4-5 additional years to complete the evaluation of an APM.** CMMI has planned to operate most APMs for a period of 4-5 years, and the final evaluation results are not released until 1-2 years after the APM ends. For example, the final evaluation of the Comprehensive Primary Care Initiative was released in May 2018, more than a year after the APM ended in 2016 and seven years after the APM was first announced in 2011.³⁷

The process CMMI uses for designing, implementing, and evaluating APMs is also extremely expensive. As shown in Table 3, CMMI reported that as of the end of fiscal year 2018, it had spent or obligated approximately \$900 million solely for model design and evaluation contracts and activities on the small number of APMs that it had implemented. In almost all of the largest APMs, CMMI spent more than \$75 million each on design and evaluation contracts.³⁸

This slow and expensive process for implementing APMs has several undesirable effects:

- **CMS is less likely to test multiple APMs.** Because it uses such a long, expensive process to design, implement, and evaluate APMs, CMS resists requests to test additional APMs, particularly APMs that it does not believe will save large amounts of money.
- **Unsuccessful APMs will continue operating for too long.** Although most of the APMs CMS has implemented have failed to produce savings or improvements in quality, CMS has resisted making significant changes

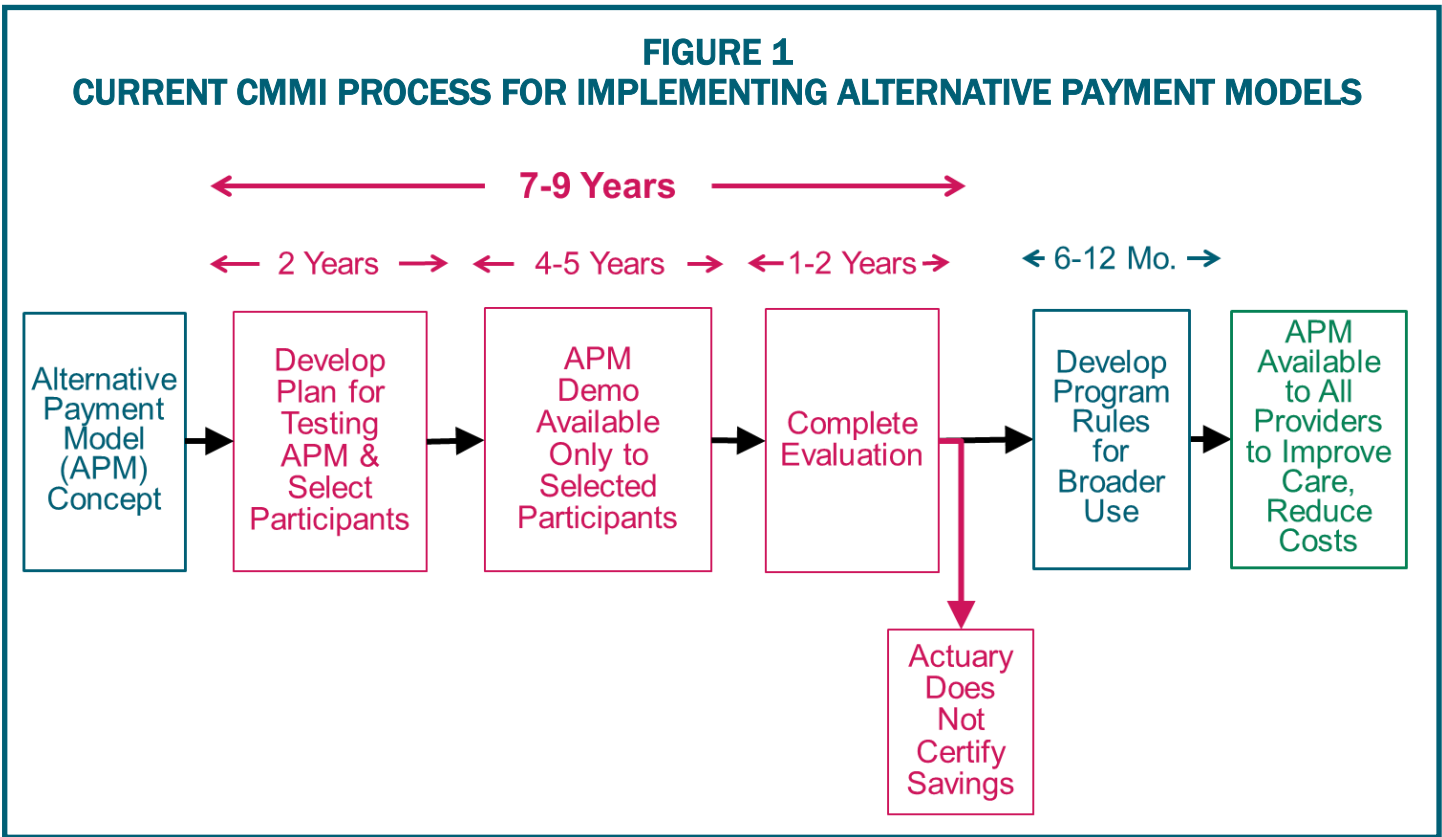
to improve them until the formal evaluation process has been completed.

- **Successful APMs will not be expanded quickly.** Even if a successful APM were to be created, CMS would not be able to expand it nationally until the formal evaluation has been completed to show that it reduces (or does not increase) spending. Since it takes 7-9 years to reach this point under the current process, and since it could take an additional year or more to promulgate regulations, in total it could take as much as a decade before a desirable APM could be made broadly available to Medicare beneficiaries across the country.

C. CMS APMs Don't Solve the Problems With FFS

There is a very simple reason why CMS APMs have failed to produce significant savings or quality improvements compared to fee-for-service payment – the APMs have not actually changed the fee-for-service payment system in a significant way. Most of the largest Alternative Payment Models created by CMS – Bundled Payments for Care Improvement (BPCI), Comprehensive Care for Joint Replacement, Comprehensive ESRD Care, and the Medicare Shared Savings Program – follow the same basic formula:

- **No changes are made in the current fee for service structure.** Every physician, hospital, and other provider participating in the APM continues to be paid under standard Medicare payment systems, i.e., they receive the same amounts for the same set of eligible services as every other provider. Even the CMS “bundled



payment” APMs do not actually provide true bundled payments; they continue to pay separate fees for the same individual services as providers outside of the APM receive.³⁹

- **Providers receive bonuses or penalties based on whether spending is less than CMS projections.** A year or more after services are delivered, the physicians, hospitals, or other providers in the APM may receive an additional payment (or be required to repay some of the payments they have already received) based on whether total spending on services to their patients was lower than what CMS projects it would have spent in the absence of the APM.⁴⁰

This approach is essentially the same as the pay-for-performance programs in Medicare (e.g., the Merit-Based Incentive Payment System), except that the bonuses and penalties for a provider in the APM are directly proportional to the amount of money that provider has saved for CMS.

