



Report to Congress

Alternative Payment Models & Medicare Advantage



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I. Executive Summary

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (Pub. L. 114-10, enacted April 16, 2015) modifies how Medicare payments are tied to the cost and quality of patient care for hundreds of thousands of doctors and other clinicians. To this end, Title I of MACRA includes several provisions directed at promoting provider participation in Alternative Payment Models (APMs) that engage providers in creating value in health care.

Section 101(e)(6) of MACRA requires the Secretary of the U.S. Department of Health and Human Services (HHS) to submit to Congress a study examining the feasibility of integrating APMs in the Medicare Advantage (MA) payment system. This study must also explore the feasibility of including a value-based modifier (VBM) and assess whether such modifier should be budget neutral. The analysis presented in this Report fulfills the Secretary's obligation under section 101(e)(6) of MACRA.

The Report is organized as follows:

- Section I is the executive summary
- Section II briefly introduces concepts and terminology central to the discussion of APMs in MA and explains the study methodology
- Section III details how Medicare has historically paid managed care plans, the current MA payment rules, and Medicare's role in the provider payment process under MA
- Section IV presents the wide range of Medicare fee-for-service (Medicare FFS) APMs
- Section V assesses the progress Medicare Advantage Organizations (MAOs) have made in incorporating APMs to pay their contracted providers
- Section VI analyzes the feasibility of integrating APMs into MA
- Section VII considers the feasibility of introducing a VBM into MA

Provider payment models that are supported by a payment approach other than traditional fee-for-service (FFS) generally emphasize value considerations in health care delivery by linking the financial incentives for providers to the total cost and quality of care they provide. APMs, for the purposes of this Report, are specific value-based payment (VBP) arrangements or initiatives that represent a meaningful shift away from the traditional volume-driven provider payment model and toward population-based provider payments such that the provider is accountable for both cost and quality of care for beneficiaries.

Medicare's payments to MAOs under current law are population-based payments that link financial incentives for MAOs to the total cost and quality of care furnished by the MAO's network of contracted providers. As a result, the MA program today effectively functions as an APM-like arrangement between the Centers for Medicare & Medicaid Services (CMS) and MAOs. However, the value-based incentives for insurers under MA may not always reach the provider(s) of care. The MAO-provider relationship, therefore, is most relevant, rather than the relationship between Medicare and the MAO.

MAOs determine, through negotiations with providers, the terms by which contracted health care providers are paid. Section 1854(a)(6)(B)(iii) of the Social Security Act (the Act), commonly known as the “non-interference clause,” prohibits CMS from requiring an organization to contract with a particular health care provider or to use a particular price structure for payment under such a contract. As a result, CMS is generally not involved in pricing or contract discussions and disputes between MAOs and the providers participating in their plan networks. MAOs have the flexibility to, but are not required to, incorporate APM strategies into their payment arrangements with providers. This Report finds that, to varying degrees, MAOs are currently exercising this flexibility and linking provider payments to APMs, but in limited ways.

This Report explores several options for furthering the use of APM arrangements between MAOs and providers, including a review of potential financial and/or rules-based incentives that could be awarded to MAOs that commit to APM adoption. A similar approach is considered for including a VBM in the MA program, which, this Report concludes, could, like APMs, potentially be designed for use under MA and in a budget neutral manner. However, current program parameters, including statutory constraints, generally limit the tools available to CMS to encourage further APM adoption. In particular, the non-interference clause precludes CMS’s from using incentives in these ways. However, CMS maintains some regulatory discretion and 1115A waiver authority.

II. Introduction

A health care “payment model” is an arrangement between a payer¹ and one or more health care providers that establishes the terms under which the provider or providers will be compensated for care furnished to the payer’s beneficiaries. Therefore, a critical component of such a model is the general approach by which participating providers are paid.

The following “payment continuum” presents the most common “payment approaches” that support health care payment models today, with each approach, moving along the continuum from (1) to (6), enabling payers to create higher levels of provider accountability than the last:

- (1) **Fee-for-service (FFS)²**: payments are made for individual units of service and triggered by the delivery of care, with no adjustments allowed for the quality and/or value of care provided.
- (2) **Pay-for-performance (P4P)**: payments are made for individual units of service and triggered by care delivery, as under the FFS approach, but providers can qualify for bonuses or, in some circumstances, be subjected to penalties for cost and/or quality related performance. Foundational or supplemental services payments – for investment in value-improving infrastructure, as an example – also fall under the P4P payment approach.
- (3) **Shared savings**: payments flow on a FFS basis as usual but if the provider is able to keep actual medical costs below expectations established by the payer on an empirical basis, he or she retains a portion, up to 100 percent, of the savings generated.³ A provider qualifying for a shared savings award must also meet standards for quality of care, which can also, under certain payment models, influence the portion of total savings the provider retains, or the “shared savings ratio.”
- (4) **Shared risk**: payments flow on a FFS basis as usual, but if a provider’s actual medical costs are above expectations, as pre-determined by the payer on an empirical basis, the provider is liable for a portion, up to 100 percent, of the cost overruns.⁴ A provider’s “liability ratio” is often determined by the quality of care furnished by the provider.
- (5) **Two-sided risk sharing**: payments flow on a FFS basis as usual but in exchange for a shared savings opportunity, providers must also agree to share in any cost overruns.⁵ The quality of furnished care plays the same role in payments as that described for approaches (3) and (4).
- (6) **Capitation/population-based payment**: payments are not tied to service delivery but rather take the form of a fixed, per patient, per unit of time (e.g., a month) sum paid in advance to the provider for the delivery of a set of services (partial capitation) or all services (full or

¹ The term “payer” is used in this Report to refer to the entity other than the beneficiary that finances the cost of health services, usually a health insurance issuer.

² Note that for the purposes of this paper, the acronym “FFS” refers to the fee-for-service payment approach while the term “Medicare FFS” refers to Medicare Parts A and B, otherwise known as Original Medicare.

³ Savings can be calculated for a particular service, set of services, or for all services provided to either an individual beneficiary or a defined population of beneficiaries over the course of a year.

⁴ Cost overruns can be calculated for a particular service, set of services, or for all services provided to either an individual beneficiary or a defined population of beneficiaries over the course of a year.

⁵ Please see the previous two footnotes.

global capitation). These payments are un-reconcilable, or mostly so; the provider assumes full risk, or close to full risk, for any costs above the capitation/population-based payment amount and retains all, or close to all, savings when costs fall below the capitation/population-based payment amount.⁶ Provider payments, penalties, and/or awards are adjusted depending on the quality of care furnished by the provider.

The Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) have recently created opportunities and incentives for transitioning the health care system, in general, away from payments for volume only and toward more value-driven care. This transition is reflected in industry trends. Provider payment models that are supported by a payment approach other than traditional FFS with no link to quality – from P4P to capitation/population-based payment approaches in the continuum above – generally aim to emphasize value considerations in health care delivery by linking the financial incentives for providers to the total cost and/or quality of care they provide. Therefore, such payment models are considered “value-based purchasing/payment” (VBP) arrangements or initiatives.

A. Alternative Payment Model Definition

While VBP encompasses a broad set of initiatives that link provider payments to the cost and/or quality of care delivered, for the purposes of this Report, we consider “alternative payment models” (APMs), to be a specific subcategory of VBP initiatives that require providers to make fundamental changes in the way they provide care. Specifically, APMs shift financial incentives further away from volume by linking provider payments to both quality *and* total cost of care results. The Administration announced in January of 2015 the goals to tie 30 percent of total Medicare FFS provider payments to APMs by the end of 2016 and to increase that share to 50 percent by the end of 2018.⁷ The Administration estimates that its initial 30 percent goal has been met as of January 2016, 11 months ahead of schedule.⁸

The Administration adopted the “Payment Taxonomy Framework” in 2014 to measure, understand, and describe the progress in the movement toward VBP and the adoption of APMs across the U.S. health care system.⁹ The framework classifies all provider payment models, regardless of payer, into four categories according to how clinicians and organizations are paid under them:

Category 1 – Fee-for-Service with No Link of Payment to Quality: payment models rely on the traditional FFS payment approach, which has no link to quality.

