MEDICARE ALTERNATIVE PAYMENT MODELS:

NOT EVERY PROVIDER HAS A PATH FORWARD

September 2017: Angela Bowen | Natalie Burton | David Muhlestein

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- → Category 3B: APMs with Upside Gainsharing/ Downside Risk

- Category 4: Population-Based Payment
  - → Category 4A: Condition-Specific Population-Based Payment
  - → Category 4B: Comprehensive Population-Based Payment
  - → Category 4C: Integrated Finance and Delivery System

- Category 3N: Risk-based Payments Not Linked to Quality

- Category 4N: Capitated Payments Not Linked to Quality[10]

Only payment models that fall under categories 3A, 3B, 4A, 4B, and 4C are APMs. Categories 1, 3N, and 4N have no link to quality and are not considered progress toward true payment reform.[11]

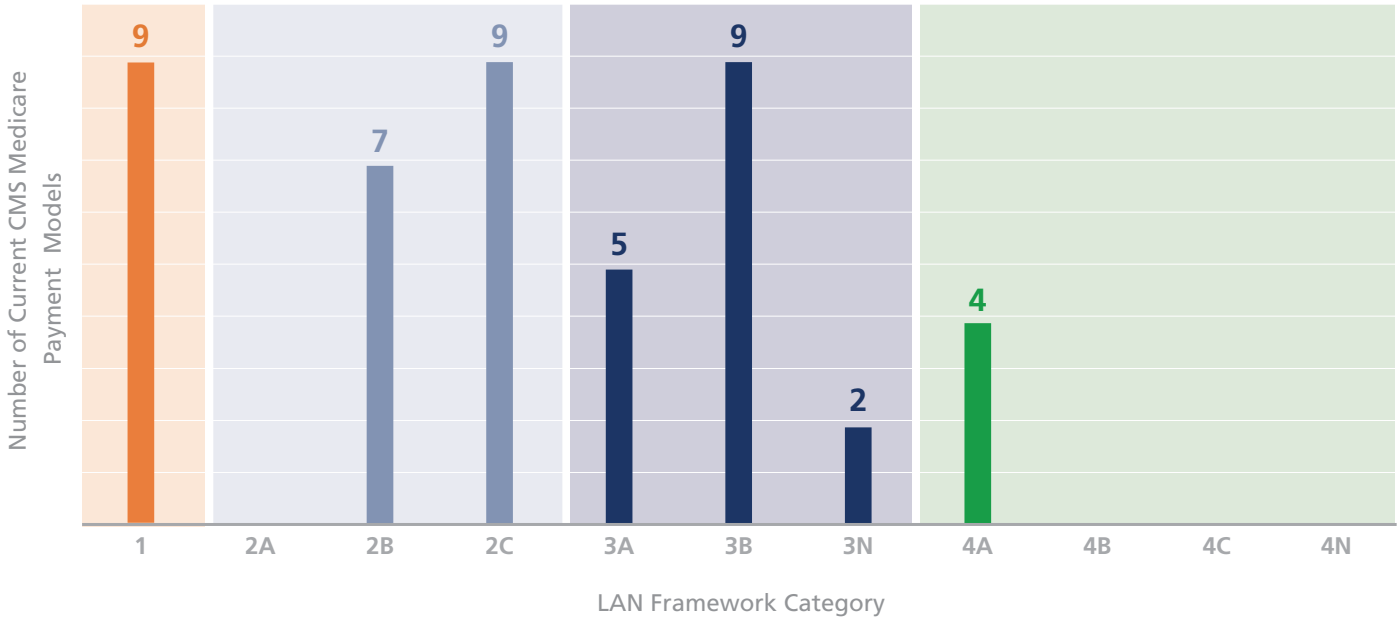
The LAN framework creates a path for providers and organizations to transition to APMs. While it is not necessary for an organization to experience every category in the LAN framework, the framework helps organizations identify the level of engagement they are currently equipped to handle and next steps for transitioning to APMs.