There are several serious problems with this approach, including:

- **Providers cannot deliver new high-value services that can reduce spending and improve quality.** One of the key problems with current fee-for-service payment systems is they do not pay adequately or at all for many high-value services, such as hiring nurses and other staff to help chronic disease patients manage their disease more effectively. Another key problem with fee-for-service payment is that if physicians succeed in keeping their patients healthier and avoiding the use of low-value tests and treatments, they will lose a portion of the money they need to sustain their practices. Most CMS APMs make no changes to fee-for-service payments that would address these problems. Even if the providers successfully reduce spending, there is no assurance they will receive a “shared savings” payment that will be adequate to offset the costs or losses they have incurred.⁴¹
- **Providers can be penalized for things they cannot control.** The methodologies CMS uses in its APMs to determine whether providers have reduced spending fail to adequately adjust for factors that are beyond the control of those providers. For example, physicians can be penalized when there are increases in the prices of drugs that their patients receive even though physicians have no control over what pharmaceutical companies charge, and the simplistic risk adjustment systems used in the APMs can penalize physicians when they care for sicker and more complex patients.⁴²
- **Providers can be rewarded for failing to deliver services patients need.** An important strength of fee-for-service payment is that when a patient needs more services or more expensive services, physicians, hospitals, and other providers will be paid to deliver those services. In contrast, under CMS APMs, providers can receive a financial bonus if they reduce spending by failing to order or deliver services that their patients need. None of the CMS APMs have quality measures that are adequate to assure that patients receive high-cost services when they need them; for example,

there are no quality measures to assure that cancer patients in an ACO continue to receive the treatments they need when increases in the prices of chemotherapy drugs would cause the ACO’s spending to exceed CMS benchmarks and targets.⁴³

CMS has attributed the failure of existing APMs to a lack of sufficient incentives for physicians and hospitals to reduce spending, and it has asserted that greater savings have been achieved when APM participants take significant “downside risk” for Medicare spending on their patients.⁴⁴ However, **the experience to date in CMS APMs provides little evidence that downside risk increases savings:**

- In 2017, the ACOs in the Medicare Shared Savings Program that took downside risk reduced Medicare spending by an average of only \$27 per beneficiary, slightly less than the \$36 per beneficiary savings from the “upside-only” ACOs. In 2018, the ACOs in the downside risk tracks reduced spending by \$98 per beneficiary, which was only slightly more than the \$69 per beneficiary from the ACOs in the upside-only track. The ACOs with downside risk started with higher average spending per beneficiary than those in the upside-only track, and even with slightly higher savings, they still had higher average spending.⁴⁵
- ACOs in the Next Generation ACO program accept the highest levels of risk (many accept responsibility for repaying 100% of any increase in spending beyond CMS targets), but the most recent CMS evaluation found that average Medicare spending has actually increased, not decreased, under this program.⁴⁶
- Hospitals in the Comprehensive Care for Joint Replacement (CJR) APM are required to take downside risk for spending on hip and knee replacements, but the most recent evaluation found that Medicare spending has increased under this program.⁴⁷

Placing providers at risk for increases in spending can mean they will be penalized if they have a higher-than-average number of patients who need expensive services, and as noted above, CMS APMs do not have mechanisms for ensuring that patients receive high-cost services when they need them. **Placing healthcare providers at greater risk for spending they cannot control, while failing to make the changes in the payment system needed to deliver care in better and lower cost ways, is more likely to harm patients and force small physician practices and hospitals out of business than it is to achieve greater savings for Medicare.**⁴⁸

Only two CMS APMs – Comprehensive Primary Care Plus (CPC+) and the Oncology Care Model (OCM) – have actually provided additional new payments to physicians beyond what is available in standard fee-for-service.⁴⁹ These payments have successfully enabled primary care practices and oncology practices to deliver high-value services that they cannot deliver under standard Medicare payment systems:

- In CPC+, primary care practices receive a new monthly Care Management Fee for each patient. The payment amounts range from \$6 per month to \$100 per month depending on the magnitude and complexity of the patient’s health problems. Participating primary care

practices have used these payments to add new services for which there are no fees under the current payment system and to expand services where current fees are inadequate to cover the costs.

- In OCM, oncology practices receive a \$160 per month payment for each cancer patient who is receiving chemotherapy treatment. Participating oncology practices have used these payments to make significant improvements in the care management services they offer to cancer patients.

However, in both CPC+ and OCM, participating practices also still receive fee-for-service payments for all traditional services, so they will still be financially penalized if they deliver fewer of those services to patients. For example, participating practices are still paid fees for every face-to-face office visit with a physician; this means that if patients don't need to come to the office as frequently due to the improved care management services a practice delivers, the practice will lose money. Moreover, participating practices can be penalized for increases in utilization or spending that are beyond their control. For example, in OCM, practices are held accountable for the total amount that Medicare spends on cancer patients, even though the primary reason for increases in cancer spending is increases in the prices of chemotherapy drugs, and oncologists cannot control those increases.

Table 4 shows that all six of the largest Medicare APMs currently in operation not only fail to solve the most important problems in the current fee-for-service system, they also fail to preserve the strengths of fee-for-service payment. CPC+ and OCM have more desirable components than the others, but under their current designs, they still have more weaknesses than strengths.⁵⁰

Rather than creating new APMs that further expand on the desirable components of CPC+ and OCM while improving the problematic elements, CMS has announced it is moving in the opposite direction, reducing or eliminating additional payments for high-value services while

giving providers even more risk for services and costs they cannot control. For example:

- In its new Primary Care First APM, CMS has eliminated the Care Management Fee paid in CPC+ and instead will make additional payments to the practice contingent on reducing hospitalization rates, while also continuing to pay fees to practices for individual office visits. This approach moves closer to the problematic shared savings model used in MSSP and CMS's other unsuccessful APMs.⁵¹
- In the Medicare Shared Savings Program, CMS is forcing all ACOs to take downside risk based on the problematic spending benchmarks used in the program, while continuing to pay all participating physicians and hospitals under the standard fee-for-service system.⁵²

D. CMS Has Refused to Implement Additional or Different APMs

In 2015, Congress recognized that CMS had done too little to create Alternative Payment Models that would enable physicians to improve care and reduce spending. In the Medicare Access and CHIP Reauthorization Act (MACRA), Congress specifically encouraged physicians to develop "physician-focused" alternative payment models (PFPMs) by:

- requiring the Secretary of Health and Human Services to establish criteria for PFPMs, including models for specialist physicians;
- authorizing individuals and stakeholder entities to submit proposals for PFPMs that meet these criteria;
- creating the Physician-Focused Payment Model Technical Advisory Committee (PTAC) to review these proposals and to prepare comments and recommendations to the Secretary regarding whether the proposals meet the HHS criteria; and

**TABLE 4
WEAKNESSES IN MEDICARE ALTERNATIVE PAYMENT MODELS**

	BPCI-A	CJR	CEC	CPC+	MSSP	OCM
CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?						
Pays for high-value services needed to improve care?	NO	NO	NO	YES	NO	YES
Aligns payments with the cost of high-quality care?	NO	NO	NO	NO	NO	NO
Assures each patient receives high-quality care?	NO	NO	NO	NO	NO	NO
Makes healthcare costs more predictable and comparable?	NO	NO	NO	YES	NO	NO
PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?						
Only pays providers when a patient receives care?	YES	YES	YES	NO	YES	YES
Higher payments for patients who need more services?	YES	YES	YES	YES	YES	YES
Payments based only on things provider can control?	NO	NO	NO	NO	NO	NO
Providers know amount of payment before delivering services?	NO	NO	NO	YES	NO	NO

