The Problems with Medicare's Alternative Payment Models and How to Fix Them

Designing Alternative Payment Models to Support Delivery of High-Value Health Care

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I. CRITERIA FOR A SUCCESSFUL ALTERNATIVE PAYMENT MODEL

A. The Four Key Problems with Fee for Service Payment

There is broad consensus that current fee-for-service payment systems are a major reason why healthcare spending has grown faster than inflation without any corresponding improvement in the quality of care or patient outcomes. There are four distinct problems with current payment systems that impede the ability to deliver high-quality care at an affordable cost[1]:

1. **There are no payments at all for many services that can enable higher-quality care to be delivered at a lower cost.** For example:
   - Physicians are generally only paid for face-to-face visits with patients, even though a phone call or email could help the patient avoid the need for far more expensive services, such as an emergency department visit. Physicians also generally aren't paid for proactive telephone outreach to patients to ensure they get services that could prevent serious health problems or identify problems at earlier stages when they can be treated more successfully and at lower cost.
   - Primary care physicians and specialists aren't paid for the time they spend communicating with each other to coordinate a patient's care, even though this can avoid ordering duplicate tests and prescribing conflicting medications. Similarly, a physician is not paid for time spent serving as the leader of a multi-physician care team, even if coordination among the physicians would result in better outcomes for the patient.
   - There is generally no payment for providing palliative care for patients in conjunction with treatment, even though this can improve quality of life for patients and reduce the use of expensive treatments.
   - There is generally no payment for providing non-health care services (such as transportation to help patients visit the physician's office) that could avoid the need for more expensive medical services (such as the patient being taken by ambulance to an emergency department).
2. **Payment rates often differ significantly from the actual cost of delivering high-quality, appropriate care.** In many cases, the payments for healthcare services are much higher than it costs the providers to deliver services; this causes spending to be higher than necessary. However, there are also many cases in which payments are *below* the cost providers incur, particularly if they deliver higher-quality services and do so only when the services are truly needed. Because a high proportion of healthcare costs is fixed in the short run, and because fees are based on average costs, providers are financially rewarded when they deliver unnecessary services and they are financially penalized when they deliver high-quality, appropriate care.
3. **There is no assurance that the services a patient receives are appropriate, high-quality, or achieve the results that the patient needs.** In other industries, customers expect products and services to have a warranty against defects and a money-back guarantee of performance. Warranties and performance guarantees reward the producers of high-quality products and services, and they encourage those producers to clearly define the benefits their products and services can and cannot be expected to provide. In contrast, physicians, hospitals, and other healthcare providers are generally paid for delivering services regardless of whether the services are delivered in the highest-quality way, regardless of whether the services have positive or negative effects on the patient, and regardless of whether the services were necessary or appropriate for the patient in the first place.
4. **It is impossible for patients or payers to predict the total amount they will need to pay for treatment of a health problem and to compare the amounts across providers.** In other industries, customers know the full price of a product before they buy it and they can compare the prices different manufacturers charge for similar products. In healthcare, patients and payers cannot even obtain an estimate of the combined fees for all of the services needed to treat or care for a health problem, much less receive a guaranteed price for all of the services they will receive.

All four of these problems contribute to higher-than-necessary healthcare spending and less-than-desirable care quality and outcomes. Unless alternative ways of paying for healthcare are developed that solve these problems, it is unlikely that significant progress will be made in improving the quality and affordability of healthcare services.

B. How an APM Should Correct the Problems with Fee for Service

"Alternative Payment Models" (APMs) are intended to pay healthcare providers in ways that will reduce spending and/or improve quality.[2] In order to be successful in supporting affordable, high-quality health care, an APM must be designed to correct the four problems with fee-for-service payments described above. Specifically:

1. **A well-designed APM should pay for the high-value services needed to improve patient care.** To be successful, an APM must make any changes needed in the way providers are paid so they are able to deliver the services that will improve outcomes and reduce

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spending. Most current APMs do not make any changes in the ways that providers are paid, but merely provide "incentives" to reduce spending or improve quality.

2. **A well-designed APM should align the amount of payment with the cost of delivering good care.** An APM must change the amounts paid for individual services so payments are aligned with the actual costs of delivering services, particularly for small providers and when the volume of services delivered changes. Many current APMs actually widen the gap between payments and costs rather than narrowing it.
3. **A well-designed APM should assure patients that they will receive appropriate, high-quality care that will achieve a good outcome for them (not just for other patients).** APMs can and should be designed with patient-level quality standards and targets that tell each individual patient in advance what they can expect in terms of quality and outcomes. Most current APMs only assess whether quality has changed on average for a group of patients, not whether it has improved or worsened for individual patients.
4. **A well-designed APM should make the cost of healthcare services more predictable and comparable.** APMs can and should specify in advance the amount that a provider will be paid and the total amount that will be spent for treatment of a particular condition or combination of conditions so that patients can compare the costs of care across providers. Many current APMs do not set spending targets until after care has already been delivered, and most do not even make final determinations as to which patients are eligible for the APM until after some or all services are delivered. This makes it impossible for a patient or their payer to know in advance how much they will need to pay for care.

Well-designed APMs represent a radical shift from the way services are paid for under both current fee-for-service systems and current APMs. However, the differences only seem "radical" to those in the healthcare industry. Well-designed APMs actually move healthcare payment closer to the way products and services are paid for in other industries. For example:

- An APM that uses a bundled payment and/or specific spending targets creates more of the kind of certainty for patients that consumers have when they purchase products and services from other kinds of businesses.
- An APM that incorporates warranties and performance guarantees gives patients the same kind of assurance they receive from other kinds of businesses that they won't pay more to correct problems and they won't pay at all for ineffective services. An APM with warranties and performance guarantees also rewards providers that deliver high-quality products and services, and it encourages providers to clearly define the outcomes their services can and cannot be expected to achieve.

C. Preserving the Strengths of Fee for Service as Well as Correcting its Weaknesses

Although there are serious problems with the fee-for-service payment system, it would not have persisted for so long without any redeeming features. A well-designed APM must not only correct the problems with the fee-for-service system, it must also preserve four important strengths of the fee-for-service payment system:[3]

1. **A provider should only be paid if a patient receives needed services.** Although there are clearly serious problems with the quality and cost of the services delivered under fee-for-service payment, the system at least gives patients and payers the confidence that they only pay something if they receive something in return. Under many "population-based payment" APMs, providers would be paid even if they do nothing for patients. A well-designed APM should ensure that patients who need help receive it.
2. **Payments should be higher for patients who need more services.** Although fee-for-service payment is criticized for rewarding "volume over value," any payment system that doesn't adequately support a higher volume of services *when more services are needed* can result in worse outcomes for patients and higher long-run costs. Many APMs fail to adjust payments for important characteristics of patients that require more services or more expensive services. Like fee-for-service, a well-designed APM will pay more to care for patients who have greater needs, but unlike fee-for-service, it will not pay more simply because more services are delivered.
3. **A provider's payment should be based on things the provider can control.** Although fee-for-service payment fails to hold providers accountable for problems they caused or could have prevented, it also does not penalize them for things outside of their control. Many current APMs go too far in the opposite direction – placing healthcare providers at financial risk for the total cost of care even though they can only control or influence a small part of it. In other industries, warranties and performance guarantees are typically limited to correcting defects the producer caused or could have prevented, and a good APM will do the same in healthcare.
4. **Providers should know how much they will be paid before delivering a service.** Under fee-for-service payment, a provider knows exactly what they will be paid for delivering a service before they deliver that service, so the provider can determine whether they are likely to receive sufficient revenue to cover their costs before they incur those costs. Under many APMs, it is impossible for the participating providers to predict how much they will be paid for the services they will deliver, and they may not know for sure how much they will receive until many months after the services are actually delivered. A well-designed APM should clearly define payment amounts and spending targets in advance, so providers, patients, and payers all know what will be paid and how much will be spent.