⁶ The use of a fixed, monthly population-based payment mechanism differentiates the capitation/population-based payment approach from the two-sided risk sharing payment approach, which relies on the FFS payment mechanism instead.

⁷ “Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume.” CMS. January 26, 2015. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3>.

⁸ “HHS Reaches Goal of Tying 30 Percent of Medicare Payments to Quality Ahead of Schedule.” HHS. March 03, 2016. <http://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html>.

⁹ Rajkumar R, Conway PH, Tavenner M. CMS – Engaging Multiple Payers in Payment Reform. JAMA. 2014 May 21;311(19):1967-8.

Category 2 – Fee-for-Service with a Link of Payment to Quality: payment models rely on the P4P payment approach, where at least a portion of payments vary based on the quality or efficiency of health care delivery.

Category 3 – Alternative Payment Models Built on Fee-for-Service Architecture: payment models rely on the shared savings, shared risk, or two-sided risk sharing payment approach, where some payments are linked to the effective and efficient management of a set of procedures, an episode of care, or a segment of the population.

Category 4 – Population-Based Payment: payment models rely on the capitation/population-based payment approach, where payments are not linked to volume but, instead, are population-based, covering all expected care-related costs for a beneficiary over a long period, such as a year or more.

With a few modifications, this taxonomy is also reflected in the White Paper created by the Health Care Payment Learning and Action Network (LAN)¹⁰ to categorize payment models for the purposes of their work to achieve the Administration’s APM goals across the health care system.

While all payment models classified into categories 2, 3, and 4 under this framework are considered VBP initiatives, only Category 3 and 4 payment models are considered APMs by the Administration. The differentiation here, again, is in how providers receive payment to provide care, or the payment approaches at play. The payment approaches featured by models classified into the latter two categories allow for larger value-based incentives and thus force the evolution of care delivery systems.

Moving from P4P to capitation/population-based payment in the continuum presented earlier involves an increasingly significant shift away from strictly volume-based payments, creating, as stated above, additional opportunities for payers to hold providers accountable for both the quality *and* total cost of care furnished, especially at the population level. Thus, Category 3 and Category 4 models, in moving further toward shared risk and population-based payments, create strong financial incentives for limiting volume and care duplication and appropriately compensate value-creating activities, such as care coordination. In essence, participants of such models must meaningfully engage in improving care delivery and focus on population health management to succeed under them. Because of this fact, Category 3 and 4 models are distinguished from other VBP initiatives as APMs. This Report relies on the Administration’s definition of APMs.

Of note, section 101(e)(2) of MACRA added section 1833(z)(3)(C) of the Social Security Act (the Act) to provide a definition for APMs that applies primarily to payments under Medicare FFS.¹¹ The law does not provide a definition of APMs that addresses arrangements between providers and other, non-Medicare payers (for example, private insurers). The definition presented here

¹⁰ For the White Paper and additional information on the LAN, please see: <https://hcp-lan.org/groups/apm-fpt/apm-framework/>.

¹¹ MACRA defines an APM as: 1) A model under section 1115A of the Act (other than a health care innovation award); 2) The shared savings program under section 1899 of the Act; 3) A demonstration under section 1866C of the Act; and 4) A demonstration required by Federal law. While MA plans might participate in a model test under section 1115A or a demonstration under other authority, depending on the specific parameters of the model or demonstration, the other provisions are not applicable to MA payments.

addresses this limitation for the purposes of this Report. Moreover, even when considering Medicare FFS payments, the MACRA definition of APMs is not necessarily the same as the definition used in this Report; not every Medicare FFS provider payment initiative characterized as an APM under MACRA will be considered an APM under the Administration's Payment Taxonomy Framework. Furthermore, the MACRA definition of "Advanced APM" or "Eligible APM" – arrangements meeting certain criteria in which eligible providers must participate to receive the APM incentive payments – is narrower and slightly different than the categorizations referenced above (see the Appendix for a visualization of this concept).¹² For instance, models under the Bundled Payments for Care Improvement (BPCI) Initiative – an episode-based payment initiative introduced by the Center for Medicare and Medicaid Innovation (Innovation Center) in 2013 as a three-year demonstration authorized under section 1115A of the Act – are considered APMs that fit under Category 3 of the Payment Taxonomy Framework, but are not considered Advanced APMs because they do not meet the MACRA-specified requirements.¹³ However, in general, the MACRA structure supports movement into Category 3 and 4 models.

B. Study Methodology

We took a multipronged approach to studying the feasibility of integrating APMs and a value-based modifier (VBM) in MA.

First, we reviewed how Medicare has historically paid managed care plans, the current Medicare Advantage (MA) payment rules, and the government's role in the provider payment process under MA. The review included relevant implementation considerations specific to the MA payment system, including how value in beneficiary care management – defined as achieving a combination of low cost and high quality health care – is currently and has historically been promoted under the MA program.

We then reviewed the APMs operating in Medicare FFS. Doing so allowed us to assess the feasibility of integrating Medicare FFS APMs into the MA payment system.

To be comprehensive in our understanding of the nature of APMs, how they are implemented to create value in health care delivery, in general, and their place in MA, we also reviewed the nature of APMs and other value-based provider payment initiatives used by Medicare Advantage Organizations (MAOs), the insurers that contract with the Centers for Medicare & Medicaid Services (CMS) to administer the Medicare benefit. Through conversations with several MAOs, we learned of, among other considerations, the factors influencing APM design and the features and characteristics of the MA program that MAOs perceive as impediments in the incorporation of APMs.

Based on our analysis, we identified potential mechanisms for and various pertinent questions related to the formal integration of APMs and a VBM into MA.

¹² An Advanced APM under MACRA is an APM that: 1) requires participants to use certified electronic health records (EHR) technology; 2) provides payment based on quality measures comparable to measures under the quality performance category of the Merit-Based Incentive Payment System (MIPS); and 3) is either a Medical Home Model expanded under section 1115A of the Act or bear more than a nominal amount of risk for monetary losses.

¹³ For additional information on the BPCI, please see: <https://innovation.cms.gov/initiatives/bundled-payments/>.

It is important to note that nothing in this Report should be construed as an interpretation of the new Merit-Based Incentive Payment System (MIPS) and APM incentive programs (collectively named the Quality Payment Program) created under MACRA. The CMS recently released a proposed rule on this subject on April 27, 2016, published in the Federal Register on May 9, 2016 (81 Fed. Reg. 28162).

III. Payment under the Medicare Part C Program

Under MA, CMS has contracted with private insurers, or MAOs, to provide Part A and Part B benefits¹⁴ to enrolled beneficiaries and has paid these contracted organizations under a capitation/population-based payment approach since the program was first introduced. The methodology for determining the fixed monthly payments has changed over time as Congress and other policymakers have attempted to contain program costs, improve the quality of care provided to MA beneficiaries, maintain program desirability for insurance organizations and beneficiaries, and promote competition among MAOs. As a result, MA plans, most of which are coordinated care plans such as health maintenance organization (HMO) and preferred provider organization (PPO) plans, remain attractive to Medicare beneficiaries and typically offer additional benefits in the form of reduced cost sharing or coverage of services that are not covered under Medicare FFS (e.g., dental and vision care). MA enrollment has been steadily increasing since 2003 and currently accounts for about one-third of all Medicare enrollees.