- requiring the Secretary of Health and Human Services to publicly post a detailed response to PTAC's comments and recommendations.⁵³

PTAC began accepting proposals for physician-focused APMs in December 2016, and over the course of the next three years, physicians, medical specialty societies, health systems, and other individuals and organizations submitted more than 30 proposals for Alternative Payment Models designed to support improved patient care at lower costs. PTAC prepared detailed analyses of all of these proposals and recommended that 16 of the proposals be implemented or tested by CMS.⁵⁴

As shown in Table 5, many of the APMs recommended by PTAC would focus on particular types of patients where there are specific opportunities to improve services in a way that will reduce Medicare spending. In some cases, these are patients with a particular health condition where delivery of additional or different services would result in lower spending overall, and in others, the patients have a range of different health conditions that would benefit from a similar change in service delivery. In most cases, the APM is designed to pay the provider more or differently for one or more services that neither the current payment system nor any existing APM adequately supports. For example:

- **Primary Care.** In contrast to the primary care APMs developed by CMMI, which continue to tie a significant portion of payments to traditional office visits and to risk adjust additional payments based solely on how many diseases the patient has, the primary care APMs that were developed by the American Academy of Family Physicians⁵⁵ and Jean Antonucci, MD⁵⁶ and recommended by PTAC would completely replace office visit fees with monthly payments that are stratified based on patient needs.
- **Specialty Medical Homes.** The Project Sonar APM⁵⁷ developed by the Illinois Gastroenterology Group has been successfully used to significantly reduce spending and improve outcomes for commercially-insured patients. Although this proposal was focused on Crohn's Disease patients because that is one of the chronic conditions gastroenterologists treat, a similar APM could be used with many other specialties for the chronic conditions those specialists treat, thereby creating even greater savings for Medicare and better outcomes for many Medicare beneficiaries.
- **Cancer Care.** PTAC recommended two different cancer care APMs, both of which better align payments for cancer care with the complexity of cancer and the cost of its treatment than the simplistic risk adjustment structure used in the CMMI Oncology Care Model. The APMs developed by both Innovative Oncology Business Solutions⁵⁸ and Hackensack Meridian Health/Cota⁵⁹ would support better quality cancer care at lower cost without creating inappropriate financial incentives for oncologists to withhold necessary treatments simply because of their cost.

- **Avoiding Hospital Admissions After ED Visits.** Although it is important to reduce unnecessary Emergency Department visits, the biggest impact on spending occurs when patients who visit the ED are admitted to the hospital. The APM developed by the American College of Emergency Physicians⁶⁰ is specifically designed to enable emergency physicians to reduce unnecessary hospital admissions for patients who have already come to the ED.

- **Hospital at Home.** The two APMs developed by the Icahn School of Medicine⁶¹ and Personalized Recovery Care, LLC⁶² would enable a significant subset of patients who need acute hospital-level care to receive care in their own homes. Similar programs have successfully operated at a large scale in Australia and other countries for many years, with multiple evaluations showing the services both save money and improve patient outcomes.

- **Palliative Care.** Multiple studies and demonstration projects have shown that providing home-based palliative care services to patients with serious, potentially life-limiting illnesses can both improve their quality of life and reduce Medicare spending, but Medicare does not currently pay for these services other than for patients on hospice. The two APMs developed by the American Academy of Hospice and Palliative Medicine (AAHPM)⁶³ and the Coalition to Transform Advanced Care (CTAC)⁶⁴ would fill this gap, significantly reducing spending and improving end-of-life care for thousands of Medicare beneficiaries with many types of advanced illnesses.

Unfortunately, as of February 2020, CMS had not even begun to test any of the 16 proposals PTAC had recommended. Moreover, the responses from the Secretary of Health and Human Services have indicated that HHS and CMS do not plan to implement or test any of the APMs that PTAC has recommended.⁶⁵

Although the leadership of HHS, CMS, and CMMI have consistently praised the work of PTAC, they have nonetheless given a variety of reasons why they will not implement the PTAC-recommended APMs. As shown in Table 6, none of these are valid reasons for refusing to implement the APMs or to follow the recommendations PTAC has made. The refusal to test even a single one of the recommended APMs is particularly surprising because almost half of the APMs recommended by PTAC were based on successful demonstration projects that had been funded by CMMI through its Health Care Innovation Awards. CMS invested more than \$70 million in these projects, and evaluation results indicated that the projects had reduced spending and/or improved quality. In addition, several of the APMs recommended by PTAC have already been implemented by private health plans and have shown good results in terms of both savings and patient outcomes. Failure to implement these APMs in the Medicare program denies the benefits of better care to millions of Medicare beneficiaries and causes Medicare spending to be much higher than necessary.

TABLE 5
Alternative Payment Models Recommended by PTAC, 2017-2019

	Proposal	Submitter	Target Population	Based on HCIA Award?	PTAC Recommendation	Date Recommended
1	ACS-Brandeis Advanced APM	American College of Surgeons	All Medicare beneficiaries		Limited-Scale Testing	5/31/2017
2	Project Sonar	Illinois Gastroenterology Group and SonarMD, LLC	Individuals with inflammatory bowel disease and other chronic conditions who are hospitalized frequently		Limited-Scale Testing	5/31/2017
3	Oncology Bundled Payment Program Using CNA-Guided Care	Hackensack Meridian Health and Cota, Inc.	Individuals who have cancer		Limited-Scale Testing	10/20/2017
4	Hospital at Home Plus	Icahn School of Medicine at Mount Sinai	Individuals with an acute medical condition eligible for hospital admission	Yes	Implementation	10/20/2017
5	Advanced Primary Care APM	American Academy of Family Physicians	Primary care practices and their patients		Limited-Scale Testing	2/28/2018
6	Incident ESRD Clinical Episode Payment Model	Renal Physicians Association	Individuals with end-stage renal disease		Implementation	2/28/2018
7	Patient and Caregiver Support for Serious Illness	American Academy of Hospice and Palliative Medicine	Individuals with a serious, potentially life-limiting illness	Yes	Limited-Scale Testing	5/7/2018
8	Intensive Care Management in Skilled Nursing Facility APM	Avera Health	Individuals in skilled nursing facilities and long-term care facilities	Yes	Implementation	5/7/2018
9	Advanced Care Model Service Delivery and Advanced APM	Coalition to Transform Advanced Care	Individuals with a serious, potentially life-limiting illness		Limited-Scale Testing	5/7/2018
10	Home Hospitalization APM	Personalized Recovery Care, LLC	Individuals with an acute medical condition eligible for hospital admission		Implementation	5/7/2018
11	Comprehensive Care Physician Payment Model	University of Chicago Medicine	Individuals whose health problems result in frequent hospital admissions	Yes	Limited-Scale Testing	10/20/2018
12	Innovative Model for Primary Care Office Payment	Jean Antonucci, MD	Primary care practices and their patients		Limited-Scale Testing	10/20/2018
13	Acute Unscheduled Care Model	American College of Emergency Physicians	Emergency Department patients who may require hospital admission		Implementation	10/20/2018
14	Making Accountable Sustainable Oncology Networks (MASON)	Innovative Oncology Business Solutions	Individuals who have cancer	Yes	Further Development and Implementation	1/29/2019
15	CAPABLE Provider Focused Payment Model	Johns Hopkins School of Nursing and Stanford Clinical Excellence Research Center	Seniors living at home who have chronic conditions and functional limitations	Yes	Testing	9/6/2019
16	Access Telemedicine Alternative Healthcare Delivery Model for Rural Cerebral Emergencies	University of New Mexico Health Sciences Center	Rural Emergency Department patients with a possible stroke or head injury	Yes	Further Development and Implementation	11/25/2019