Many current APMs have had poor results not only because they fail to correct the problems with fee-for-service systems, but also because they fail to preserve its strengths.[4] Some types of proposed APMs would be even worse in this respect.

D. The Components of An Alternative Payment Model

The ability of an Alternative Payment Model to correct the problems with current fee-for-service payment systems while preserving the strengths of fee-for-service payment depends on how four key components of the APM are designed:

1. **Payments for Services.** The APM needs to pay healthcare providers in a way that reduces or eliminates any barriers in the current payment system that impede delivering high-value services to the eligible patients;
2. **Accountability for Spending.** The APM needs a mechanism for assuring patients and payers that avoidable spending will decrease (if the goal of the APM is to achieve savings), or that spending will not increase (if the goal of the APM is to improve quality);
3. **Accountability for Quality.** The APM also needs a mechanism for assuring that patients will receive equal or better quality of care and outcomes as they would with the kind of care they receive under the current payment system; and
4. **Patient Eligibility.** The APM needs a mechanism for determining which patients will be eligible for the services supported by the APM.

There are multiple ways to implement each of these components, and the decisions made about one component affect the decisions about the others.

CHQPR's report *How to Create an Alternative Payment Model*[5] provides a detailed, step-by-step description of how to design and implement a good APM, including:

- identifying opportunities to reduce spending or improve quality.
- identifying the changes in services that will reduce spending or improve quality in the opportunity areas.
- identifying the barriers that current payment systems create to making the changes in services that will reduce spending or improve quality.
- designing the APM to overcome the barriers and to assure delivery of higher-value care.

Current APMs have not been successful because they have not been designed to focus on specific opportunities for reducing avoidable spending or specific areas where patients are experiencing poor outcomes, they have not identified ways that care delivery could change to achieve lower spending or better outcomes and how much those care delivery approaches would cost, and they have not identified the specific aspects of current payment systems that need to change in order to enable the implementation of higher-value care delivery.

E. Criteria for Evaluating APM Designs

The likelihood that an APM will be effective in achieving savings and improving quality can be determined by answering eight questions to assess whether it corrects the problems in fee-for-service payment while preserving its strengths.

Does the APM Correct the Problems with FFS?

1. Does the APM pay for the high-value services needed to improve patient care?
2. Does the APM align payment amounts with the cost of delivering high-quality care?
3. Does the APM assure each patient they will receive appropriate, high-quality care?
4. Does the APM make the cost of diagnosing or treating a health condition more predictable and comparable?

Does the APM Preserve the Strengths of FFS?

1. Will a provider only be paid under the APM if a patient receives care?
2. Are payments under the APM higher for patients who need more services?
3. Is the provider's payment under the APM based on things the provider can control?
4. Will providers know how much they will be paid under the APM before delivering services?

As will be seen in the next section, most of the Advanced Alternative Payment Models in Medicare fail to meet the majority of these criteria. Because of this, it is not surprising that their performance to date has fallen far short of expectations, and it is unlikely that their future performance will be better unless major changes are made to the APM designs.

II. THE PROBLEMS WITH CURRENT MEDICARE APMs

As of the end of 2018, the Centers for Medicare and Medicaid Services (CMS) had created only a dozen APMs that qualify as “Advanced Alternative Payment Models” under MACRA (the Medicare Access and CHIP Reauthorization Act).[6] These are:

- Tracks 2 and 3 in the Medicare Shared Savings Program (MSSP), and two variations on this program created as demonstration programs — Track 1+ ACOs and the Next Generation ACO program. In regulations issued in December 2018, CMS announced that Tracks 1+, 2, and 3 would be terminated, and ACOs would only qualify for Advanced APM status if they were in the new Basic Level E or Enhanced Tracks.
- The Bundled Payments for Care Improvement Advanced (BPCI-A) demonstration.
- The Comprehensive Care for Joint Replacement (CJR) demonstration.
- The Comprehensive ESRD Care (CEC) demonstration for Large Dialysis Organizations (LDOs) and the two-sided risk track for smaller organizations (non-LDOs).
- The Comprehensive Primary Care Plus (CPC+) demonstration.
- The Oncology Care Model (OCM) demonstration.
- The Maryland All-Payer and Total Cost of Care demonstrations, which are only available in Maryland.
- The Vermont Medicare ACO demonstration, which is only being implemented in Vermont.

Some of these APMs are merely minor variations on the others, and some are only available to a limited number of providers. There are only six basic types of Advanced APMs that are available in multiple locations across the country (BPCI-A, CJR, CEC, CPC+, MSSP/ACOs, and OCM).[7] Table 1 shows that none of these six APMs meets the majority of the eight criteria defined in Section I-E.

The charts on pages 6-11 show that the six Advanced APMs in Medicare fare poorly on these important criteria because of the ways that each of the four key APM components are designed.

TABLE 1
EVALUATION OF MEDICARE ADVANCED APMs BASED ON CRITERIA FOR SUCCESSFUL APMs

	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 the cost of healthcare services 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 how much they will be paid before delivering services?	NO	NO	NO	YES	NO	NO

Weaknesses in Component #1 of Medicare APMs

Most of the current Medicare Advanced APMs do little or nothing to directly address the barriers current payment systems create to delivering better care:

- The largest of the Advanced APMs, the Medicare Shared Savings Program, makes no changes at all in the underlying payment systems for services other than waiving restrictions on the use of telehealth, home visits, and skilled nursing facilities. It simply awards shared savings bonuses or imposes financial penalties based on Component #2.
- Only two of the Medicare APMs – Comprehensive Primary Care Plus and the Oncology Care Model – provide new payments to participating providers that can be used for services that are not paid for, or not paid for adequately, under current payment systems. However, it is unclear whether the payment amounts are adequate to cover the costs of the services needed to achieve the goals of the APMs, particularly for practices with small numbers of Medicare patients.

Instead of being paid directly for delivering new high-value services that their patients need, or being paid more for services that are currently underpaid, the providers in most of the APMs are expected to pay for those services and costs through "shared savings" payments they may receive in the future if spending on the patients is lower than target spending amounts set by CMS. (Different APMs refer to these payments using different names, including "Performance-Based Payments" and "Net Payment Reconciliation Amounts.")

Weaknesses in Component #2 of Medicare APMs

In most of the Medicare Advanced APMs, providers are expected to be accountable for almost all Medicare spending on a patient the providers are treating, either for an entire year or for an "episode" lasting several months. This includes spending on services that a patient receives for conditions that are completely unrelated to the care that the APM participants are being paid for, spending on services delivered by providers who are not participating in the APM, spending increases due to increases in the prices of drugs, and other factors beyond the control of the APM participants.[8] Spending targets are set by CMS using complex methodologies that do not fully adjust for differences in patient needs.[9]

The only Advanced APM that bases accountability on utilization of specific services rather than total spending on all services the patient receives is the Comprehensive Primary Care Plus (CPC+) APM. This was a change from the original Comprehensive Primary Care Initiative (CPCI), in which a portion of the payments to practices were expected to come from shared savings on the total cost of care for the patients. When CMS terminated CPCI and replaced it with CPC+, it explicitly chose not use a total cost of care shared savings component, stating that shared savings was not a desirable way to pay primary care practices.[10]

Also, the potential penalties in most of the APMs are very large – if spending is higher than target amounts, a participating provider could have to pay CMS as much as 20% of the total amount Medicare is spending on services for all of the participating patients' needs. Because total Medicare spending on the patients in an APM is typically many times more than the total payments to the providers participating in the APM, particularly when the providers are physician practices, the penalties under the APM could potentially be larger than the total revenues of the participating providers. This means the providers would have to accept a high level of financial risk in order to participate in the APM.

The only exception is the CPC+ APM, where the penalty for high levels of utilization is limited to returning one-half of the Performance-Based Incentive Payment that CMS has paid to the primary care practice in advance.