This section describes how Medicare has historically paid managed care plans, the current MA payment rules, and the government's limited role in the provider payment process under MA. The MA program features key elements – such as a population-based payment approach, quality adjusted payments, and an emphasis on care coordination – which are essential characteristics of certain APMs (as detailed further in Section IV). The MA program is not an APM, however, because these elements do not have a direct influence on contracting between MAOs and providers and, therefore, financial incentives for providers. Instead, the elements are instituted to directly influence only MAO behavior, which does impact provider behavior given the nature of collaboration between MAOs and providers in caring for MA enrollees.

A. History of MA Payment

This section reviews the laws that most significantly changed the MA payment structure. The discussion highlights the reasoning behind some of the current payment rules, discussed later, including the stakeholder concerns that were taken into account to bring the MA payment system to where it is now.

Social Security Act Amendments of 1972

The Social Security Act Amendments of 1972 (Pub. L. 92-603) introduced managed care into the Medicare program by authorizing Medicare to enter into contracts with health maintenance organizations (HMOs) under section 1876 of the Act. Under these contracts, HMOs agreed to provide all Part A and Part B services in return for a monthly capitated payment for each enrolled beneficiary. HMOs were required to allow open enrollment by all Medicare-eligible beneficiaries within the area where the plan was offered, regardless of beneficiary health status.

The 1972 amendments established two types of contracts: reasonable cost reimbursement contracts and risk contracts. Under reasonable cost reimbursement contracts, HMOs were paid the

¹⁴ Most MA plans also provide a prescription drug benefit under Part D and supplemental benefits in addition to these Medicare benefits.

reasonable cost actually incurred in providing Medicare covered services to Medicare enrollees. Each month, HMOs received an interim per capita payment for each Medicare enrollee. Adjustments were made at the end of the contract period to bring the interim payments made to the HMO into agreement with the reimbursement amount determined payable to the HMO for services rendered to Medicare enrollees during that period.

Under risk contracts, HMOs received prospective monthly payments based on the estimated cost of treating an average beneficiary in traditional FFS Medicare in the enrollee's county of residence. This figure is referred to as the "average area per capita cost" (AAPCC). At the end of its contract year, the HMO's reasonable costs of furnishing services to its Medicare enrollees were compared to the retrospectively determined AAPCC incurred for that year. If the HMO's costs were less than the AAPCC, the HMO received 50 percent of the savings, up to a maximum of 10 percent of the AAPCC, as a bonus. Conversely, if the HMO's costs were higher than the AAPCC, the HMO was required to absorb the difference. However, these losses could be carried forward into subsequent years and offset from savings realized in future years.

The asymmetrical nature of the risk reimbursement provisions, which allowed HMOs to receive only half of the savings they achieved (up to a maximum of 10 percent of the AAPCC) while exposing them to potentially unlimited losses, failed to provide a strong financial incentive for HMOs to enter into risk-sharing contracts with CMS. In addition, only a small number of HMOs met the eligibility requirements for entering into a Medicare contract, which included a minimum enrollment of at least 25,000 beneficiaries and an operating history of at least two years. As a result, from 1972 to 1982, only one HMO maintained a risk contract with CMS on a continuing basis.

Tax Equity and Fiscal Responsibility Act of 1982

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Pub. L. 97-248) expanded the definition of eligible organizations so that more plans could qualify to enter into risk contracts with Medicare. TEFRA further amended the risk contracting program by permitting payment to be made on a prospective capitated basis without retroactive adjustments of the rate.

Capitation rates were set at 95 percent of the AAPCC for a given beneficiary, with payments adjusted to account for demographic factors and county of residence. Payments were discounted five percent based on the assumption that HMOs could operate more efficiently than FFS providers, and that the government should share in the cost savings. If an HMO's projected costs were lower than the federal payments, the HMO had to apply the difference between costs and payments to provide extra benefits to enrollees, or return the difference to the federal government.

In the period from 1985 to 1997, Medicare private health plan enrollment grew to about 6 million beneficiaries. Enrollment was concentrated primarily in urban counties, raising concerns about the lack of managed care options in rural areas. The Government Accountability Office (GAO), among others, expressed concerns over studies that found excess spending due to inadequate risk

adjustment of payments to reflect the healthier-than-average population that was enrolled in the private plans.¹⁵

Balanced Budget Act of 1997

Section 4001 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105-33) added sections 1851 through 1859 to the Social Security Act (the Act), establishing a new Part C of the Medicare program, known as the Medicare+Choice (M+C) program. Under section 1851(a)(1) of the Act, every individual entitled to Medicare Part A and enrolled under Part B, except for individuals with end-stage renal disease (ESRD), could elect to receive benefits either through the traditional Medicare FFS program or an M+C plan, if one were offered where he or she lived.

The primary goal of the M+C program was to provide beneficiaries with a wider range of health plan choices through which to obtain their Medicare benefits than were previously available. The BBA authorized a variety of private health plan options for beneficiaries, including both the traditional managed care plans (such as those offered by HMOs under TEFRA) and new options that were not previously authorized. The following types of Medicare M+C plans were authorized under the new Part C:

- M+C coordinated care plans, including HMO plans (with or without point-of-service options), provider-sponsored organization (PSO) plans, and preferred provider organization (PPO) plans;
- M+C medical savings account (MSA) plans (combinations of a high-deductible M+C health insurance plan and a contribution to a M+C MSA); and
- M+C private fee-for-service (PFFS) plans.

The BBA also introduced a new methodology for calculating plan payments. Instead of calculating payments on the basis of average FFS spending in a county, as under TEFRA, county rates were calculated as the highest of:

- (1) A minimum payment, or “floor,” set at \$367 per month in 1998 and increased annually;
- (2) A “blended” payment rate, calculated as a weighted average of the county rate and a price-adjusted national rate; or
- (3) An amount reflecting a two percent increase from the previous year’s county rate.

The BBA’s “floor” on payment increases was designed to encourage plans to expand their services into primarily rural areas that historically had low payment rates and few, if any, managed care options.

In response to mounting evidence that HMOs were subject to favorable selection, with HMO enrollees possessing above-average health relative to the Medicare population as a whole, the BBA required that plan payments be risk adjusted for enrollee health status and demographic factors, no later than January 2000. By risk adjusting payments, plans would receive larger payments to

¹⁵ GAO, “Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments,” GAO/HEHS-97-16, Apr. 25, 1997, accessed at <http://www.gao.gov/assets/230/224084.pdf>.

account for the higher health care costs of less-healthy beneficiaries. This eliminated the incentive for plans to prefer enrolling healthier beneficiaries.

In 2000, CMS began implementing health-based risk adjustment using the Principal Inpatient Diagnostic Cost Group (PIP-DCG) model. The PIP-DCG model estimated health status using demographic factors and the most serious principal reason for an inpatient stay from any hospital admission that occurred during the prior year. Specifically, the PIP-DCG model was adjusted for age, gender, Medicaid eligibility, whether originally entitled to Medicare due to disability, and working aged status, as well as health status.

Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

The Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106-113), enacted November 29, 1999, amended the M+C provisions of the BBA. In addition, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub. L. 106-554), enacted December 21, 2000, further amended the M+C provisions of the BBA and BBRA.

To account for the quickly rising costs of providing care to Medicare beneficiaries, and to encourage increased participation in the M+C program, the BBRA and BIPA increased M+C payments and provided financial incentives to M+C organizations that agreed to offer plans in areas that were not served by any M+C plans. In order to soften the financial impact of implementing risk adjustment on managed care organizations, these laws also modified CMS's timeline for phasing in its risk adjustment methodology, which had been developed in response to the BBA risk adjustment directive.