TABLE 6
ANALYSIS OF CMS REASONS FOR NOT IMPLEMENTING PTAC RECOMMENDATIONS

CMS Reason for Not Implementing PTAC-Recommended Models	Analysis
<p>PTAC’s recommendations, and selected components of the APMs recommended by PTAC, have been incorporated into the APMs that CMS has developed.</p>	<p>The primary care and kidney care APMs announced by CMS in 2019 are not based on the primary care and kidney care models recommended by PTAC nor do they follow the recommendations made by PTAC. For example:</p> <ul style="list-style-type: none"> • the CMS Primary Care First APM fails to incorporate several of the essential components of the two primary care APMs recommended by PTAC.⁶⁶ • Whereas nephrologists felt they could significantly improve quality and reduce spending using the APM developed by the Renal Physicians Association and recommended by PTAC, nephrologists have expressed concern about their ability to participate in the CMS Kidney Care First APM.⁶⁷ • In its End-Stage Renal Disease Treatment Choices APM, CMS has proposed paying large bonuses to nephrologists when their patients receive kidney transplants, even though PTAC specifically recommended against such bonuses because of the shortage of kidney donors.⁶⁸
<p>The APMs recommended by PTAC will only affect a small number of patients and will not save significant amounts of money for Medicare.⁶⁹</p>	<p>There are few patient conditions or procedures that individually represent a large amount of Medicare spending, so the only way to generate a large amount of total savings will be through combining smaller amounts of savings for individual groups of patients. Moreover, the goal of APMs is to improve care for Medicare beneficiaries, not simply to achieve the maximum savings possible. Reducing spending without harming patients will require use of multiple APMs that address the unique issues involved in treating each individual group of patients.</p>
<p>Specialty-specific APMs will fragment care delivery.</p>	<p>One of the criteria PTAC uses in recommending specialty-specific APMs is whether they have sufficient provisions for ensuring coordinated delivery of care between the specialists and primary care physicians. Moreover, ACOs cannot be successful unless the specialists in the ACOs can be paid in ways that enable them to deliver high-value care.</p>
<p>CMS has to spend several years and tens of millions of dollars to design, implement, and evaluate APMs, so it does not have the capacity to implement multiple additional APMs.</p>	<p>In most cases, PTAC has recommended that APMs be initially tested on a small scale, which would not require the large numbers of staff and expensive contracts CMMI has used for its current APMs. CMMI has more than enough resources to support testing additional models, since it received a new \$10 billion appropriation to continue its work beginning in federal fiscal year 2020 and the APMs it has implemented so far did not come close to using all of the funds Congress appropriated for fiscal years 2011-2019.</p>
<p>The proposals recommended by PTAC do not include adequate estimates of their impacts and/or they are missing key details needed to implement an APM.</p>	<p>Most physicians and other stakeholder groups do not have access to the Medicare data needed to fully specify an APM. HHS has prohibited PTAC from providing data and technical assistance to groups developing APMs, and HHS has been unwilling to provide data or technical assistance through other means. One of the reasons PTAC has recommended that CMS initially conduct limited scale testing of the APMs is to enable the proposals to be refined using real-world data.</p>
<p>CMS cannot implement APMs that require use of proprietary technology, such as Project Sonar that was recommended by PTAC.</p>	<p>PTAC has not recommended APMs that <i>require</i> use of proprietary technology. Some of the providers that developed proposals to PTAC have indicated that they plan to utilize the APM payments to purchase proprietary technologies because they believe the technologies will help them to achieve the outcomes in the APM, but there is no requirement in the APM that other providers would have to use the same technology. In particular, the payment model developed for Project Sonar does not require the use of proprietary technology, and PTAC specifically addressed that issue when it recommended that CMS test it.⁷⁰</p>

III. 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 savings for the Medicare program and improve the quality of care for Medicare beneficiaries:

1. Design and implement *patient-centered* APMs;
2. Use a “bottom-up” instead of a top-down approach to designing APMs; and
3. Use a more efficient and effective approach for testing APMs.

A. Design and Implement Patient-Centered Alternative Payment Models

As discussed previously, almost all of the CMS APMs that have been implemented to date have been variations on the same “shared savings” approach. This simplistic approach has failed to remove the barriers in the fee-for-service system that prevent healthcare providers from delivering higher-value services, and the crude incentives in the APMs have the potential to harm the patients who have the greatest needs.⁷¹ Moreover, the experience to date provides no basis for believing that significantly better results will be achieved simply by increasing the amount of downside risk in current or similar models.⁷²

Rather than continuing to add more and more “incentives” and “risk” on top of its current fee-for-service payment systems, CMS needs to take a completely different approach to designing APMs – a *patient-centered* approach.⁷³ Design of a patient-centered APM requires the following four steps:

- Step 1:** Identify one or more specific opportunities for reducing spending and/or improving the quality of care for a subgroup of Medicare beneficiaries (e.g., those who have a particular chronic disease or a combination of conditions);
- Step 2:** Identify the changes in care delivery that will reduce spending or improve quality in those opportunity areas for those patients;
- Step 3:** Identify the barriers in the current payment system that prevent or impede implementing the improved approach to care delivery;
- Step 4:** Design an Alternative Payment Model that removes the barriers in the current payment system and assures the delivery of higher-value care.

This is the type of approach that was envisioned by Congress when it created the Center for Medicare and Medicaid Innovation. The enabling statute clearly states that

CMMI is only permitted to test models where “there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures.”⁷⁴

A Patient-Centered Alternative Payment Model designed through this process looks very different than the simplistic risk-based models that CMMI has used to date. There are four key components to a Patient-Centered APM⁷⁵:

Component #1: Removal of the barriers in the current payment system. An APM will not be successful unless it makes sufficient changes to the current payment system that will enable participating providers to deliver a set of services that can improve quality and reduce spending. The specific changes needed will depend on the nature of the payment barriers identified in the APM design process. In some cases, all that is needed is to pay for one or more services that are not paid for (or not paid for adequately) under current payment systems, while in other cases, current payments will need to be replaced with a condition-based bundled payment.