Weaknesses in Component #3 of Medicare APMs

In most of the Medicare Advanced APMs (the Medicare Shared Savings Program, the Oncology Care Model, Bundled Payments for Care Improvement – Advanced, and the Comprehensive Care for Joint Replacement program), there is no direct penalty if a provider delivers poor quality care to patients unless the provider's spending is higher or lower than the target amount. Quality scores are based on averages calculated across all patients and they only affect Shared Savings or repayment amounts, not payments for individual services, so if a provider delivers poor quality care to a patient, the provider will still be paid for the services delivered to that patient, and there may be no penalty at all if the average level of quality for all patients is not affected.[11]

In addition, because the APMs only use quality measures focused on a narrow range of quality issues, it is possible that providers could receive bonuses for reducing spending even though patients received poorer quality care in areas that are not measured.

Weaknesses in Component #4 of Medicare APMs

Most of the Medicare Advanced APMs determine the eligibility of patients exclusively or primarily using retrospective attribution methodologies driven by fee-for-service utilization, rather than allowing providers and patients to determine in advance whether the patient is eligible and wants to participate in the APM. Changes have been made in several of the Medicare Advanced APMs so that patients can now voluntarily enroll, but most patients' participation is still primarily determined based on how many office visits a patient made to the providers in the APM, not based on whether the patient wants to be in the APM or is willing to participate in different approaches to care delivery the provider will use.

The two Medicare episode payment models — BPCI Advanced and CJR — determine eligibility of an inpatient admission based on the Diagnosis Related Group (DRG) assigned to the patient's hospital stay. However, the DRG is not assigned until after the patient is discharged, and the DRG depends on all of the conditions for which the patient was treated in the hospital, not just the reason the patient was admitted. For example, a patient who experiences severe complications from hip or knee surgery could be assigned to a different DRG and thereby the provider would not be subject to the cost or quality accountability under the APM for that patient. Moreover, under BPCI-A, patients with a chronic condition are only eligible if they are admitted to the hospital.

BUNDLED PAYMENTS FOR CARE IMPROVEMENT ADVANCED (BPCI-A)[12]

APM STRUCTURE

Component #1: Adequate Payment for Needed Services	All providers continue to be paid using standard payment systems and payment amounts, except for waivers of restrictions on telehealth services, post-discharge home visits, and the 3-day minimum hospital stay required for SNF services. The accountable entity may receive a Net Payment Reconciliation Amount (NPRA) long after services are delivered if total spending for all eligible patients is lower than a target spending amount.
Component #2: Accountability for Spending	The accountable entity must repay CMS if the total risk-adjusted spending for all eligible patients during their hospital admissions or outpatient procedures and during the 90-day period afterward is higher than the target spending amount for those patients. Total repayments are limited to 20% of the target spending. Repayments are also required if spending for patients during the 90-120 day period after discharge is significantly higher than expected.
Component #3: Accountability for Quality	Quality is assessed by averaging several measures across all participating patients and across different types of procedures and comparing the averages to national benchmarks. Some conditions/procedures have more quality measures than others. Good quality scores will result in up to a 10% higher NPRA when actual spending is below target levels and will result in up to 10% higher repayments to CMS when spending is above target levels.
Component #4: Patient Eligibility Determination	A patient is included (a) if they have an inpatient admission for one of 29 conditions or procedures that are classified into one of 105 Diagnosis Related Groups or if they receive one of 3 specified outpatient procedures, (b) if their care is provided by a physician group or hospital that has agreed to participate in BPCI Advanced for that type of condition or procedure, and (c) if they do not die before discharge from the hospital.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Pays for high-value services needed to improve care?	NO	There are no new payments for care management services or new forms of post-acute care. If the accountable entity ultimately receives an NPRA payment, it could be used to offset losses on unpaid services.
Aligns payments with the cost of high-quality care?	NO	There are no changes in the amounts currently paid for services regardless of changes in volume or methods of care delivery.
Assures each patient receives high-quality care?	NO	There is no penalty for poor quality if actual spending matches the target spending level. All providers are still paid for services delivered to a patient who receives poor quality care. The quality measures do not prevent providers from receiving an NPRA payment if they reduce spending in a way that harms one or more patients.
Makes the cost of healthcare services more predictable and comparable?	NO	Not all patients who receive a procedure or have a health condition are included, including those who experience a serious complication during the hospital admission. Total payments for a patient or a particular procedure are never determined because reconciliations are based on spending for all types of episodes. Patient cost-sharing is still based on services received, with no limit for an individual episode.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Only pays providers when a patient receives care?	YES	Patients are only included if they have been admitted to the hospital or received one of the eligible outpatient procedures, and most payments continue to be based on the number and types of services the patient receives.
Higher payments for patients who need more services?	YES	Payments for services are primarily based on the number and types of services patients receive. However, target prices are not adjusted for characteristics affecting post-acute care needs, so the providers may be penalized if patients need unusually high levels of post-acute care.
Payments based only on things provider can control?	NO	The accountable entity is responsible for the spending on all services the patient receives during the 120 days after the hospital stay or outpatient procedure, including services for unrelated conditions and services that are ordered by other providers.
Provider knows how much they will be paid before delivering services?	NO	The physician group, hospital, or other entity that is accountable for spending will not know if the patient is eligible until after the patient is discharged from the hospital, and they will not know the actual net amount they will be paid for services to eligible patients until after all claims for services received by the patients have been paid and financial reconciliation of episodes has been completed.

Comprehensive Care for Joint Replacement (CJR)[13]

APM STRUCTURE

Component #1: Adequate Payment for Needed Services	All providers continue to be paid using standard payment systems and payment amounts, except for waivers of restrictions on telehealth services, post-discharge home visits, and the 3-day minimum hospital stay required for SNF services. The hospital may receive a Net Payment Reconciliation Amount (NPRA) long after services are delivered if total spending for all eligible patients is lower than a target spending amount.
Component #2: Accountability for Spending	The hospital must repay CMS if the total spending for all eligible patients during their hospital admissions and the 90-day period following discharge is higher than the target spending amount for those patients. Total repayments are limited to 20% of the target spending (lower limits apply to small and rural hospitals).
Component #3: Accountability for Quality	Quality is assessed based on (1) post-surgical complication rates for elective hip and knee procedures and (2) patient experience ratings for all eligible patients, compared to all hospitals and to past performance for the same hospital. Low quality scores will reduce the spending target by 0.5%-1.5%, which can result in higher repayments and/or smaller NPRA payments. If quality is below acceptable levels, no NPRA will be paid even if spending is below target levels.
Component #4: Patient Eligibility Determination	A patient is included if they are classified into one of the two Diagnosis Related Groups associated with initial hip or knee replacement surgery (both elective surgery and treatment for a fracture) at a hospital that has been required to participate or has agreed to participate voluntarily (where that is allowed) and if the patient does not die before the end of the episode.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Pays for high-value services needed to improve care?	NO	There are no new payments for care management services or new forms of post-acute care. If the hospital ultimately receives an NPRA payment, it could be used to offset losses on unpaid services.
Aligns payments with the cost of high-quality care?	NO	There are no changes in the amounts currently paid for services regardless of changes in volume or methods of care delivery.
Assures each patient receives high-quality care?	NO	There is no penalty for poor quality if actual spending matches the target spending level. All providers are still paid for services delivered to a patient who receives poor quality care. The quality measures do not prevent a hospital from receiving an NPRA payment if it reduces spending in a way that harms one or more patients.
Makes the cost of healthcare services more predictable and comparable?	NO	Patient eligibility is not determined until after hospital care has been delivered. Patients may be excluded if serious complications occur during the hospital admission. The total payment for an individual patient is never determined because reconciliations are netted out across all eligible patients at the hospital, so it is impossible to compare the actual payments different hospitals receive for specific types of surgery and patients. Patient cost-sharing is still based on services received, with no limit for an individual episode.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Only pays providers when a patient receives care?	YES	Patients are only included if they have received hip or knee surgery, and most payments continue to be based on the number and types of services the patient receives.
Higher payments for patients who need more services?	YES	Payments for services are primarily based on the number and types of services patients receive. However, target prices are not adjusted for characteristics affecting post-acute care needs, so the hospital may be penalized if patients need unusually high levels of post-acute care.
Payments based only on things provider can control?	NO	The hospital is responsible for spending on all services the patient receives during the 90 days after hospital discharge, including services for unrelated conditions and services that are ordered by other providers.
Providers know how much they will be paid before delivering services?	NO	The hospital will not know if the patient is eligible until after the patient is discharged from the hospital, and it will not know the actual net amount it will be paid for services to eligible patients until after all claims for services received by the patients have been paid and financial reconciliation of episodes has been completed.