BIPA also required the implementation of a risk adjustment model using not only diagnoses from inpatient hospital stays, but also from ambulatory settings beginning in 2004. As a result, CMS selected a new risk adjustment model to begin in 2004: the CMS hierarchical condition categories (CMS-HCC) model, which adjusts plan payments using diagnoses recorded on both inpatient and outpatient claims. Each CMS-HCC category is assigned a weight, based in part on the cost of treating the same condition in a FFS beneficiary. For beneficiaries with multiple diagnoses, the weight for each condition is added together to determine the risk score. Risk adjustment payments are approximately proportional to risk score. The risk adjusted payments to MA plans were also required to be adjusted by a "budget neutrality" factor to ensure that payments to MA organizations, in the aggregate, did not decrease as a result of risk adjustment.

B. Current MA Payment Rules¹⁶

MAOs are currently paid under a methodology initially established by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) and modified by the ACA. Some of the most significant current MA payment rules are described in this section to provide a foundation for the discussion later in this Report on integrating APMs into the MA payment system.

Medicare Prescription Drug, Improvement and Modernization Act of 2003

The MMA (Pub. L. 108-173), enacted on December 8, 2003, renamed the “Medicare+Choice” program “Medicare Advantage” (MA). The law further changed how payment rates were set and substantially increased Medicare payments to MA plans to further encourage MAO participation and enrollment in MA plans.

In addition to providing changes for payments in 2004 and 2005, the MMA introduced the current bid-based approach for determining MA payment rates, beginning with payments in 2006. Under this approach, an MA organization (MAO) submits plan bids on an annual basis that represent its estimate of the amount it would cost to provide the Part A and Part B benefit package to enrollees of average health. Each bid is compared to a payment area’s benchmark, or “MA payment rate,” which is the maximum amount that Medicare will pay MA plans for the provision of Part A and Part B benefits in that area.

For 2004, the MMA required that the benchmark be set at the county level to equal the highest of: (1) an urban or rural floor payment; (2) 100 percent of risk adjusted FFS costs in the county – rather than the 95 percent established by TEFRA; (3) a minimum update over the prior year rate of two percent or the growth rate for national FFS costs, whichever was greater; or (4) a blended payment rate update. For 2005 and subsequent years, the blended rate amount and “floor” amounts no longer applied; payments in 2005 were based on the higher of the 2004 rate plus the Medicare growth percentage or 100% of the AAPCC (equivalent to the Medicare FFS costs) for the area. Beginning in 2006, these figures were used to set the benchmark against which plans submitted bids for the cost of providing Medicare Part A and Part B services. The benchmarks increase based on the Medicare growth percentage, except for years when CMS rebases the Medicare FFS rate, when the rate is the higher of the previous year rate plus the Medicare growth percentage or the Medicare FFS rate in a given year. The MMA requires CMS to rebase the Medicare FFS rates no less frequently than every three years.

Also beginning with 2006, the MMA established that bidding by MA organizations determines payment for Medicare Part A and Part B benefits, with bids based on an organization’s monthly expected revenue needs for covering those benefits rather than set solely administratively. The bidding process also determines how much, if anything, a Medicare enrollee would have to pay for Part A and Part B benefits and how much an enrollee would receive in rebates or benefits in addition to Part A and Part B benefits. When the plan bid exceeds the benchmark, the plan is

¹⁶ Each of the payment rules described below are intended as summaries, and are not to be construed as fulsome descriptions for any particular year. For additional details on specific payment methodologies, please refer to the appropriate payment year’s Advance Notice and Rate Announcement located here: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtgSpecRateStats/Announcements-and-Documents.html>.

required to charge a member premium for the amount by which the bid exceeds the benchmark. When a plan bid is below the benchmark, the plan retains 75 percent of the difference between the bid and benchmark, or the “beneficiary rebate amount,” which the plan must use to pay for additional benefits not covered under FFS or to buy-down premiums. As such, the net payment for an MA plan with a below-benchmark bid was established by the MMA to equal the bid amount plus the beneficiary rebate amount.

Risk adjustment was retained in the MA program as a key component of the bidding and payment processes. The MMA also made it possible for MA plans to offer Part D prescription drug coverage to beneficiaries beginning in 2006 in addition to coverage of services and benefits covered under Part A and Part B.

Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (Pub. L. 109-171) was enacted on February 8, 2006, and codified the phase out of the risk adjustment budget neutrality factor. The budget neutral risk adjustment factor phase-out began in 2007 and was completed in 2011. Section 5301 of the Deficit Reduction Act of 2005 (DRA) also added section 1853(k) of the Act to create a single rate book for calculating Medicare Advantage (MA) payments and applicable adjustments. The DRA also modified the methodology for updating the MA payment rates by adding section 1853(k)(1)(B) of the Act. Beginning in 2007, the statute no longer provides for the 2 percent minimum update.

Affordable Care Act

On March 23, 2010, President Obama signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111-148). On March 30, 2010, the President signed into law H.R. 4872, the Health Care and Education Reconciliation Act of 2010 (the “Reconciliation Act,” or HCERA) (Pub. L. 111-152), which modifies a number of Medicare provisions in PPACA and adds several new provisions. These laws are collectively referred to as the Affordable Care Act of 2010 (ACA).

MA payment rates linked to FFS costs

The ACA altered the MA payment methodology established by the MMA in many ways, including strengthening the link between MA payment rates and FFS costs. The ACA amendments to the MA statute specified that, moving forward, MA payment rates would be tied solely to FFS rates, equaling a percentage of the average FFS costs in the plan’s service area. Specifically, the benchmark under the ACA, or the “Specified Amount,” is set at 95 percent, 100 percent, 107.5 percent, or 115 percent of the projected per capita FFS costs in a particular county, with higher percentages applied to counties with the lowest historical FFS spending. In practice, CMS ranks all counties by their estimated annual per capita FFS spending in the prior year, places them into quartiles, and determines the “applicable percentage” as illustrated in Table 1 below.

Table 1. FFS Quartile Assignment Rules under the Affordable Care Act

Quartile	Applicable Percentage
4 th (highest cost county)	95%
3 rd	100%
2 nd	107.5%
1 st (lowest cost county)	115%

This change in methodology was statutorily implemented with a gradual transition beginning in 2012 and lasting two, four, or six years, depending on the magnitude of a county's transition.¹⁷ The benchmark during the transition period is calculated as a blend of the Specified Amount and the pre-ACA benchmark detailed under the MMA section above. The percentage of this blend depends on the assigned transition period for a particular county. As described through Table 2 below, the blended amount is reduced each year, until all benchmarks reach 100 percent of the specified amount in 2017.

Table 2. Blended Benchmark Calculations

Year	Two Year County Blend		Four Year County Blend		Six Year County Blend	
	Pre-ACA	ACA	Pre-ACA	ACA	Pre-ACA	ACA
2012	1/2	1/2	3/4	1/4	5/6	1/6
2013	0	100%	1/2	1/2	2/3	1/3
2014	0	100%	1/4	3/4	1/2	1/2
2015	0	100%	0	100%	1/3	2/3
2016	0	100%	0	100%	1/6	5/6
2017	0	100%	0	100%	0	100%

The changes in the calculations of MA benchmarks provisioned by the ACA are intended to lead to reductions in many of the county benchmarks.