APPLYING THE LAN FRAMEWORK TO CURRENT CMS MEDICARE INITIATIVES

In a recent *Health Affairs Blog* post entitled, "The Changing Payment Landscape of Current CMS Payment Models Foreshadows Future Plans," Leavitt Partners categorized Medicare payment and care delivery models by phase: research, testing, and adoption.[2] This white paper builds on that work by analyzing 63 current CMS Medicare payment and care delivery models using the LAN Alternative Payment Model Framework. Medicare models that have not officially begun or that were designed for dual-eligible individuals were excluded. Eighteen of the Medicare models analyzed were models for health care delivery or research initiatives rather than payment models. Because the LAN framework was only designed to categorize payment models, these 18 models were also excluded. The remaining 45 models were categorized using the LAN framework according to the dominant form of payment. However, it should be noted that some payment models do not fit cleanly into the LAN framework categories, which can result in differing opinions on how the model should be categorized. The figure below summarizes the results of this analysis.

Figure 1.1 displays several Medicare payment models under many of the categories of the LAN framework. The Category

Figure 1.1 Catgorization of Current CMS Medicare Payment Models Using the LAN Framework



1, 3N, and 4N models do not represent progress towards payment reform because neither category is linked to value, showing that there are still many Medicare payment models that were built for the FFS system. Despite this continued link to the FFS system, CMS' testing of and support for APMs has encouraged many providers to transition to APMs.

Since only payment models in categories 3A, 3B, 4A, 4B, or 4C are APMs, these are the most important categories for identifying progress towards payment and delivery reform. Category 2 models can also be essential stepping stones that prepare providers to participate in an APM. While Figure 1.1 reveals a shortage of category 4 Medicare payment models, it is encouraging that CMS has created many category 2 and 3 models. Figure 1.2 below simplifies Figure 1.1 by separating the payment models into two categories, APMs and non-APMs.

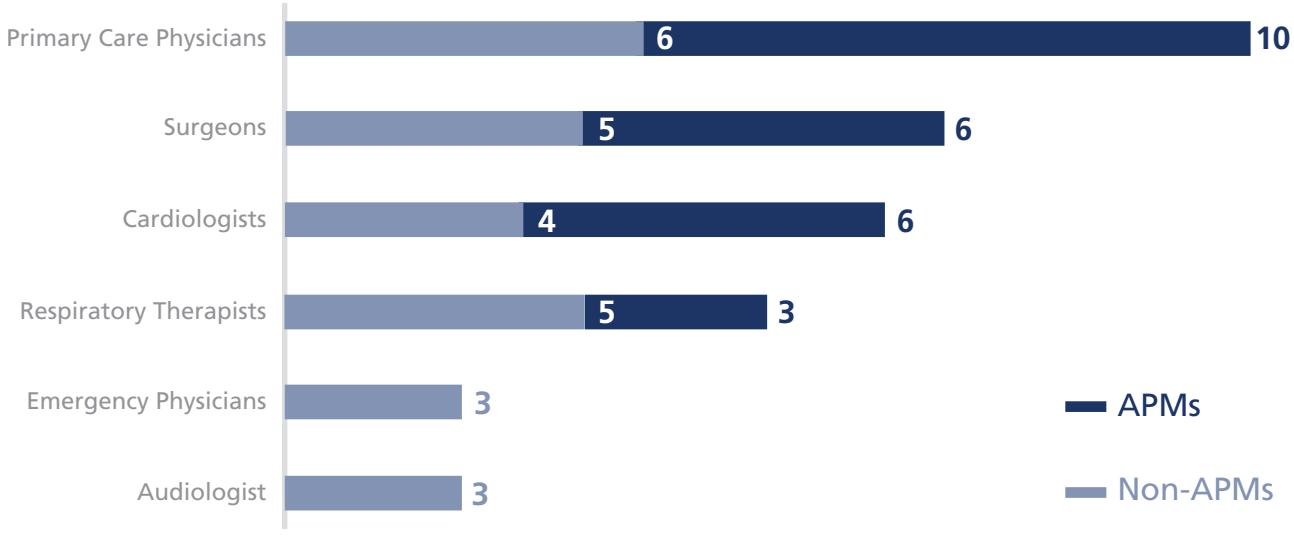
Figure 1.2 Categorization of Current CMS Medicare Payment Models by APMs

SPECIFIC PROVIDER ACCESS TO CMS MEDICARE APMS

While Figure 1.2 appears to indicate that providers have numerous opportunities to participate in APMs, many of the Medicare payment models are only available to select provider types. We looked at the availability of Medicare APMs to six provider types that represent a variety of practice settings: primary care physicians, emergency physicians, cardiologists, surgeons, respiratory therapists, and audiologists. Our analysis demonstrates that some provider types have few or no avenues to participate in a Medicare APM.