Comprehensive ESRD Care (CEC)[14]

APM STRUCTURE

Component #1: Adequate Payment for Needed Services	All providers continue to be paid using standard payment systems and amounts, but the ESRD Seamless Care Organization (ESCO) is permitted to provide performance-based payments to physicians and to provide payments and technology to patients. The ESCO may receive a Shared Savings Payment long after services are delivered if total spending for assigned patients is lower than the Benchmark spending amount by more than the Minimum Savings Rate.
Component #2: Accountability for Spending	The ESCO must repay CMS if the total spending for all assigned patients exceeds the Benchmark spending amount by more than the Minimum Loss Rate. The repayment is based on a percentage of the amount by which total spending exceeds the Benchmark. The repayment is higher if quality scores are lower, but no more than 15% of the benchmark spending.
Component #3: Accountability for Quality	Quality is assessed using a quality score based on 5 quality measures averaged across all assigned patients and compared to national benchmarks. Lower quality scores will result in smaller Shared Savings Payments (if spending is lower than the benchmark) and higher amounts of repayments (if spending is higher than the benchmark).
Component #4: Patient Eligibility Determination	A patient is assigned to the ESCO if the patient has End Stage Renal Disease (ESRD) and if the patient's first visit to a dialysis facility was a facility that is part of the ESCO. Patients continue to be assigned to the ESCO unless they receive a kidney transplant or they receive the majority of their dialysis treatments outside of the geographic market served by the ESCO.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Pays for high-value services needed to improve care?	NO	There are no new payments for care management services or any other high-value services that could help to reduce spending. If the ESCO ultimately receives a Shared Savings Payment, it could be used to offset losses on unpaid services.
Aligns payments with the cost of high-quality care?	NO	There are no changes in the amounts currently paid for services regardless of changes in volume or methods of care delivery.
Assures each patient receives high-quality care?	NO	Quality is only measured as an average for all patients, and all providers are still paid for services delivered to a patient who receives poor quality care. There is no penalty for poor quality unless spending differs from the Benchmark by more than the Minimum Savings or Loss Rate. The quality measures do not prevent an ESCO from receiving a Shared Savings Payment if it reduces spending in a way that harms one or more patients.
Makes the cost of healthcare services more predictable and comparable?	NO	There is no mechanism for predicting the amount that will be spent for services to any individual patient, and there is no direct, accurate way for patients to compare the cost and quality of care they would receive from different ESCOs. Patient cost-sharing is still based on services received, with no limit over any time period.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Only pays providers when a patient receives care?	YES	Most payments to providers continue to be based on the number and types of services the patient receives. However, the ESCO could receive a Shared Savings Payment for delivering fewer services to patients than they need.
Higher payments for patients who need more services?	YES	The dialysis providers and nephrologists in the ESCO will receive higher fee-for-service payments initially if they deliver more services or more expensive services to patients. However, the providers could then have to repay a portion of the payments if the patients assigned to the ESCO have higher needs that cause total spending to exceed the Benchmark spending amount.
Payments based only on things provider can control?	NO	The Shared Savings Payment or repayment amount for an ESCO is based on total spending on all services received by assigned patients during the year, including services for conditions unrelated to end stage renal disease and services delivered by dialysis facilities or other providers that are not part of the ESCO.
Providers know how much they will be paid before delivering services?	NO	The dialysis facilities and nephrologists participating in the ESCO will not know the net amount they will be paid for services to eligible patients until after all claims for services received by the patients have been paid and reconciliation has been completed.

Comprehensive Primary Care Plus (CPC+)[15]

APM STRUCTURE

Component #1: Adequate Payment for Needed Services	Primary care practices in both Tracks 1 and 2 receive a quarterly risk-adjusted Care Management Fee (CMF) and an annual Performance-Based Incentive Payment (PBIP) for each patient in addition to all standard Physician Fee Schedule payments. Practices participating in Track 2 receive higher CMF and PBIP amounts and also receive a quarterly Comprehensive Primary Care Payment (CPCP) for each patient, but receive 40-65% lower payment amounts for Physician Fee Schedule services.
Component #2: Accountability for Spending	The practice is accountable for the rate at which its patients are admitted to a hospital or visit an Emergency Department for any reason. Up to 50% of the Performance-Based Incentive Payment (i.e., up to $1.25 per patient per month in Track 1 and $2.00 pmpm in Track 2) must be repaid if the ratios of the risk-adjusted rates of ED visits and hospital admissions to the expected rates are worse than the 80th percentile for non-CPC+ practices.
Component #3: Accountability for Quality	In 2019, quality is assessed based on the patient experience of care and two clinical quality measures (blood pressure and blood sugar control) averaged across all eligible patients and compared to national benchmarks. Up to 100% of the Performance-Based Incentive Payment (i.e., up to $2.50 per patient per month in Track 1 and $4.00 pmpm in Track 2) must be repaid if the average performance on the measures for the patients in the practice is worse than the 70th percentile for non-CPC+ practices.
Component #4: Patient Eligibility Determination	A practice is eligible for payments for a patient if the patient received either a Wellness Visit or Chronic Care Management Services from that practice or if the plurality of the patient's primary care visits over the previous two years were at the practice. Beginning in 2019, a patient can also be included if they attest that the practice is coordinating their health care.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Pays for high-value services needed to improve care?	YES	The CMF and PBIP represent additional, flexible payments that can be used to deliver services that are underpaid or not paid for at all under the Physician Fee Schedule or other payment systems.
Aligns payments with the cost of high-quality care?	NO	Payment amounts do not vary based on the number of eligible patients and may not be sufficient to cover the cost of delivering high-quality services in small and rural practices.
Assures each patient receives high-quality care?	NO	The practice will still be paid for a patient even if the patient receives poor-quality care or if the patient experiences a hospital admission. Quality is only assessed on average across all patients, and the measures used may be unrelated to the major health problems the patient is experiencing.
Makes the cost of healthcare services more predictable and comparable?	YES	A significant portion of the payment to the practice for care of a patient is prospectively defined based on the patient's characteristics. A patient would be better able to compare the cost and quality of different practices.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Only pays providers when a patient receives care?	NO	A practice will receive some payments for a patient even if no services are provided.
Higher payments for patients who need more services?	YES	A portion of payments will be based on the number and type of services delivered, particularly for practices in Track 1, and Care Management Fees will be higher for patients with more health problems.
Payments based only on things provider can control?	NO	The practice may be assigned accountability for a patient who does not want care management from the practice. The utilization and quality measures are not completely within the control of a primary care practice.
Providers know how much they will be paid before delivering services?	YES	The amount the practice will be paid for a patient is mostly known before any services are delivered.