Component #2: Accountability for reducing avoidable spending. If the APM pays providers more or differently to support a different approach to service delivery, the providers should take accountability for making the reductions in spending that the revised services are designed to achieve. However, instead of holding providers accountable for spending targets that are calculated by adjusting past spending levels using arbitrary “discounts” and trend factors, as CMS has done to date, an APM should define any spending targets based on a determination of what it will *actually cost* the providers to deliver services in a different and better way. Accountability should be limited to the specific types of utilization and spending that the APM was designed to influence, and the APM should not put the providers at risk for things such as drug prices or unrelated patient health problems that they cannot control.

Component #3: Accountability for maintaining or improving care quality and outcomes. The APM also needs to include mechanisms for assuring patients that reductions in spending are being achieved without harming the quality of care they receive. If the APM was intended to *improve* the quality of care, not just maintain current levels of quality, then the providers participating in the APM will need to take accountability for achieving those improvements. Here again, the accountability component of the APM must focus on the specific aspects of quality and the types of outcomes the APM was designed to maintain or improve,

and it should not put the participating physician practices and other providers at risk for outcomes they cannot control.

Component #4: Definition and enrollment of appropriate patients. It is important that the APM clearly define the types of patients the participating providers will be accountable for, and that the performance standards in the accountability components of the APM are feasible to achieve for those patients. Unless there are adequate mechanisms for adjusting the quality and cost measures for all relevant differences in patient characteristics, there will need to be exclusions or separate APMs for the highest-need patients. Moreover, in contrast to current CMS APMs where patients are retrospectively “attributed” to APMs and providers, the providers participating in the APM need to know which patients they will be accountable for before services are delivered, and their patients need to understand and support the changes in services they will be receiving. The best way to do this is to have patients voluntarily agree to participate in the APM before services are delivered.

There is no single alternative payment model with these characteristics that will work for all types of patients and all types of healthcare providers. Different medical conditions require different types of treatment, and different patients with the same medical condition will also require different approaches to treatment. The opportunities to improve quality and reduce Medicare spending will differ for different types of health problems and patient needs, so the changes in care delivery needed to address those opportunities will also differ. Current payment systems create different kinds of barriers for different changes in care delivery, and the relevant payment barriers need to be removed in order for adequate changes to be made in services. Consequently, the payment changes, accountability components, and patient eligibility in an APM will need to be customized to all of these differences in order to successfully reduce spending without harming patients. A detailed explanation of how to design each of these four components is available in CHQPR’s report *How to Design an Alternative Payment Model*.⁷⁶

The Appendix shows example of how a Patient-Centered APM could be designed to support high-quality care for patients with one or more chronic conditions. More detail on that APM and other examples of Patient-Centered APMs for primary care, cancer care, and maternity care are available in reports from CHQPR.⁷⁷

B. Use a Bottom-Up Instead of a Top-Down Approach to Creating APMs

As explained above, the first step in creating a Patient-Centered APM is to identify specific opportunities to reduce spending and improve quality for patients. The people who are in the best position to do that are the physicians, hospitals, and other providers who care for the patients. Moreover, the providers of care are also in the best position to know what aspects of current payment systems create barriers to better care delivery and to assess whether a different payment model would ade-

quately remove those barriers without creating unmanageable risk or administrative burdens. Consequently, it seems obvious that healthcare providers need to play a major role in the development of APMs if the APMs are going to be successful in helping providers achieve significant impacts on savings and quality.

CMMI initially pursued a “bottom-up” approach when it was first created. Rather than simply deciding itself what innovations should be pursued, CMMI invited healthcare providers and other stakeholders to submit ideas. Through two rounds of Health Care Innovation Awards (HCIA) in 2012 and 2014, CMMI provided over \$1 billion in grant funds to support the implementation of 146 pilot projects testing innovative approaches to care delivery across a wide range of medical conditions.⁷⁸ Moreover, the second round of the Health Care Innovation Awards specifically required each participant to develop a payment model that would sustain their project if it was successful. As noted earlier, almost half of the APMs recommended by PTAC were developed by healthcare providers who had already used an HCIA grant to successfully pilot test a better approach to care delivery and who now need an alternative payment model that can sustain and expand it.

However, rather than following through on this bottom-up approach and working with the providers to implement APMs that could sustain and expand the successful HCIA projects, CMMI instead began following a “top-down” approach, designing APMs itself with little or no involvement of the providers who would ultimately need to participate in them. As a result, rather than being active partners with CMS in the development of APMs and supporters of the final product, providers have generally been both surprised and disappointed by the details of CMS-developed APMs when they are first announced.

Congress created PTAC in an effort to restore a bottom-up approach and encourage development of APMs by physicians and other practitioners. Physicians and other providers responded enthusiastically to this opportunity by submitting 10 proposals for APMs to PTAC within the first six months and a total of 36 proposals in the three years between December 2016 and December 2017. After detailed reviews, PTAC recommended that 16 of these proposals be tested or implemented by CMS. The refusal to implement even one of these 16 APMs indicates that CMS does not support the process that Congress created.

Instead of continuing to resist this desirable bottom-up approach to APM design and implementation, CMS should embrace it 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 APMs recommended by PTAC. As described earlier, the APMs recommended by PTAC would help improve care for many groups of Medicare beneficiaries who have been ignored under current CMS APMs, as well as allow many additional types of physician practices to participate in an APM. Implementing APMs for the projects that received Health Care Innovation Awards

would enable CMS to achieve a return on the millions of dollars it has already invested in those projects. If CMS feels that different groups of patients or aspects of care are higher priorities than those addressed by the PTAC-recommended models, CMS could invite stakeholders to develop proposed APMs in those areas and CMS could make a commitment to implement the best of those proposals.

- **Provide data and technical assistance to help physicians and other stakeholders to develop good APMs.** As noted in Table 6, two of the reasons that CMS has used to justify its refusal to implement APMs developed by physicians and other groups are (1) that estimates of the potential impacts have not been provided and (2) that there are weaknesses or gaps in the payment methodology. However, it is virtually impossible for physician practices and most providers to fully specify an APM or estimate its impact because they do not have access to Medicare data on utilization and spending, and most physicians and other groups have little or no experience in the complexities of payment system design. To correct these problems, the Secretary of Health and Human Services should either permit the Physician-Focused Payment Model Technical Advisory Committee to provide data and technical assistance to APM developers, or HHS should create a separate mechanism for doing so.⁷⁹
- **Work collaboratively with providers to refine the details of APMs and encourage participation.** No matter how much effort is devoted to planning and design of an APM, unexpected challenges will inevitably arise once it is first implemented. The more innovative the changes in care delivery and payment, the more likely this is to happen. Changes to address these issues need to be made in a way that supports achieving the goals of the APM while avoiding problems for the participating providers or their patients. The only way to do this successfully is by planning the changes through a collaborative process involving both the participating providers and CMS.