The lack of access to Medicare APMs is increased when Medicare payment models are only available to limited geographies, such as the Maryland All-Payer Model which is only available in Maryland. Therefore, to more accurately represent the average provider's access to APMs, geographic specific APMs were also removed. Figure 1.3 shows the disparity in access to Medicare APMs across various provider types.

Figure 1.3 Current CMS Medicare Models Available to Specific Provider Types



Primary care physicians, surgeons, and cardiologists, have the most opportunities to participate in a Medicare APM. However, further analysis is necessary to determine whether all primary care physicians, surgeons, and cardiologists have access to an APM that is viable for a provider's unique practice, location, and patients.

Less common provider types, such as respiratory therapists and audiologists, have fewer Medicare APM options. Respiratory therapists can only participate in three Medicare APMs, and audiologists do not have access to any Medicare APMs. Figures 2.4 and 2.6 in the Appendix show that these providers can participate in a 2B payment model, which could prepare providers to move into APMs into the future. However, there is less reason for providers to participate in a preparatory arrangement if there are no APMs to move into.

Perhaps the most surprising finding is that emergency physicians also do not have access to any Medicare APMs, even though 40,809 emergency physicians billed Medicare last year.[12] An article from the *American Journal of Emergency Medicine* pointed out that emergency care faces unique challenges in payment reform because emergency providers may only see a patient once, emergency physicians are required to treat patients regardless of their ability to pay, and emergency care has a high degree of diagnostic uncertainty.[13] However, the article concluded that APMs could be developed despite these challenges to reduce unnecessary admissions and testing, and decrease future health care costs of discharged patients.[13]

NEW PAYMENT MODELS NEEDED

While providers without access to a Medicare APM could potentially participate in a commercial APM, a provider's access to a Medicare APM is important. There are currently 56 million Medicare patients, and that number is expected to grow to 81 million by 2030.[14] Also, many providers are more likely to try a CMS model before engaging in a commercial APM because CMS models have defined rules and don't require individual negotiation. Finally, CMS is a leader in the transition from FFS to APMs, and many payers follow its lead. For example, Medicare is not the only payer without any APMs specific to emergency care. Commercial payers have also failed to develop emergency care specific payment models.[13] Consequently, CMS leadership is crucial for the creation and widespread adoption of new payment models.

Individuals and organizations can encourage CMS to develop new Medicare payment models for providers types that currently do not have access to a Medicare APM. For example, stakeholders can submit a physician-focused payment model (PFPM) proposal to the Physician Focused Payment Model Technical Advisory Committee (PTAC) or comment on existing PFPM proposals.[15] PTAC was created under section 101(e)(1) of MACRA and is authorized to make recommendations to the Secretary of the Department of Health and Human Services.[14] PTAC has the ability to recommend a PFPM proposal for limited-scale testing, implementation, or implementation with a high priority, and the secretary is required to respond to the recommendation.[15] Even though the PTAC process is limited since it focuses on physician-led models without providing a similar voice to other clinician types, it provides an avenue to solicit ideas and receive feedback.

CMS has already done much to encourage the adoption of APMs. For all providers to experience the benefits of APMs, governmental and private engagement with provider types that do not qualify for current Medicare APMs is necessary to develop new payment models. Ideally, for each provider type, new Medicare payment models would be developed in a variety of LAN framework categories, with an emphasis on APMS, and without geographical limitations on where the model is offered.