Medicare Shared Savings Program - Basic Level E and Enhanced (MSSP)[16]

APM STRUCTURE

Component #1: Adequate Payment for Needed Services	All providers continue to be paid using standard payment systems and payment amounts, except for waivers of restrictions on telehealth services and the 3-day minimum hospital stay required for SNF services. The Accountable Care Organization (ACO) may receive a Shared Savings Payment long after services are delivered if total spending for assigned patients is lower than the Benchmark spending amount by more than the Minimum Savings Rate.
Component #2: Accountability for Spending	The ACO must repay CMS if the total spending during the year for all assigned patients exceeds the Benchmark spending amount by more than the Minimum Loss Rate. The repayment amount is based on a percentage of the amount by which total spending exceeds the Benchmark, but the repayment amount can be no more than a maximum percentage of the benchmark spending and/or a maximum percentage of the total revenues the ACO participants receive from the Medicare program. The repayment amount is higher if quality scores are lower.
Component #3: Accountability for Quality	Quality is assessed using a quality score based on 23 quality measures averaged across all assigned patients and compared to national benchmarks. Lower quality scores will result in smaller Shared Savings Payments (if spending is lower than the benchmark) and higher amounts of repayments (if spending is higher than the benchmark).
Component #4: Patient Eligibility Determination	A patient is assigned to the ACO if (a) the patient designates an ACO clinician to be responsible for coordinating their overall care or (b) the patient received more primary care visits during the previous year from ACO clinicians than from other providers.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Pays for high-value services needed to improve care?	NO	There are no new payments for care management services or any other high-value services that could help to reduce spending. If the ACO ultimately receives a Shared Savings Payment, it could be used to offset losses on unpaid services.
Aligns payments with the cost of high-quality care?	NO	There are no changes in the amounts currently paid for services regardless of changes in volume or methods of care delivery.
Assures each patient receives high-quality care?	NO	Quality is measured as an average for all patients, and providers are still paid for services if a patient receives poor quality care. There is no penalty for poor quality unless spending differs from the Benchmark by more than the Minimum Savings or Loss Rate. The quality measures do not prevent an ACO from receiving a Shared Savings Payment if it reduces spending in a way that harms one or more patients.
Makes the cost of healthcare services more predictable and comparable?	NO	There is no mechanism for predicting the amount that will be spent on services to any individual patient, and there is no direct, accurate way for patients to compare the cost and quality of care they would receive from different ACOs. Patient cost-sharing is still based on services received, with no limit for the year.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Only pays providers when a patient receives care?	YES	Most payments to providers continue to be based on the number and types of services the patient receives. However, the ACO could receive a Shared Savings Payment for delivering fewer services to patients than they need.
Higher payments for patients who need more services?	YES	The providers in the ACO will receive higher fee-for-service payments initially if they deliver more services or more expensive services to patients. However, the providers could then have to repay a portion of the payments if the patients assigned to the ACO have higher needs that cause total spending to exceed the Benchmark spending amount.
Payments based only on things provider can control?	NO	The Shared Savings Payment or repayment amount for an ACO is based on total spending on all services received by assigned patients during the year, including services delivered by providers who are not part of the ACO, with only limited adjustments for new health problems the patients develop.
Providers know how much they will be paid before delivering services?	NO	A provider participating in the ACO will not know the net amount it will be paid for services to eligible patients until after all claims for services received by the patients have been paid and financial reconciliation has been completed.

Oncology Care Model (OCM)[17]

APM STRUCTURE

Component	Description
Component #1: Adequate Payment for Needed Services	An oncology practice can receive $160 Monthly Enhanced Oncology Services (MEOS) payments each month for a patient who is receiving chemotherapy, in addition to all standard fee-for-service payments. The practice can also receive a Performance-Based Payment long after services are delivered if total spending for all eligible patients is below a target amount.
Component #2: Accountability for Spending	If the total spending on all services received by patients during the six months following initiation of chemotherapy is higher than a formula-based target amount, the practice must repay CMS the difference (the "recoupment"), up to a maximum of 20% of the total spending.
Component #3: Accountability for Quality	Twelve quality measures, averaged across all patients in the oncology practice and compared to national benchmarks, are used to calculate a quality score. If average spending is below the target amount, the Performance-Based Payment is adjusted based on the quality score.
Component #4: Patient Eligibility Determination	A patient is eligible for a period of six months after they begin receiving chemotherapy if the patient makes more Evaluation & Management visits involving a cancer diagnosis to the oncology practice than to other physician practices. A patient can be eligible for an additional six months if chemotherapy continues for more than six months.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Question	Answer	Explanation
Pays for high-value services needed to improve care?	YES	The MEOS payment can be used to deliver services that are underpaid or not paid for under the Physician Fee Schedule and other payment systems.
Aligns payments with the cost of high-quality care?	NO	The MEOS payment is not adjusted based on the number of patients treated or their needs, so the payments may not cover the cost to deliver high-quality cancer care services, particularly in small practices. The practice may experience losses if expensive drugs needed by patients cause spending to exceed the target spending amount.
Assures each patient receives high-quality care?	NO	There are not quality measures specific to every type of cancer, and there is no penalty for poor quality unless actual spending is below the target spending amount. The oncology practice is still paid for services delivered to a patient who receives poor quality care. The quality measures do not prevent an oncology practice from receiving a higher payment if it reduces spending in a way that harms one or more patients.
Makes the cost of healthcare services more predictable and comparable?	NO	The "Target Prices" for each patient that are used to determine the target spending amount for the practice are not based on the specific clinical characteristics of the patients and their cancers, and therefore cannot provide a realistic estimate of what services the patient will need or what they will cost, so it is impossible to compare oncology practices in terms of the cost of treating similar patients. There is no accountability for spending on chemotherapy paid for through Part D. Patient cost-sharing is still based on services received, with no limit for an individual episode.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Question	Answer	Explanation
Only pays providers when a patient receives care?	NO	A patient must receive at least one chemotherapy treatment in order for the practice to be paid, but the practice can continue to receive MEOS payments and receive a Performance-Based Payment even if the patient does not receive services they need.
Higher payments for patients who need more services?	YES	The oncology practice will receive higher fee-for-service payments initially if it delivers more services. However, it could then have to repay a portion of the payments if patients have higher needs that cause total spending to exceed the target spending amount. The amount of the MEOS payment is not adjusted based on patient needs, and there is no additional payment for services to patients who do not receive chemotherapy or services needed by patients after chemotherapy ends.
Payments based only on things provider can control?	NO	The Performance-Based Payment or recoupment amount for a practice is based on total spending on all services received by the patient during a six month period after chemotherapy begins, including services for conditions unrelated to the cancer and for factors such as increases in drug prices that the oncology practice cannot control.
Providers know how much they will be paid before delivering services?	NO	The practice will not know the actual net amount it will be paid for a patient until after a six month episode has ended and reconciliation calculations have been made.

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III. CREATING BETTER ALTERNATIVE PAYMENT MODELS

A. Will Greater Financial Risk Make APMs More Successful?

CMS and other payers have asserted that the disappointing results in current APMs are because the APMs do not create enough "financial risk" for the participating providers. Proposed solutions have included requiring providers to accept higher levels of financial risk (i.e., the healthcare providers would be responsible for refunding a higher proportion of their payments if total spending on their patients was higher than target levels) and creating "population-based payments" in which healthcare providers would be expected to deliver all of the services a patient needs for a fixed monthly or annual payment.

However, there is no evidence that simply increasing the financial risk for physicians, hospitals, and other providers in these APMs would result in greater savings for Medicare or other payers.[18] A more plausible explanation for the failure of current APMs is that the APMs have not actually corrected the problems with fee-for-service payment systems. Moreover, both patients and providers will understandably be concerned about participating in risk-based and population-based payment models that fail to preserve the strengths of the current fee-for-service system and fail to assure patients they will receive high-quality care.

B. Better Ways to Design APMs

Fortunately, there are ways to design Alternative Payment Models that correct all of the problems with the fee-for-service system while also preserving all of its strengths. Table 2 shows four general APM designs that are better than both current shared savings APMs and the population-based APMs currently being promoted by CMS and other payers. The four designs are:[19]

- **Accountable Payment for Service.** A provider receives a new or revised payment for delivering a specific service to patients, and the payment is reduced if targets for spending on specific services and performance on quality measures are not achieved.
- **Accountable Bundled Payment.** A provider or team of providers receives a bundled payment to enable delivery of a group of services to patients or to treat a particular condition, and the payment is reduced if targets for spending on specific services and performance on quality measures are not achieved.
- **Outcome-Based Payment.** A provider is only paid for a service or group of services if standards or targets for quality and spending are achieved.
- **Bundled/Warrantied Payment.** A provider or team of providers receives a bundled payment to deliver a group of services to patients, and the provider team is responsible for using the payment to cover the costs of necessary services and also to pay for avoidable services or services needed to address complications of treatment.