C. Use a More Efficient and Effective Approach for Testing APMs

In the process CMS currently uses for developing APMs, CMS selects a small number of APMs, develops a detailed design for the APMs, initiates testing of each APM with a large number of providers and patients, and immediately launches an extensive and expensive evaluation of that APM design. This approach assumes that CMS staff can determine which APMs will be successful and what designs will work best. However, the result to date has been that both CMS and hundreds of healthcare providers have spent thousands of hours of time and hundreds of millions of dollars on a small number of APMs that have not been successful and are not being continued.

This is not how successful innovations have occurred in healthcare and other industries. For example:

- successful venture capitalists do not try to pick just one or two start-up firms and invest all of their assets in those businesses; instead, they invest smaller

amounts in multiple entrepreneurs, allow each of the businesses in this portfolio to develop and test their products, and then they invest additional resources in the subset of firms whose products show initial success. Venture capitalists expect that the majority of the companies they invest in will fail or at best have limited success, and that only a small subset of the companies will have significant success. However, they also know that it is impossible to accurately pick the “winners” in advance, so investing in multiple companies actually increases the likelihood of ultimate success.

- successful companies do not immediately move new products from the design table to full-scale production. One or more prototypes are created and then “beta-tested” on a limited scale to identify problems and opportunities for improvement. The design is then revised before broader production begins. Even after the product is being widely used, product designs continue to be refined based on feedback from customers until the most successful product has been developed.

CMS should use a similar approach for APMs, i.e., beta testing a larger number of APMs, rather than trying to pick a small number of “winners” in advance, and then continuing the subset of APMs where the beta test has indicated that success is more likely. Rather than launching an extensive and expensive evaluation immediately, CMS should initially conduct a simple evaluation to determine which APMs show promising results, and then conduct a more detailed evaluation of those APMs after enrolling a larger number of participating providers.

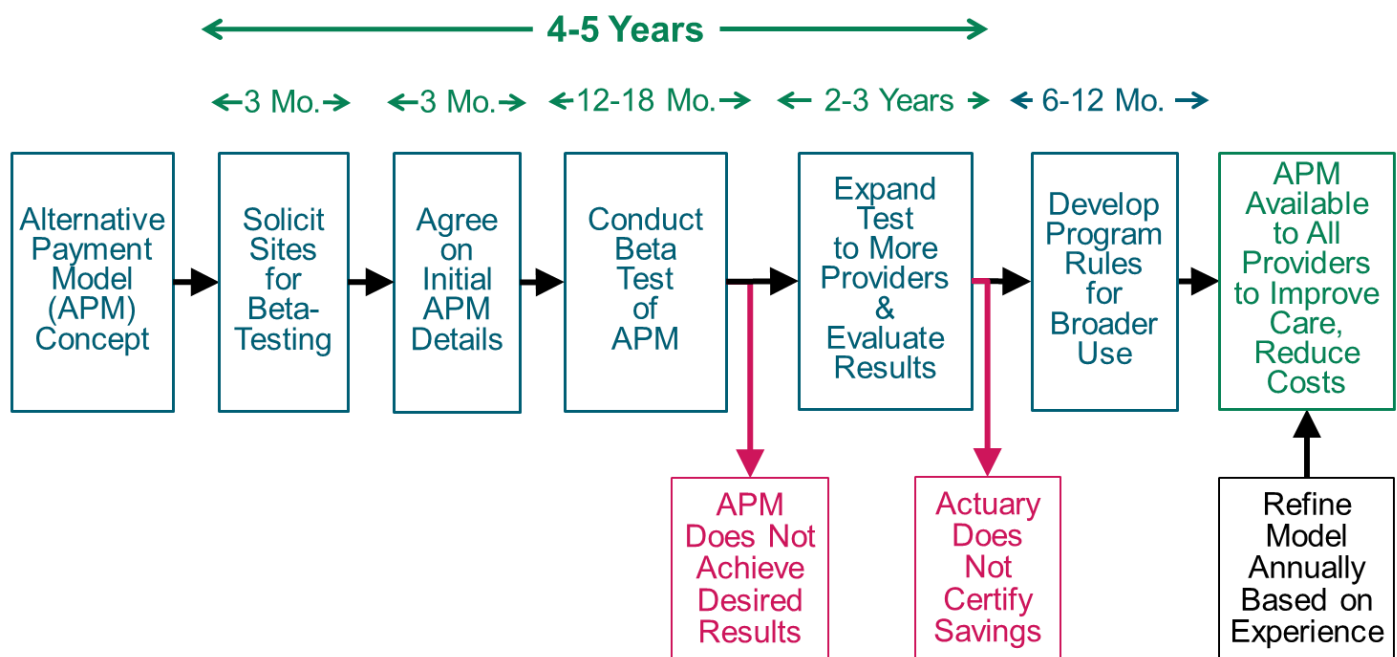
A beta testing process is particularly important for an APM that is designed to support a new approach to care delivery. There will likely be little experience with how much the new approach to care delivery will cost for different types of patients or the results it will produce because current payment systems do not support that type of care. This not only makes it impossible to accurately predict the impact of the APM before it is implemented, it also makes it difficult to determine the “right” payment amounts, performance standards, and risk adjustments for the APM until after the APM is already in place. A beta test allows an APM to get started with a clear understanding that revisions will likely need to be made once some initial experience has been gained.

CMMI’s authorizing statute clearly permits this type of beta testing. There are no limits in the law as to (1) how many providers can participate in testing an APM, (2) how an evaluation of the APM should be conducted, (3) how quickly a determination must be made as to whether an APM improves quality or reduces spending, or (4) how often the design of an APM can be modified before it is terminated or expanded. In fact, Congress explicitly prohibited CMMI from requiring that an APM be budget neutral initially, and it authorized CMMI to modify the design and implementation of an APM after testing has begun if the model is not expected to either improve quality without increasing spending or reduce spending without reducing quality.⁸⁰

The following steps could be used by CMS to implement a beta-testing process for APMs:

1. **Recruit Beta Test Providers.** When a desirable APM is proposed, (e.g., when a physician-focused alternative payment model is recommended by PTAC), CMMI would recruit and select initial beta-testing providers or sites. This could be done within 90 days.
2. **Set the Initial APM Parameters.** CMMI would work with the beta-test providers to develop the initial parameters for implementing the APM. This process could be completed within 90 days after the providers are selected.
3. **Initiate Beta Testing and Refine the APM.** Over the next 12-18 months, the providers participating in the beta test would be paid through the APM and they would use the new payments to restructure the way they deliver care. CMMI and the providers would work together to continuously refine the details of the APM to ensure it results in a “win-win-win” for the patients, the providers, and the Medicare program.
4. **Conduct a Preliminary Evaluation of Impacts.** During the final months of the beta testing process for an APM, CMMI would complete a preliminary evaluation of the results. The preliminary evaluation would focus narrowly on the criteria required by law, i.e., whether the APM appears to be reducing Medicare spending and/or improving the quality of care for patients. Because of the small number of beta test participants, it would be impossible to determine whether results were statistically significant, but the preliminary evaluation could assess whether the direction and magnitude of the results were consistent with the goals of the APM.
5. **Initiate a Second Phase of Testing with Additional Providers.** If the preliminary evaluation results from the beta test are positive, CMMI would then invite a larger number of providers to participate in a second phase of testing. The number and types of providers would be designed to assure an adequately-powered evaluation with a group of providers that are representative of providers nationally. The positive initial evaluation results and endorsements from the providers that participated in the beta test should make it easier to recruit a representative set of providers to participate without any need to mandate participation. Recruitment and selection of these additional providers could be completed within 3 months after the initial evaluation results are available.
6. **Evaluate the Impacts on Spending and Quality.** CMMI would commission an evaluation to determine the impacts the APM has on spending and quality during the second phase of testing. CMMI could also evaluate other aspects of the APM implementation process, but this should be done separately so that it does not delay release of the results on the key spending and quality measures. The initial results of the impact evaluation could be available as early as 2 years after initiation of the second phase of testing.
7. **Continue Successful APMs and Modify or Terminate Unsuccessful APMs.** If the evaluation clearly shows that the APM has been successful, CMS could make it available nationally. If the evaluation indicates that impacts have been improving but have not yet reached an adequate level, CMS could decide to continue testing for an additional period of time. If the evaluation shows the APM has not been successful,

**FIGURE 2
IMPROVED CMMI PROCESS FOR IMPLEMENTING ALTERNATIVE PAYMENT MODELS**



CMS could either modify or terminate the APM. If a decision is made to terminate the APM, a phase-out period with transition assistance should be created for the providers who had been involved in testing so they are not penalized for their willingness to test an innovative APM.

This process would be significantly faster, less expensive, and more successful than the current approach:

- As shown in Figure 2, the design and testing of an APM could be completed within a 4-5 year period rather than the 7-9 years needed under the current approach, and successful APMs could be expanded nationally in half the time it would currently take.
- Far less would be spent on evaluations of unsuccessful APMs, and evaluation resources could be concentrated on APMs that have the greatest chance of success.
- A larger number of APMs could be tested, and providers would be more engaged in making them successful because they had been directly involved in designing them, which would increase both the number of successful APMs and the magnitude of their success.
- Many more Medicare beneficiaries would be able to receive higher-quality care for a wider range of health problems.
- Greater savings would be achieved more quickly for the Medicare program.

Modifications Needed to Support Successful Primary Care Payment Reform

Primary care is the one area where modifications to this process will be needed. While there are differences of opinion about the best way to structure payments for primary care services, there is broad consensus that the current payments are both inadequate and too narrowly focused on face-to-face office visits. CMMI has been testing primary care APMs for nearly ten years that both increase the amount of payments to primary care practices and provide more flexibility in how services can be delivered. However, the majority of Medicare beneficiaries and primary care providers have been excluded from these APMs. **Testing of additional primary care APMs should be designed so that every Medicare beneficiary in the nation has an opportunity to participate in a patient-centered primary care APM that provides adequate, flexible payments.** The Primary Care First APM that is currently being pursued by CMMI fails to achieve either of those goals.⁸¹

In addition, the *primary* goal of good primary care should be to improve patients' health, not to save money for Medicare. Providing higher and more flexible payments for primary care that enable delivery of better primary care services to Medicare beneficiaries will likely result in fewer avoidable hospitalizations, fewer unnecessary tests and medications, and fewer inappropriate referrals to specialists, which in turn will produce savings for Medicare. However, it is unrealistic to expect that these savings will be sufficient to fully offset the cost of the higher payments needed to adequately support primary care, much less to achieve net savings overall, during a short beta test period or even the 5-year time period typically used in CMMI evaluations.⁸² Creating more financial risk for primary care practices, as CMMI has proposed to do in its Primary Care First initiative, is more likely to accelerate the loss of primary care providers than to achieve greater savings for Medicare.

The biggest benefits of primary care will likely be seen beyond the five-year time horizon used in CMMI demonstration projects, through slowing the progression of chronic disease and even preventing some diseases from occurring at all, not just trying to avoid hospitalizations for those who already have such conditions. Although Congress explicitly authorized CMMI to undertake demonstrations that are not initially budget neutral, it requires CMMI to focus on projects that would reduce Medicare spending, and to terminate projects if they are expected to increase Medicare spending. As a result, even though Congress has consistently supported increased investment in primary care, the small increases in net spending that have occurred under the CMMI primary care APMs make it impossible for them to be continued because of the way the law is currently written.⁸³ **In order to successfully reform payments for primary care, Congress will need to change the statute so CMMI can continue primary care APMs that successfully improve the quality of care even if they do not reduce short-term spending.**

APPENDIX

Example of a Patient-Centered APM for Management of Chronic Disease

Under this Alternative Payment Model (APM), an individual who has the symptoms of a serious chronic disease or who has been diagnosed with the disease would choose one or more teams of providers that are participating in the APM to diagnose, treat, and manage the individual's condition. Seven types of payments would be available under the APM in order to match the different kinds of services that the patient would need and the different outcomes that can be achieved during five different phases of care:

- 1. Diagnosis and Initial Treatment.** A *Diagnosis Team* would receive a one-time bundled Diagnosis and Initial Treatment Payment to cover most of the services needed to determine if the patient has the chronic disease, and if so, to treat the disease for an initial period of time in order to ensure the diagnosis is accurate and the treatment is effective. The payment would be higher for those patients who are diagnosed as having the disease and initiate treatment for it.
- 2. Continued Treatment for a Patient with a Well-Controlled Condition.** A *Treatment Team* would receive a quarterly bundled Treatment and Care Management Payment to provide appropriate services for patients whose condition can be well-controlled with standard medications or other treatments. In some cases, the Treatment Team would be the same as the Diagnosis Team and in other cases it might be a different group of providers. In most cases, the Treatment Team for this group of patients would be led by a primary care physician, with support from appropriate specialists and other staff.
- 3. Continued Treatment for a Patient With a Difficult-to-Control Condition.** If the patient's condition proved difficult to control during the initial treatment period or if it could only be controlled using special medications or treatments that require careful monitoring, a *Treatment Team* would also receive a quarterly bundled Treatment and Care Management Payment to provide appropriate services, but the payment amounts would be higher than for patients with well-controlled conditions, reflecting the greater risk of complications and higher level of services needed. The Treatment Teams for these patients could either be led by physicians specializing in the disease or by primary care physicians with specialty support.
- 4. Hospitalization for an Exacerbation of the Condition.** Hospitals would receive three separate types of payments to cover the costs of services to the small subset of patients who would need to be hospitalized for exacerbations of their condition:
 - a. A Standby Capacity Payment for each patient who has the chronic condition, regardless of whether they needed to be hospitalized. This would support the fixed costs the hospital incurs to maintain adequate inpatient capacity for these kinds of patients.
 - b. A Bundled/Warranted Payment if the patient requires a visit to the Emergency Department or has an inpatient admission for symptoms related to their chronic condition. This would cover all of the costs of the ED visit or hospital admission and any post-acute care services during the 30 days following discharge that were not provided by the patient's Treatment Team.
 - c. An Outlier Payment if a patient required an unusually large number of services.
- 5. Palliative Care for an Advanced Condition.** For patients whose condition has reached an advanced stage, a *Palliative Care Team* could receive a monthly Palliative Care Payment to provide palliative care services to the patient in addition to any treatment or care management services the patient was receiving from a Treatment Team.