ACA introduction of quality adjusted MA payments

In addition to tethering MA payment rates to FFS Medicare costs, the ACA also introduced quality adjusted payments into the MA program. Specifically, the ACA authorized rewarding high quality MA plans via positive adjustments to the specified county benchmarks and rebate amounts beginning in 2012. By changing MA plan payment in such a way, the ACA created an incentive for MAOs to invest in quality improvement.

In implementing this policy, CMS relies on the five-star quality rating system that was established for MA in 2008 and became increasingly important under the ACA. Using a methodology detailed in the following subsection, CMS assigns an Overall Star Rating to each MA plan that indicates

¹⁷ A county's specific transition period was determined by the difference between the county's Specified Amount in 2010 and the pre-ACA benchmark calculated for the same year. The Specified Amount in 2010 was calculated solely for the purpose of assigning each county its appropriate transition period as the transition to the ACA payment methodology did not begin until 2012.

the quality of care it provides to its beneficiaries. The rating ranges from 1 star to 5 stars, with 5 stars indicating the highest level of quality.

Table 3. Star Ratings Scale

Star Rating	Definition
5 Stars	Excellent Performance
4 Stars	Above Average Performance
3 Stars	Average Performance
2 Stars	Below Average Performance
1 Star	Poor Performance

Plans must earn at least a 4 star rating to receive an increase in their MA benchmark. As such, two different MA plans in the same county could have two different benchmarks, given that one of the plans is designated as high quality under the Star Rating system while the other is not. The increase, or “quality bonus payment” (QBP), takes the form of a percentage add-on to the applicable percentage (see Table 1). Table 4 shows the QBP percentage for each Star Rating for 2017 payments.

Table 4. Percentage Add-on to Applicable Percentage for Quality Bonus Payments

Star Rating	2017 QBP Percentage
5 Stars	5%
4.5 Stars	5%
4 Stars	5%
3.5 Stars	0%
3 Stars or Fewer	0%

Benchmark quality adjustments are also doubled for plans with higher Star Ratings in certain urban counties with low FFS expenditures and high MA enrollment historically. To prevent the overinflating of MA payment rates, however, the ACA imposes a “benchmark cap,” stipulating that the final, quality-adjusted benchmark for a county in a given year cannot exceed the pre-ACA benchmark calculated for the same county in the same year.

The ACA also modified the MMA-established beneficiary rebate amount by linking it to MA plan quality. The portion of the difference between a plan’s bid and its benchmark that is retained by the plan, or the “MA rebate percentage,” now varies by a plan’s Star Rating and maxes out at 70 percent, instead of the MMA-mandated 75 percent. As shown in Table 5, these changes were phased in over a three year period, beginning in 2012. As of 2014, the fully phased-in MA rebate percentages equal either 50, 65, or 70 percent, depending on the plan’s Star Rating.

Table 5. MA Rebate Percentages

Star Rating	2012	2013	2014 and Beyond
4.5 or 5 Stars	73.33%	71.67%	70%

Star Rating	2012	2013	2014 and Beyond
3.5 or 4 Stars	71.67%	68.33%	65%
3 Stars or Fewer	66.67%	58.33%	50%

Five-Star Quality Rating System

The Part C and D Star Rating system supports the efforts of CMS to improve the level of accountability for the care provided by physicians, hospitals, and other providers that participate in the MA program. Initially, the plan quality ratings, made available for consideration on the Medicare Plan Finder website, were issued primarily to help beneficiaries in selecting an MA plan. Since the introduction of quality adjusted payments in MA, however, the ratings play a more substantive role, influencing MA plan payments as detailed above. As a result, the Star Rating calculation methodology is closely followed by MAOs and, according to organizations surveyed by CMS for the purposes of this Report (see Section V), has a significant impact on their decision making, especially in regards to care model design.

CMS structured the current Part C and D Star Rating system to be consistent with the six priorities in the National Quality Strategy.¹⁸ The six priorities include: making care safer by reducing harm caused by the delivery of care; ensuring that each person and family are engaged as partners in their care; promoting effective communication and coordination of care; promoting the most effective prevention and treatment practices for the leading causes of mortality; working with communities to promote wide use of best practices to enable healthy living; and making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

These priorities are most evident in the Star Rating measure set. MA-PD plans are currently rated on up to 44 unique quality and performance measures; MA-only plans (without prescription drug coverage) are rated on up to 32 measures; and stand-alone prescription drug plans (PDP) are rated on up to 15 measures.¹⁹ The measures span five broad categories, including:

- (1) Outcome measures that focus on improvement to a beneficiary's health as a result of care that is provided;
- (2) Intermediate outcome measures that concentrate on ways to help beneficiaries move closer to achieving a true outcome;²⁰
- (3) Patient experience measures that represent beneficiaries' perspectives about the care they receive;
- (4) Access measures that reflect processes or structures that may create barriers to receiving needed health care; and

¹⁸ The CMS Quality Strategy for 2016 is available at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy.pdf>.

¹⁹ For the most current list of measures and methodology included in the Star Ratings, please reference the Technical Notes available at <http://go.cms.gov/partcanddstarratings>.

²⁰ Medication adherence is an example of an intermediate outcome that plays a part in achieving true outcomes like an avoided readmission.

(5) Process measures that capture a method by which health care is provided.

CMS particularly emphasizes measures under the first two categories. Under the 2016 Star Rating calculation methodology, for example, outcome and intermediate outcome measures are weighted three times as much as process measures. In the same year, patient experience and access measures are weighted 1.5 times as much as process measures and a weight of 1.0 is assigned to all new measures. Moreover, the Part C and D quality improvement measures receive a weight of 5.0 to further reward contracts for the strides they make to improve the care provided to Medicare enrollees.

CMS continues to enhance the Star Rating calculation methodology, considering modifications to the measure set and other performance specifications, to both ensure that ratings truly reflect the quality of care provided under MA and incentivize MAOs to foster continuous quality improvement. To do so, CMS conducts a comprehensive review of the measures that make up the Star Ratings each year, assessing the reliability of the measures, clinical recommendations, feedback received from stakeholders, and data issues. The CMS also works with consensus building entities, such as the National Committee for Quality Assurance (NCQA), on measure concept development, specifications, and endorsement.

CMS determines the Star Ratings for MA plans in advance of the annual enrollment period each fall. These ratings (overall and per measure) are determined at the contract level, meaning all plans under the same contract receive the same star designation, and are based on two different methods: clustering or relative distribution and significance testing. The data used to calculate the ratings for every measure in the measure set comes from multiple sources, such as Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, Health Outcome Survey (HOS), Prescription Drug Event (PDE) data, and the CMS Independent Review Entity (IRE). The overall Star Rating is calculated by taking the weighted average of all the measure ratings a contract receives. As mentioned earlier, the rating ranges from 1 star to 5 stars, with 5 stars indicating the highest level of quality.

In 2016, close to 71 percent of MA enrollees will be enrolled in a 4 or 5-star plan, compared to an estimated 60 percent in 2015 and 17 percent in 2009. Moreover, the enrollment-weighted average Star Rating for MA-PD plans in 2016 is 4.03, compared to 3.92 in 2015, and about half of all active MA-PD plans in 2016 earned 4 stars or higher. Such results are indicative of both the improving quality of plans participating in the MA program as well as the generally high quality of care received by MA enrollees.

Electronic Health Records Program (EHR)

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), in part, authorizes incentive payments under the Medicare program for certain eligible professionals (EPs) and hospitals to promote the adoption and meaningful use of certified electronic health records (EHR) technology. Medicare and Medicaid EHR incentive payments began in 2011 and end in 2016.