C. Creating Effective APMs for Care of Chronic Conditions

A logical place to focus in implementing better APM designs in Medicare would be improving care for patients with asthma, chronic kidney disease, COPD, diabetes, heart failure, inflammatory bowel disease, and other chronic conditions. Many patients with these conditions are hospitalized for exacerbations of their disease that could have been avoided through better care management services, in-home services, and other services that are paid for inadequately or not at all under current Medicare payment system.

Despite the fact that a large percentage of Medicare patients have one or more of these chronic conditions and that there are significant opportunities to improve outcomes and reduce spending on their care, CMS has not implemented any APMs that are specifically focused on improving the overall care of patients with these conditions and helping them avoid hospitalizations.[20] None of the existing CMS APMs provide different types of payment for the specialists who typically manage or co-manage the care of the subset of patients who are most at risk of complications, even though these physicians are often in the best position to help these patients avoid hospitalizations.

No one APM design will likely be feasible, desirable, or effective for all patients with these chronic diseases or for providers in all communities. As examples, two different APM designs are described on page 14:

- **APM for Care Management of Chronic Disease.** This is an example of how an APM could make one targeted change to payment to address a specific opportunity for improvement, while leaving the rest of the payment system unchanged.[21]
- **APM for Management of a Chronic Condition.** This example illustrates how an APM could replace the current fee-for-service payment system for the many different kinds of services needed to diagnose and manage one or more chronic conditions.[22]

The tables on pages 15 and 16 show how each of the four components of the two APMs would be designed, and how both of the APM designs meet all eight of the criteria described in Section I-E, i.e., addressing all four of the key problems with current fee-for-service payment systems while preserving all four of the strengths of the current payment system.

TABLE 2
COMPARISON OF WELL-DESIGNED APMs TO CURRENT APMs and FFS

	Current APMs		Well-Designed APMs			
	Shared Savings/ Risk	**Population-Based Payment**	**Accountable Payment for Services**	**Accountable Bundled Payment**	**Outcome-Based Payment**	**Bundled/ Warrantied Payment**
Component #1: Adequate Payment for Needed Services	No change in FFS	Flexible payment for each patient; higher amounts for some but not all needs	Payments for new high-value service(s) and/or higher payments for existing service(s)	Bundled payment for group of services from a provider team	Payments for new high-value services and/or higher payments for existing services	Bundled payment for group of services from a provider team
Component #2: Accountability for Spending	Penalty for increase in total spending on patients	Fixed payment regardless of services needed or delivered	Penalty if spending controllable by provider exceeds target		Penalty if spending controllable by provider exceeds target	
Component #3: Accountability for Quality	None unless spending differs from targets	Penalties for poor performance on population-level quality measures	Penalty if quality controllable by provider falls short of target for individual patient	Penalty if quality controllable by provider falls short of target for individual patient	No payment if quality standards are not met	Compensation for problems caused by failure to deliver high-quality care
Component #4: Patient Eligibility Determination	Attributed based on service utilization	Attributed based on service utilization	Patient selects provider team	Patient selects provider team	Patient selects provider team	Patient selects provider team
CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?						
Pays for high-value services needed to improve care?	NO	YES	YES	YES	YES	YES
Aligns payments with the cost of high-quality care?	NO	NO	YES	YES	YES	YES
Assures each patient receives high-quality care?	NO	NO	YES	YES	YES	YES
Makes the cost of healthcare services more predictable and comparable?	NO	YES	YES	YES	YES	YES
PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?						
Only pays providers when a patient receives care?	YES	NO	YES	YES	YES	YES
Higher payments for patients who need more services?	YES	NO	YES	YES	YES	YES
Payments based only on things provider can control?	NO	NO	YES	YES	YES	YES
Providers know how much they will be paid before delivering services?	NO	YES	YES	YES	YES	YES

APM FOR CARE MANAGEMENT OF CHRONIC DISEASE (APM-CM)[21]

Under this APM, an individual who has been diagnosed with a chronic disease would choose a Chronic Care Management Team that is participating in the APM to provide care management services for one or more of the patient's chronic conditions. The patient would be classified into one of four need/risk categories based on characteristics that affect their likelihood of exacerbations and hospitalizations and the intensity of care management services the patient would need to prevent exacerbations and hospitalizations.

The Chronic Care Management Team would receive a quarterly Care Management Payment in addition to any fee-for-service payments the Team received for office visits, procedures, etc. needed to treat the patient's condition(s). The amount of the Care Management Payment would be higher for a patient in a higher need/risk category. Except for patients in the Very High Risk category, the Team would not receive a quarterly Care Management Payment if the patient was admitted to the hospital during the quarter for reasons related to the chronic conditions the Team is supposed to be managing. For Very High Risk patients, the Team would be expected to maintain or reduce the rate at which the patients were being hospitalized before they began receiving the care management services supported by the APM.

The APM would reduce spending and improve outcomes by reducing the rate of avoidable hospital admissions.

APM FOR MANAGEMENT OF A CHRONIC CONDITION (APM-CC)[22]

Under this 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. 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.
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.
4. **Hospitalization for an Exacerbation of the Condition.** Hospitals would receive three separate types of payments to cover the costs of services to patients who 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 capacity.
    b. A Bundled/Warrantied 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. The patient's need/risk classification could change at any time, and subsequent payments would reflect the new need/risk category.

Diagnosis Teams, Treatment Teams, hospitals, and Palliative Care Teams would receive no payment for a patient if the providers failed to meet evidence-based care standards in providing services to that patient. Payments to a Team or hospital would be reduced if desirable outcomes were not achieved. Treatment Teams would receive no payment for low- and moderate-risk patients 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.

APM for Care Management of Chronic Disease (APM-CM)[21]

APM STRUCTURE

Component #1: Adequate Payment for Needed Services	A new Care Management Payment would provide adequate payment to support the cost of high-quality care management services for patients with a chronic disease. Higher amounts would be paid for patients with characteristics that increase the risk of hospitalization or require more care management services. A Chronic Care Management Team could also receive all current fee-for-service payments in addition to the Care Management Payment.
Component #2: Accountability for Spending	For patients not classified as very high risk, the Chronic Care Management Team would not receive the Care Management Payment during a calendar quarter if the patient had a condition-related hospital admission during the quarter. For very high risk patients, the Care Management Payments would be reduced by 10% if the patients were hospitalized for condition-related reasons at a significantly higher rate than in previous years. If the rate of condition-related hospital admissions is significantly higher than the national average, the Team would no longer be eligible to receive the Care Management Payment, and if the payer's average condition-related spending for the patients increases, the payments could be terminated.
Component #3: Accountability for Quality	In addition to being accountable for reducing condition-related hospital admissions, the Care Management Team would no longer be eligible to receive the Care Management Payments if the mortality rate for patients increased significantly.
Component #4: Patient Eligibility Determination	Patients would be eligible for the care management services if they have one or more designated chronic diseases and if either (a) the diseases have reached a specified level of severity or (b) the patients have other characteristics creating a high risk for hospitalization.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Pays for high-value services needed to improve care?	YES	The Care Management Payment would provide additional resources needed to deliver care management services that could reduce the rate of hospitalizations and improve patient outcomes.
Aligns payments with the cost of high-quality care?	YES	The Care Management Payment would match the cost of delivering high-quality services to patients with different levels of need in order to achieve rates of condition-related hospitalizations at or below national averages.
Assures each patient receives high-quality care?	YES	A Care Management Team would not receive a Care Management Payment for a patient during a calendar quarter if the patient is hospitalized for a problem related to the chronic disease(s) for which they are receiving care management services.
Makes the cost of healthcare services more predictable and comparable?	YES	A payer would be able to determine the expected combined cost of care management services and hospital admissions for eligible patients based on the patients' characteristics. Payers and patients could compare the cost of care management services and the rates of hospital admissions for different Care Management Teams.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Only pays providers when a patient receives care?	YES	A Care Management Team would only be paid for care of a patient during a calendar quarter if the patient received the services necessary to avoid condition-related hospitalizations.
Higher payments for patients who need more services?	YES	Higher Care Management Payments would be paid for patients with more severe conditions and other characteristics that require more or higher-cost services.
Payments based only on things provider can control?	YES	Care Management Teams would only be accountable for condition-related hospital admissions, spending, and mortality.
Providers know how much they will be paid before delivering services?	YES	The amounts of the Care Management Payments and the expected rates of hospital admissions would be known in advance based on the nature and severity of the patients' conditions and other patient characteristics that affect the need for services.