APPENDIX

Figure 2.1 Primary Care Physicians

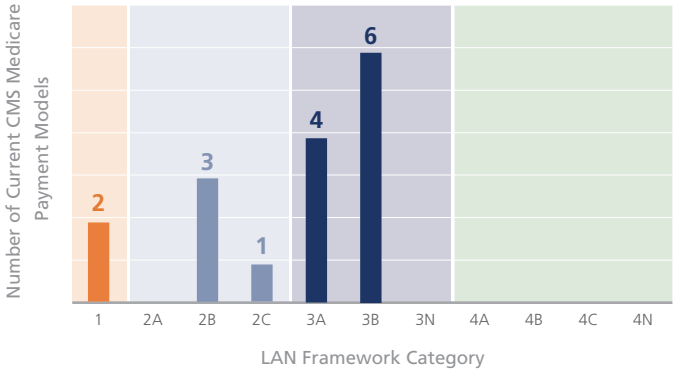


Figure 2.2 Surgeons

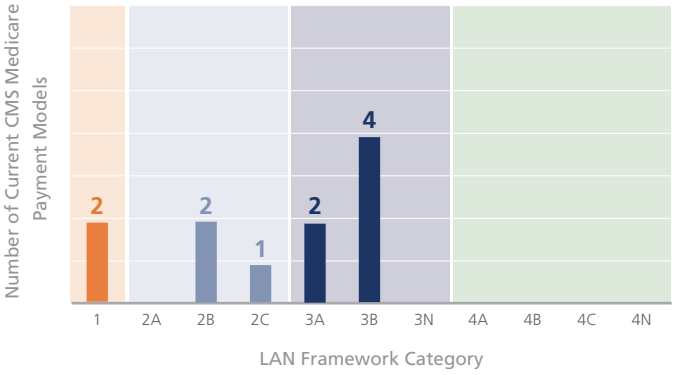


Figure 2.3 Cardiologists

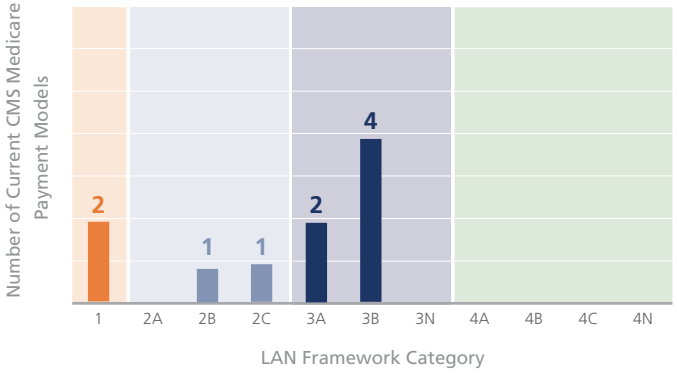


Figure 2.4 Respiratory Therapists

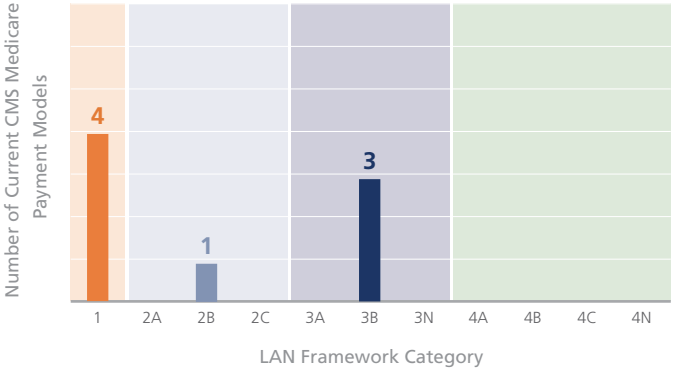


Figure 2.5 Emergency Physicians

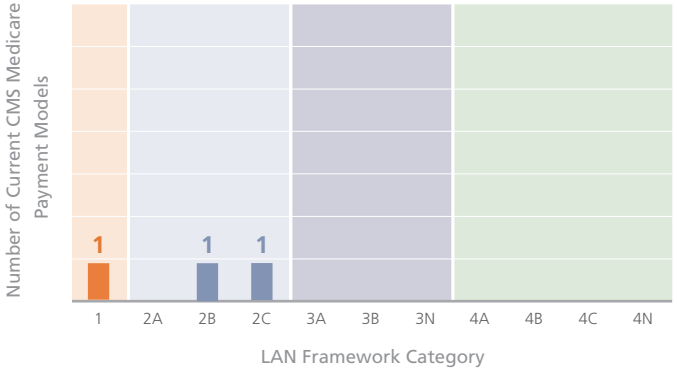
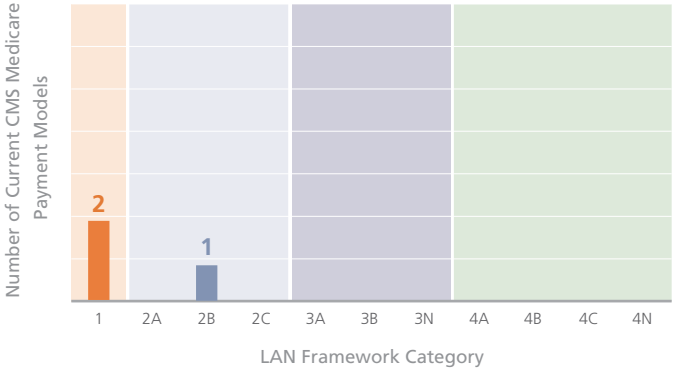


Figure 2.6 Audiologist



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