Subsections (l) and (m) of section 1853 of the Social Security Act further extend the incentives to the MA program, specifying that MAOs may also qualify for incentive payments on behalf of their

affiliated EPs and hospitals that meaningfully use certified EHR technology.²¹ In other words, when a provider who is affiliated with an MAO demonstrates meaningful use of certified EHR technology, the MAO receives an EHR incentive payment from CMS. Whether the payment is passed on to the provider or retained by the MAO is determined by the contractual arrangement between the MAO and its provider.

The last year that qualifying MAOs may receive EHR incentive payments is 2016. Beginning in 2015, CMS applies a payment adjustment to the monthly prospective payments of qualifying MAOs in proportion to the percentage of the MAO's MA EPs or MA-affiliated eligible hospitals that do not demonstrate meaningful use of certified EHR technology during the applicable reporting period. This penalty only applies to qualifying MAOs that previously received incentive payments under the MA EHR program.

Payments to Providers in MA

CMS does not make payments directly to providers under the MA program. In fact, the law permits CMS to pay only MAOs for services furnished to MA enrollees, with some exceptions, prohibiting CMS from making any payments directly to providers under MA.²² As a result, CMS makes capitated monthly payments to MAOs with which it contracts to provide Part A and Part B services to enrolled beneficiaries. Under MA, MAOs are at-risk for managing these monthly revenues to pay providers for Medicare services furnished to their enrollees.²³

An MAO typically contracts with providers, forming a network, to deliver care at negotiated rates. The CMS refers to network providers as “contracted providers.” MAOs and contracted providers agree to the terms and conditions of payment through private negotiations, independent of CMS. Section 1854(a)(6)(B)(iii) of the Act (the non-interference clause), moreover, formally prohibits CMS from requiring MAOs to contract with particular providers or to use particular payment arrangements in their contracts. Generally, this means that CMS is not involved in pricing or contract discussions or disputes between MAOs and network or prospective network providers.

Even in the situation where an MA enrollee receives care out-of-network, payments to the non-contracted provider, like those to a contracted provider, are the responsibility of the MAO. The capitated monthly payment from CMS to an MA plan is intended to cover all care for its Medicare enrollees, regardless of whether the covered care was received in-network or out-of-network.

²¹ The criteria used to determine whether a qualifying MAO may receive an incentive payment on behalf of an EP are set forth at 42 CFR part 495, subpart C.

²² See section 1851(i)(2) of the Act, which provides that only an MAO shall be entitled to receive payments from the Secretary for services furnished to its MA enrollees, subject to sections 1853(a)(4) (payment to FQHCs), 1853(e) (special rules for enrollees in MSA plans), 1853(g) (certain in-patient hospital stays that straddle enrollment periods), 1853(h) (hospice care), 1857(f)(2) (prompt payments to non-contracting providers), 1858(h) (payments to essential hospitals), 1886(d)(11) (medical education costs), and 1886(h)(3)(D) (GME costs).

²³ Exceptions apply in certain circumstances. Per the regulation at 42 C.F.R. section 422.109, if CMS determines that the estimated cost of Medicare services furnished as a result of a particular national coverage determination (NCD) or legislative change in benefits is “significant,” MAOs are not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account such costs. Thus, since September 19, 2000, CMS has paid on a FFS basis for qualified clinical trial items and services provided to MA enrollees in clinical trials that are covered under the Clinical Trials NCD.

However, MAOs still control coverage and cost-sharing for non-emergency out-of-network services. An MA preferred provider organization (PPO) or private fee-for-service (PFFS) plan may impose higher beneficiary cost sharing for out-of-network care, while an HMO plan may deny payment if an enrollee goes out of network for non-emergency care. In the scenario where an MA enrollee receives emergency services from a non-contract provider, on the other hand, the MAO is held financially responsible, regardless of the enrollee's plan type.²⁴ In most out-of-network care scenarios, though, the provider payment obligation is that of the MAO, not CMS.

In contrast, under Medicare FFS, CMS makes payments directly to eligible providers²⁵ for services furnished to Medicare beneficiaries. Such differences are meaningful when discussing strategies for incorporating APMs into the MA program, primarily because the majority of the APMs implemented in the Medicare program and identified in section 101(e) of MACRA apply to provider payments under the Medicare FFS program.

²⁴ When an MAO is required to pay for out-of-network emergency services, the non-contract provider must accept, as payment in full, the amount he or she would have received if the beneficiary were enrolled in Medicare FFS. However, if the provider's bill is lower, the MAO may pay the lower billed amount. By contrast, where an MAO arranges for non-emergency covered care to be provided by an out-of-network provider, the MAO is required to pay the non-contracted provider the amount he or she would have received if the beneficiary were enrolled in Medicare FFS, less the beneficiary's cost-sharing under the MA plan. The non-contracted provider is obligated to accept that amount as payment in full.

²⁵ Eligible Medicare FFS providers include physicians, hospitals, skilled nursing facilities, long-term care hospitals, and laboratories.

IV. Medicare FFS Alternative Payment Models

Since the ACA was enacted, an increasing share of Medicare FFS payments to providers have been tied to the quality and the cost of care they provide to beneficiaries, supported by the development of APMs. To indicate the importance of APMs in Medicare's shift away from the traditional volume-driven care model, the Administration, in January of 2015, announced the intent to tie 30 percent of total Medicare FFS provider payments to APMs by the end of 2016 and to increase that share to 50 percent by the end of 2018.²⁶ As stated in the Introduction of this Report, the Administration estimates that its initial 30 percent goal has been met as of January 2016, 11 months ahead of schedule.²⁷

As detailed in the Introduction of this Report, APMs are those VBP initiatives that use alternative provider payment approaches, such as the shared savings, shared risk, two-sided risk sharing, or capitation/population-based payment approaches, to incentivize providers to engage in delivery system reforms that create value in health care. Most Medicare FFS APMs can generally be categorized under one of the following three general strategies²⁸ for delivery system reform:

- (1) **Accountable Care Organizations (ACOs):** Healthcare organizations agree to be accountable for the overall quality and cost of care provided to a population of Medicare beneficiaries over a specified period of time. ACOs may be eligible to receive shared savings payments if they meet the quality performance standard and reduce the rate of growth in expenditures for their beneficiary population and those ACOs participating in a two-sided risk model may be accountable for shared losses if expenditures for their beneficiary population increase. ACOs are typically comprised of groups of doctors, hospitals, and other health care clinicians, and their voluntary collaboration to produce desired population health outcomes is critical to this strategy.
- (2) **Bundled Payments:** Provider payments are based on the per-capita expected costs for individual episodes of care, as defined by the payer. Providers generally assume financial risk for incurred episodic costs that exceed a pre-determined applicable target amount.
- (3) **Primary Care Medical Homes (PCMH):** Primary care providers and practices receive supplemental payments to engage in a team-based model of care with the patient at the center and serve as the central source for heightened care coordination and care delivery. A portion of payments to certain PCMH model participants may also be tied to their cost and quality related performance.

These APM strategies are not characterized by the use of any one provider payment approach – each strategy can potentially be implemented with multiple APMs that all pay providers

²⁶ "Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume." CMS. January 26, 2015. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3>.

²⁷ "HHS Reaches Goal of Tying 30 Percent of Medicare Payments to Quality Ahead of Schedule." HHS. March 03, 2016. <http://www.hhs.gov/about/news/2016/03/03/hhs-reaches-goal-tying-30-percent-medicare-payments-quality-ahead-schedule.html>.

²⁸ CMS is testing other models that do not fall under these three strategies – the Accountable Health Communities Model and the Maryland All-Payer Model are two examples.

differently.²⁹ Although this is not always the case with Medicare FFS APMs, an individual APM could also potentially utilize multiple alternative payment approaches concurrently or over time as the model evolves and participant needs change. The Pioneer ACO Model described later in this section, for example, required payments to ACOs be made either under a shared savings or two-sided risk sharing approach during the initial two performance years and provides an opportunity for ACOs to transition to a population-based payment approach thereafter.