APM for Management of a Chronic Condition (APM-CC)[22]

APM STRUCTURE

Component	Description
Component #1: Adequate Payment for Needed Services	Seven new bundled payments would be created to provide adequate revenues to support the costs of the kinds of services that patients with a chronic condition would need during five different phases of care. The payments would be stratified into several need/risk-based categories so that higher payments are made for patients who typically require additional or more expensive services.
Component #2: Accountability for Spending	Bundled payments would replace existing fee-for-service payments for all planned services, so that spending for each patient would be more predictable. For patients not classified as high risk, Treatment Teams would not be paid for a patient if that patient had a condition-related ED visit or hospital admission; for high risk patients, the payment would be reduced by 25% if an ED visit or hospital admission occurs. If an ED visit or admission occurs, the hospital would receive a bundled/warrantied payment covering both the hospital services and any post-acute care services for 30 days.
Component #3: Accountability for Quality	Participating providers would receive no payment for a patient if they failed to meet evidence-based care standards in providing services to the patient. Payments would be reduced if desirable patient-reported outcomes were not achieved.
Component #4: Patient Eligibility Determination	Patients would be eligible to participate initially if they have the symptoms of a serious chronic disease, and they would be eligible on an ongoing basis if they have been diagnosed with the disease.

CORRECTS PROBLEMS IN FEE-FOR-SERVICE PAYMENT?

Question	Answer	Explanation
Pays for high-value services needed to improve care?	YES	The new payments would provide the flexibility to deliver high-value services that cannot be delivered today, such as care management services, in-home services, etc.
Aligns payments with the cost of high-quality care?	YES	The new payments would match the cost of delivering high-quality services to patients with different levels of need as the number of patients needing services changes.
Assures each patient receives high-quality care?	YES	There would be no payment for a patient unless the services the patient received met evidence-based standards of quality, and Treatment Teams would not be paid during a calendar quarter if the patient has a condition-related ED visit or hospital admission.
Makes the cost of healthcare services more predictable and comparable?	YES	The total payment for an individual patient's chronic condition and the patient's cost-sharing amount would be known in advance based on the nature and severity of the patient's chronic condition, and patients could compare the cost and quality of services delivered by different provider teams.

PRESERVES STRENGTHS OF FEE-FOR-SERVICE PAYMENT?

Question	Answer	Explanation
Only pays providers when a patient receives care?	YES	A provider team would only be paid for care of a patient during a month or calendar quarter if the patient received appropriate, evidence-based services during that time period.
Higher payments for patients who need more services?	YES	Payment levels would be higher for patients with more severe conditions and other characteristics that require more services or higher-cost services.
Payments based only on things provider can control?	YES	Provider teams would only be accountable for services related to the patient's condition and for achievable outcomes.
Providers know how much they will be paid before delivering services?	YES	The amount of payment for each individual patient would be known in advance based on the nature and severity of the patient's condition and other patient characteristics that affect the need for services.

IV. VALUE-BASED CARE REQUIRES BETTER-DESIGNED APMs

There are many opportunities to significantly reduce spending by Medicare and other payers without harming patients, but these opportunities cannot be pursued without significant changes to current payment systems.[23] Despite the urgent need for Alternative Payment Models that will address these issues, the majority of physicians, hospitals, and other healthcare providers in the country are not participating in an Alternative Payment Model. Most providers have not even had an opportunity to do so because of the small number and narrow focus of the APMs that had been created, but in other cases, providers who could participate in an APM have chosen not to do so. Although this has frequently been blamed on unwillingness by providers to move away from fee-for-service payment, in most cases it likely is due to the providers' unwillingness to participate in a poorly-designed APM that could harm their patients and/or make it difficult to financially sustain high-quality services. The best evidence that providers want to participate in well-designed APMs is the dozens of proposals for APMs that physicians have developed and submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) hoping that CMS will implement them.[24]

There is no one Alternative Payment Model that will be able to effectively support high-quality care for every type of patient or to effectively address all of the different opportunities to reduce spending in ways that will not harm patients. Multiple, different APMs will be needed. Although every effort should be made to design and operationalize these APMs similarly when possible, similarity of APM design primarily benefits payers, not patients or providers. In many cases, an APM that is trying to address a specific health problem will need to be different from other APMs in order to have the maximum impact on spending and provide the best assurance to patients that they will receive equal or better-quality care. Moreover, since so few different types of APMs have been implemented to date, there is no way to know which design is best, and a greater diversity of APM designs in the short run will help improve understanding of what works and what doesn't.

Many people erroneously believe that creating multiple APMs is undesirable because it will increase fragmentation of care and it will undercut efforts to improve coordination, such as through Accountable Care Organizations. However, if an APM is designed to encourage lower spending and better outcomes, the providers participating in the APM will automatically have an incentive to address fragmentation problems and to improve coordination whenever that would truly achieve better results. The APM would encourage coordination when it is desirable, rather than trying to mandate arbitrary concepts of "coordination" that may increase costs without any corresponding benefits. As for ACOs, one of the biggest problems they have faced is that the Medicare Shared Savings Program does not change the fee-for-service systems used to pay the physicians, hospitals, and other providers who are part of the ACOs, making it impossible for those providers to pursue opportunities for savings and quality improvement. Well-designed APMs can help ACOs be more successful than they are today.

Whether one believes that patients will receive better care in an integrated delivery system, through an ACO, from professional collaboration among independent providers, or through the patients' own choices of providers and self-coordination of services, the healthcare providers who are delivering care to the patients need to be compensated appropriately when they deliver high-quality services. Even if Medicare or a health insurance plan pays an integrated delivery system or multi-specialty physician group to address all of a patient's needs using a single capitated payment, that system or group will have to develop ways of compensating each individual physician, hospital, and other provider for what they do. If the compensation systems use a fee-for-service structure, as most such compensation systems do today, then it will create the same problems with patient care as would occur if the health plan made fee-for-service payments directly to each individual physician, hospital, etc. "Population-based payment systems" do not solve the problems with fee-for-service payment, they simply shift them from payers to providers. In these situations, well-designed condition-specific APMs will still be needed, but they will be needed to serve as methods of compensation for the individual providers who are delivering specific kinds of care to individual patients.

Alternative Payment Models and other types of payment reforms hold the potential for accelerating progress toward more affordable and higher-quality care if, but only if, they are designed in the right way. Faster progress in developing and implementing well-designed APMs needs to be a national priority.