The payments in each phase would be stratified into several need/risk-based categories so that higher payments are made for patients who have characteristics that typically require additional or more expensive services, including comorbidities, functional limitations, and access to supportive services in their community. The patient's need/risk classification could change at any time if the patient's needs change, and subsequent payments would reflect the new need/risk category in order to ensure the patient could always receive the most appropriate services.

A Diagnosis Team, Treatment Team, hospital, or Palliative Care Team would receive no payment for the services they delivered to a patient if the Team failed to meet evidence-based care standards in providing those services. Payments to a Team or hospital would be reduced if desirable outcomes were not achieved. Treatment Teams would receive no payment during a calendar quarter for a low- or moderate-risk patient if the patient visited the ED or was hospitalized.

The APM would reduce spending and improve outcomes by reducing the rate of avoidable emergency department visits and hospital admissions and by reducing the utilization of unnecessary medications, tests, and other services.

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 69. For example, in the response to PTAC’s recommendation that CMS pursue testing of the Project Sonar proposal, the Secretary of Health and Human Services suggested that spending associated with patients with inflammatory bowel disease was not large enough to warrant pursuing implementation of an alternative payment model to improve care for these patients, saying that “Patients with IBD accounted for only 1.25 percent of Medicare FFS spending.” Comments from Secretary Thomas Price on Project Sonar, September 7, 2017. Available at <https://aspe.hhs.gov/system/files/pdf/257541/PTACProjectSonar.pdf>
 70. Physician-Focused Payment Model Technical Advisory Committee. *Report to the Secretary of Health and Human Services, Comments and Recommendation on Project Sonar* (May 2017). Available at <https://aspe.hhs.gov/system/files/pdf/255906/SonarReportSecretary.pdf>
 71. Much of the small amount of gross savings that has occurred in CMS APMs is due to lower spending on facility-based post-acute care (i.e., Skilled Nursing Facilities and Inpatient Rehabilitation Facilities). This is not surprising because (a) it has been known for many years that there is unnecessary use of post-acute care, particularly facility-based post-acute care, and unnecessarily long stays in skilled nursing facilities (SNFs), and (b) most providers participating in APMs do not operate post-acute care facilities, so a reduction in payments for facility-based post-acute care does not reduce the revenue of the APM participants. It is possible that even greater reductions in SNF days could be achieved through use of innovative forms of home-based post-acute care, but none of the current APMs allow providers to be paid for delivering new types of post-acute care services. Also, the risk adjustment structures in the APMs fail to adjust for differences in patients’ needs for post-acute care, which means that the APMs

- can discourage providers from performing surgeries on higher-need patients who would require use of facility-based post-acute care.
72. Miller HD. *How to Fix the Medicare Shared Savings Program*. Center for Healthcare Quality and Payment Reform (June 2018) Available at: http://www.chqpr.org/downloads/How_to_Fix_the_Medicare_Shared_Savings_Program.pdf
 73. Miller HD. *Why Value-Based Payment Isn't Working, and How to Fix It*. Center for Healthcare Quality and Payment Reform (October 2017). Available at: <http://www.chqpr.org/downloads/WhyVBPIsNotWorking.pdf>.
 74. 42 U.S.C. 1315a.
 75. Miller HD. *How to Create an Alternative Payment Model*. Center for Healthcare Quality and Payment Reform (December 2018). Available at: http://www.chqpr.org/downloads/How_to_Create_an_Alternative_Payment_Model.pdf
 76. Miller HD. *How to Create an Alternative Payment Model*. Center for Healthcare Quality and Payment Reform (December 2018).
 77. Miller HD. *The Problems with "Primary Care First" and How to Fix Them*. Center for Healthcare Quality and Payment Reform (May 2019). Available at: http://www.chqpr.org/downloads/Fixing_Problems_with_Primary_Care_First.pdf
Miller HD. *A Better Way to Pay for Cancer Care*. Center for Healthcare Quality and Payment Reform (December 2019). Available at: http://www.chqpr.org/downloads/Patient-Centered_Cancer_Care_Payment.pdf
Center for Healthcare Quality and Payment Reform. *An Alternative Payment Model for Maternity Care*. Available at: http://www.chqpr.org/downloads/MaternityCare_APM.pdf
 78. More information on the Health Care Innovation Awards is available at <https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/> and <https://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html>
 79. In MACRA, Congress appropriated funding that PTAC could use to provide technical assistance to applicants, but it has been prohibited by HHS from doing so, even after Congress amended the law in an effort to give PTAC that authority. PTAC requested that HHS establish a mechanism for providing technical assistance to applicants, but it has failed to do so. August 4, 2017 Letter from Physician-Focused Payment Model Technical Advisory Committee to HHS Secretary Thomas E. Price, available at <https://aspe.hhs.gov/system/files/pdf/255906/PTACLetterSecPriceLessonsLearned.pdf>
 80. Section 1115A of the Social Security Act explicitly permits the Secretary of HHS to continue a payment model as long as the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. Moreover, if a payment model is not achieving these goals, the law gives the Secretary of HHS the power to modify the payment model rather than terminate it. Decisions to continue or modify a model can be made before an evaluation of the model is completed. 42 U.S.C. 1315a.
 81. Miller HD. *The Problems with "Primary Care First" and How to Fix Them*. Center for Healthcare Quality and Payment Reform (May 2019). Available at: http://www.chqpr.org/downloads/Fixing_Problems_with_Primary_Care_First.pdf
 82. The evaluation of the Comprehensive Primary Care Initiative found that there was no net savings to Medicare and a small, non-significant increase in net spending due to the higher payments paid to the primary care practices. The first-year evaluation of the Comprehensive Primary Care Plus demonstration found that there were no reductions in total Medicare spending for the patients receiving care from participating practices, so the additional payments made to the participating primary care practices increased net spending by a small amount. Mathematica Policy Research. *Evaluation of the Comprehensive Primary Care Initiative, Fourth Annual Report* (May 2018). Available at <https://downloads.cms.gov/files/cmimi/CPC-initiative-fourth-annual-report.pdf>. Mathematica Policy Research. *Independent Evaluation of Comprehensive Primary Care Plus (CPC+), First Annual Report* (April 2019) Available at <https://downloads.cms.gov/files/cmimi/cpcplus-first-ann-rpt.pdf>.
 83. Although CMS has the authority to create new types of payments for every primary care practice in the country, and it is planning to increase office visit fees for primary care practices in 2021, CMS is constrained by budget neutrality rules that are even more narrowly defined than those facing CMMI, since CMS cannot consider savings in spending on hospital services, post-acute care services, or prescribed medications as offsets for higher payments to primary care physicians. As a result, when CMS increases payments to primary care physicians, it has to reduce payments to specialists whether payment reductions are justified or not.



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