This section provides a description of the three APM strategies prevalent under Medicare FFS, focusing on the key design features of a payment model under each strategy as well as how those design features take shape under Medicare FFS initiatives.

A. Accountable Care Organization Initiatives

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and/or other health care providers, who come together voluntarily to coordinate care for a patient population. ACOs are financially accountable to Medicare for their ability to effectively and efficiently manage the cost and quality of care for an assigned group of beneficiaries over the course of a performance year.³⁰ In linking ACO payments to the overall care for a population over a performance year, this payment strategy places a high level of importance on an ACO's ability to monitor the health conditions of beneficiaries and facilitate provider collaboration for a holistic approach in treating them. Additionally, in creating accountability at the population level, this strategy calls on an ACO to identify and more effectively care for potential high cost beneficiaries among the population of beneficiaries the entity is responsible for. Accordingly, an ACO, as a healthcare delivery model, is focused on redesigned care management processes, like centralized care coordination, to produce timely, efficient, and high-value interventions throughout the continuum of care, especially for at-risk beneficiaries.

A critical design element of an ACO payment arrangement is the linkage of a beneficiary with an ACO, called "beneficiary attribution," for the purpose of tracking the ACO's performance. Beneficiary attribution determines the patient population an ACO is responsible for in a performance year. Again, responsibility in the ACO context relates to financial accountability; an ACO's final payment is tied to its ability to create value in the care of its attributed beneficiaries. Beneficiary attribution in Medicare is done by determining whether a beneficiary has chosen to receive a sufficient level of the requisite primary care services from certain ACO professionals, so the ACO may be appropriately designated as exercising basic responsibility for that beneficiary's care.³¹

²⁹ It is important to note that across most payment approaches, listed in the Introduction of this Report, the provider payments flow mostly on a FFS basis as usual.

³⁰ An ACO is defined as much by this payment arrangement as it is by the fact that it is an entity representing a coalition of providers. In other words, a physician group or health care system is not an ACO unless it participates in such a payment arrangement.

³¹ For the most part, primary care practitioners can be associated with just one ACO. Each initiative also has particular rules for beneficiary attribution. A beneficiary is not attributed to an ACO when he or she does not receive any primary care services, receives more such services from practitioners associated with different ACOs, or does not voluntarily align with the ACO.

Beneficiary attribution under most Medicare ACO initiatives is generally “invisible” to the beneficiary and a beneficiary’s attribution status does not restrict his or her choice of provider. Attribution under Medicare does not equate to a beneficiary’s formal enrollment in an ACO; attributed beneficiaries are free to obtain services outside of their ACO. However, under many Medicare ACO initiatives, all covered services received by an ACO’s attributed beneficiaries, including those received from providers outside of the ACO’s network, are considered by CMS when evaluating the entity’s performance. Therefore, ACOs under Medicare often have an incentive to build relationships with their beneficiaries through patient engagement activities and, whenever possible, carefully track the care they receive.

An ACO’s performance is measured relative to standards for quality as well as total spending that are established each performance year specifically for the ACO’s attributed beneficiary population. A Medicare ACO is assigned a composite quality score reflecting both its performance in a given year and year-over-year improvement over a range of quality measures assessing patient experience of care, care coordination, patient safety, preventive health and at-risk populations. The ACO must demonstrate that it has satisfied the requisite quality performance requirements to be eligible to share in any savings. In a similar manner, Medicare evaluates an ACO’s financial performance by comparing actual ACO spending to the ACO’s financial benchmark. Actual spending for a Medicare ACO is the total Medicare FFS expenditures incurred in the care of its attributed beneficiaries during a performance year.³² A Medicare ACO’s financial benchmark for a performance year is largely based on historical Medicare FFS spending of beneficiaries attributed to the ACO during the benchmark years as well as national and, sometimes, regional trends in Medicare FFS spending and it is updated each year based on new experience.³³ In effect, the cost benchmark represents an estimate of the total Medicare FFS expenditures that would be expected for a similar population in the absence of the ACO’s care improvement efforts in that year.

Under Medicare, the ACO payment arrangement exists primarily as a shared savings strategy. Accordingly, a Medicare ACO that achieves both quality and spending objectives, as determined via the performance measurement methodology described above, is eligible to retain a portion, up to 100 percent under certain Medicare FFS ACO initiatives, of the financial savings it helps produce. While financial efficiency must be demonstrated to be eligible to share in savings, quality performance dictates both eligibility as well as the share of total savings the ACO retains – the higher the savings, the larger the shared savings pool and the higher the quality of care, the larger the shared savings payment incentive.³⁴

Many of Medicare’s ACO initiatives also feature a performance-based two-sided risk sharing payment approach, under which, in exchange for a shared savings opportunity, participants also

³² As mentioned above, the scope of services considered when evaluating an ACO’s performance is not limited only to those provided by the ACO-affiliated providers. Thus, actual spending for a Medicare ACO includes FFS expenditures for services received by an attributed beneficiary from a provider not affiliated with the ACO.

³³ While this description adequately describes CMS’s existing efforts to evaluate the financial efficiency of ACOs in a general sense, it is important to note that the particulars of benchmarking methodology continue to evolve under Medicare. Specifically, aware that a methodology dependent on past performance leads to decreasing benchmarks over time for effective ACOs – which can make it more difficult to achieve year-over-year savings – CMS is exploring ways to accurately account for efficiencies achieved by an ACO in prior performance years.

³⁴ In other words, a cost-efficient ACO must also meet a quality standard to qualify for any reward, and the level of quality achievement influences the proportion of savings shared.

assume downside risk. Under such an arrangement, a Medicare ACO with total expenditures in excess of the financial benchmark is liable for a portion, up to 100 percent under certain Medicare FFS ACO initiatives, of the additional spending. The ACO's liability ratio is adjusted in favor of the ACO based on the entity's performance on the quality measures. Medicare may disqualify the low-quality ACO from any shared savings incentives altogether (the latter is also a common provision under a one-sided, shared savings arrangement).

Although each of the common elements are implemented in a mostly consistent manner across Medicare's ACO initiatives, variations do exist to better accommodate operational objectives, as informed by stakeholder needs. The ACO initiatives currently in place under Medicare are listed in Table 6 below along with information on where relevant materials on the initiatives can be found.

Table 6. Medicare ACO Initiatives

Initiative	Authority	Further Information
Medicare Shared Savings Program	Section 1899 of the Act	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html
Pioneer ACO Model	Section 1115A of the Act	https://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html
Next Generation ACO Model	Section 1115A of the Act	https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/index.html
ACO Investment Model	Section 1115A of the Act	https://innovation.cms.gov/initiatives/ACO-Investment-Model/index.html
Comprehensive ESRD Care Model	Section 1115A of the Act	https://innovation.cms.gov/initiatives/comprehensive-ESRD-care/index.html

B. Bundled Payment Initiatives

Bundled payment initiatives tie provider payments to the expected costs for “episodes of care” and, thereby, link payments for multiple services that beneficiaries receive during an episode. In doing so, they emphasize care coordination across multiple health care settings; provider flexibility in resource allocation decisions; and value, instead of volume, considerations in the treatment of high priority clinical conditions. Critical to the design of a bundled payment model is how an episode of care is defined and which payment approach is employed.