ENDNOTES

1. Miller HD. *How to Create an Alternative Payment Model* Center for Healthcare Quality and Payment Reform (December 2018).
2. In the Medicare program, "Alternative Payment Model" (APM) has a specific meaning that was established by Congress in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), namely that the APM must either reduce Medicare spending or at least not cause spending to increase beyond what it would have otherwise been.
3. Miller HD. *Why Value-Based Payment Isn't Working, and How to Fix It*. Center for Healthcare Quality and Payment Reform (October 2017).
4. Ibid.
5. Miller HD. *How to Create an Alternative Payment Model* Center for Healthcare Quality and Payment Reform (December 2018).
6. In MACRA, Congress required that physicians who participate at a minimum level in APMs that meet additional criteria would receive a bonus equal to 5% of their Medicare fee-for-service payments in 2019-2024, receive a higher annual update than other physicians after 2025, and be exempt from the requirements of the Merit-Based Incentive Payment System. In order to qualify for these incentives, a minimum percentage of the physician's revenues or patients must come from an "Alternative Payment Entity," and the Alternative Payment Entity must either "bear financial risk for monetary losses under the APM in excess of a nominal amount" or be designated as a medical home expanded by CMS under Section 1115A of the Social Security Act. When CMS promulgated regulations implementing this portion of MACRA it labeled APMs that meet the criteria for physicians to receive bonuses as "Advanced Alternative Payment Models." As of the beginning of 2019, most of the APMs that had been implemented by CMS did not meet the statutory requirements of MACRA or the requirements of CMS regulations needed to qualify as an Advanced APM. Centers for Medicare and Medicaid Services. *Alternative Payment Models in the Quality Payment Program as of November 2018*.
7. Although the Next Generation ACO (NextGen ACO) demonstration has different options for payment under Component #1 than the Medicare Shared Savings Program, CMS has not released information on how many of the ACOs in the NextGen ACO program are using these options. Moreover, CMS did not include the NextGen options when it revised the structure of MSSP in December 2018 even though it had the ability to do so. Since it is not clear that the NextGen ACO program will continue to be used in the future, it is not analyzed in this report.
8. A detailed summary and comparison of Component 2 of Advanced APMs in Medicare is available in Table 13 of *How to Create an Alternative Payment Model*.
9. For example, in the Medicare Shared Savings Program, when a patient is first assigned to an ACO, CMS calculates that patient's risk score using the standard Hierarchical Condition Category risk adjustment methodology and adjusts the benchmark during the first performance year based on that risk score, i.e., if the patient has a high risk score, the benchmark will be adjusted upward to reflect the expectation that spending will be higher for that patient. However, for patients who were first assigned to the ACO in previous years, the benchmark is adjusted differently. Even if new diagnoses have been assigned to the patients, the benchmark will not be increased on that basis, but if the existing patients' health status improves, the benchmark will be reduced. Centers for Medicare and Medicaid Services. . *Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications, Version #6* (May 2018).
10. In the May 9, 2016 edition of "CPC+ Frequently Asked Questions," CMS stated "We have seen in the Original CPC Model that shared savings ...has certain limitations in motivating practices to control total cost of care. For example...total cost of care may be challenging for small primary care practices to control and there are no independent incentives for improved quality; and ....the amount of any shared savings payments is unknown in advance and the complexity of the regionally aggregated formula and paucity of actionable cost data leaves practices doubtful of achieving any return. The incentive payment methodology in CPC+ will address some of these limitations. The incentive design is stronger because it can be more closely measured at the practice level, will incorporate measures that primary care practices can directly impact, and will be more easily understood by practice leaders."
11. A detailed summary and comparison of Component 3 of Advanced APMs in Medicare is available in Table 14 of *How to Create an Alternative Payment Model*.
12. The description and analysis of the Bundled Payments for Care Improvement - Advanced (BPCI-A) demonstration are based on the information that was publicly available as of January 1, 2019. Sources include:

    Centers for Medicare and Medicaid Services. *BPCI Advanced Target Price Specifications, Model Years 1 and 2* (February 2018).

    Centers for Medicare and Medicaid Services. *BPCI Advanced Clinical Episode Construction Specifications, Model Years 1 and 2* (March 2018).

    Centers for Medicare and Medicaid Services. *BPCI Advanced Clinical Episode Reconciliation Specifications, Model Years 1 and 2* (June 2018).

    Centers for Medicare and Medicaid Services. *BPCI Advanced Frequently Asked Questions (FAQs)* (March 2018).

13. The description and analysis of the Comprehensive Care for Joint Replacement (CJR) demonstration are based on the information that was publicly available as of January 1, 2019. Sources include:

    Centers for Medicare and Medicaid Services. 42 CFR Part 510—Comprehensive Care for Joint Replacement Model.

    Centers for Medicare and Medicaid Services. *Overview of CJR Quality Measures, Composite Quality Score, and Pay-for-Performance Methodology* (Undated).

14. The description and analysis of the Comprehensive ESRD Care (CEC) demonstration are based on the information that was publicly available as of January 1, 2019. Sources include:

    Centers for Medicare and Medicaid Services. *Comprehensive ESRD Care (CEC) Model: Request for Applications* (May 2016).

    Centers for Medicare and Medicaid Services. *Appendix D: Quality Performance* (for LDOs) (Undated).

    Centers for Medicare and Medicaid Services. *Appendix D: Quality Performance* (for non-LDOs) (Undated).

    Centers for Medicare and Medicaid Services. *Comprehensive End Stage Renal Disease Care (CEC) Model 2019 Quality Measure Set*. (Undated)

15. The description and analysis of the Comprehensive Primary Care Plus (CPC+) demonstration are based on the information that was publicly available as of January 1, 2019. Sources include:

    Centers for Medicare and Medicaid Services. *CPC+ Payment and Attribution Methodologies for Program Year 2019* (December 2018).

    Centers for Medicare and Medicaid Services. *Final CPC+ Electronic Clinical Quality Measure (eCQM) Reporting Requirements: Overview for the 2019 Measurement Period* (November 2018).

16. The description and analysis of the Basic Level E and the Enhanced Tracks of the Medicare Shared Savings Program are based on the information that was publicly available as of January 1, 2019. Sources include:

    Centers for Medicare and Medicaid Services. *Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations—Pathways to Success and Extreme and Uncontrollable Circumstances Policies for Performance Year 2017*. 83 FR 67816 et seq. (December 31, 2018)

    Centers for Medicare and Medicaid Services. *Medicare Shared Savings Program: Shared Savings and Losses and Assignment Methodology Specifications, Version #6* (May 2018)

    Centers for Medicare and Medicaid Services. *Medicare Shared Savings Program Quality Measure Benchmarks for the 2019 Performance Year* (December 2018).

17. The description and analysis of the Oncology Care Model (OCM) are based on the information that was publicly available as of January 1, 2019. Sources include:

    RTI International and Actuarial Research Corporation. *OCM Performance-Based Payment Methodology, Version 3.2* (December 27, 2017).

    RTI International and Tellgen. *OCM Quality Measures Guide, Version 2.2* (July 2018)

18. Miller HD. *How to Fix the Medicare Shared Savings Program*. Center for Healthcare Quality and Payment Reform (June 2018).

    Was the Medicare Shared Savings Program Successful in 2017? Center for Healthcare Quality and Payment Reform (August 2018).

19. More information on these four designs is available in *How to Create an Alternative Payment Model*.

20. The Bundled Payments for Care Improvement Advanced demonstration includes episodes for asthma, COPD, and heart failure, but only for patients who have been hospitalized for those conditions and only for a 90 day period following discharge, There is no CMS APM that enables physicians to manage the care of patients with these conditions in order to prevent hospitalizations from occurring in the first place.

21. A more detailed description of the APM for Care Management of Chronic Disease is available at: http://www.chqpr.org/downloads/CareManagement_APM.pdf

22. A more detailed description of the APM for Management of a Chronic Condition is available at: http://www.chqpr.org/downloads/ChronicCondition_APM.pdf

23. Detailed examples of opportunities to reduce spending without harming patients are included in CHQPR's report *How to Create an Alternative Payment Model*.

24. More information on the proposals submitted to the Physician-Focused Payment Model Technical Advisory Committee and the recommendations PTAC has made to the Secretary of Health and Human Services is available at https://aspe.hhs.gov/proposal-submissions-physician-focused-payment-model-technical-advisory-committee.

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