An episode of care in this context consists of a group of services, or “bundle,” provided to a single beneficiary during a specified, usually substantial period of time, referred to as an “episode/bundle

length,” following a significant medical event related to a “clinical episode,”³⁵ or diagnosis, of focus. Under Medicare’s bundled payment initiatives, the bundle itself commonly consists of substantially all health care services provided over the episode length to most accurately capture the quality of all care furnished, account for provider flexibility, and encourage care coordination.³⁶ In defining an episode of care, CMS determines which clinical conditions to focus on and considers the care setting or service category in which the costs for the treatment of those conditions are concentrated.

As suggested above, the final payment to a service provider under a bundled payment arrangement is directly related to an episode of care as it is adjudicated on a per-episode basis and varies based on the participant’s episode-specific quality and cost performance. Like under Medicare’s ACO initiatives, participant performance under Medicare’s bundled payment initiatives is measured relative to standards for quality and total cost established each year on an empirical basis. The standards, however, are established for each individual episode of focus under the particular model, not a population of attributed beneficiaries, and performance is measured for each episode, individually, instead of for all care over an entire year like under the ACO arrangement.

Most Medicare bundled payment models rely on the two-sided risk sharing payment approach to compensate model participants, which are usually hospitals, provider practices, and clinics where episodes are initiated or entities specializing in coordinating care across multiple settings and/or sites. Therefore, most providers under Medicare’s bundled payment initiatives are paid on a FFS basis augmented by a retrospective payment adjustment to account for differences between an episode-specific target amount and the incurred Medicare FFS expenditures for that episode. While the two-sided risk-sharing arrangement is common across most bundled payment models, the particulars of the arrangement can vary by model.

The Medicare bundled payment initiatives listed in Table 7 below employ these principles in practice.

Table 7. Medicare Bundled Payment Initiatives

Initiative	Authority	Further Information
Bundled Payment for Care Improvement Initiative	Section 1115A of the Act	https://innovation.cms.gov/initiatives/Bundled-Payments/
Comprehensive Care for Joint Replacement Model	Section 1115A of the Act	https://innovation.cms.gov/initiatives/cjr

³⁵ Note that an “episode of care” (or “episode”) is not the same as a “clinical episode.” A clinical episode is essentially a diagnosis or a medical complication or treatment/procedure.

³⁶ The episode cost target determined by the payer is usually adjusted to account for riskier patients that may require more services than a patient of average risk.

C. Primary Care Medical Home Initiatives

A primary care medical home (PCMH), also known as a patient-centered medical home, is a way of organizing primary care providers to focus on care coordination, improved access to care, patient education, and other such services to improve population-based care. Broadly speaking, PCMH initiatives are focused on promoting five core “comprehensive” primary care functions:

- (1) **Access and continuity:** meeting needs and emergencies in a timely manner, while maintaining continuity of care guided by the patient’s medical history
- (2) **Planned care for chronic conditions and preventive care:** proactively assessing patient needs and providing appropriate and timely chronic and preventive care, including individualized plans of care for high-risk patients and integrated team-based approaches
- (3) **Risk-stratified care management:** implementing care management and extra support for patients with serious or multiple medical conditions
- (4) **Patient and caregiver engagement:** integrating culturally competent self-management support and the use of decision aids for patients and families to actively participate in decision-making
- (5) **Coordination of care across the medical neighborhood:** collaboration among providers to coordinate and manage care transitions, referrals, and information exchange

PCMH initiatives typically feature financial and non-financial mechanisms to support and encourage primary care providers to invest in these functions. Under Medicare’s PCMH initiatives, the non-financial mechanisms include expert guidance, regular performance feedback and data sharing, assistance with data systems and health IT, etc. Financial mechanisms under Medicare PCMH initiatives most often take the form of population-based monthly care management fees intended to both incentivize primary care providers to engage in the above functions and to provide them the resources they need to do so meaningfully. Some Medicare PCMH models also rely on a shared savings payment approach, with quality and financial benchmarks playing a similar role as under Medicare’s ACO and bundled payment initiatives in determining provider eligibility for shared savings awards.

Beneficiary attribution to participating practices using claims-based algorithms is another common characteristic of Medicare’s PCMH initiatives, important for the performance evaluation of and, thereby, final payment to participating providers. Performance of Medicare PCMH participants is often measured in relation to annual milestones. The milestones under the Medicare Comprehensive Primary Care Initiative, for instance, fall under the following nine categories: budget, care management for high-risk patients, access and continuity, patient experience, quality improvement, care coordination, shared decision making, learning collaborative participation, and health information technology.³⁷

³⁷ The CPC is a multi-payer model. A list of milestones is available at <https://innovation.cms.gov/Files/x/CPCI-Milestones.pdf>.

Finally, the involvement of private payers and state Medicaid programs is also a key component of some Medicare PCMH initiatives. This multi-payer approach is intended to align the incentives for desired care norms across a large proportion of any given practice's patients.

Table 8. Medicare PCMH Initiatives

Initiative	Authority	Further Information
Comprehensive Primary Care Initiative	Section 1115A of the Act	https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/
Multi-Payer Advanced Primary Care Practice	Section 402 of the Social Security Amendments of 1967	https://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/
Independence at Home Demonstration	Section 1866D of the Act	https://innovation.cms.gov/initiatives/Independence-at-Home/
Comprehensive Primary Care Plus Initiative	Section 1115A of the Act	https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus/

V. Ability of MA Organizations to Incorporate APMs into their Payment Structures

In the Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (published April 6, 2015), CMS noted that Medicare FFS and commercial insurers have continued to implement programs using incentive payments to increase provider efficiency, reduce costs, and improve the health outcomes of patients. In the Call Letter, CMS also indicated that it would reach out to MAOs to gain a better understanding of the extent to which they have been doing the same and, specifically, of their current use of APMs. The CMS recently completed this undertaking, engaging in conversations with several of the largest MAOs as well as a number of smaller organizations about their current use of value-based contracting and APMs. This section highlights the important findings gathered through such efforts that are relevant when examining the feasibility of integrating APMs into the MA program.

We specifically asked MAOs to describe the structure and elements of their APMs, how they collaborate with providers to deliver high value care, any infrastructure needed to support APMs, and to discuss challenges operating APMs in the both the MA program and the commercial market. The specific questions asked by CMS included the following:

(1) Payment Arrangements:

- Describe your APM arrangements, including payment structure and risk arrangements.
- If your models involve a payment continuum, describe each stage and provider movement along the continuum. Do you offer provider support to move along the continuum?

(2) Contracting with Providers:

- How do you select providers with whom you contract for in-network services and what are the primary factors in that selection process?
- Are there any differences involved when contracting with specialists vs. primary care providers under alternative payment arrangements and what are the unique challenges in contracting with specialists?

(3) Collaborating with Providers:

- How do you involve physicians in the development and implementation of VBP initiatives?
- Have you experienced any resistance from providers with whom you contract to the incorporation of quality or value based payment methodologies?

(4) Infrastructure Support:

- In your experience what infrastructural elements support the use of APMs?
- What kinds of data are shared in the collaboration with physicians?

(5) Medicare Advantage vs. Commercial:

- What differences do you consider when creating a package for MA vs. commercial offerings and what are the challenges specific to MA?

Through the responses of MAOs to these questions, we found that many of the arrangements MAOs have in place to pay their contracted providers resemble many of the Medicare FFS models discussed in Section IV of this Report. MAOs use such arrangements to encourage higher quality or to encourage a more holistic approach to care by a provider. In our discussions with them, MAOs indicated that they agree to different payment structures with different providers depending on both the MAO's goals and priorities and the provider's ability and willingness to share data, adopt new care management methods, and assume risk. Many of the MAOs discussed their concurrent use of several APMs that support various payment approaches along the payment continuum first detailed in the Introduction of this Report when contracting with providers.

A. Alternative Payment Models Currently in Use by MAOs

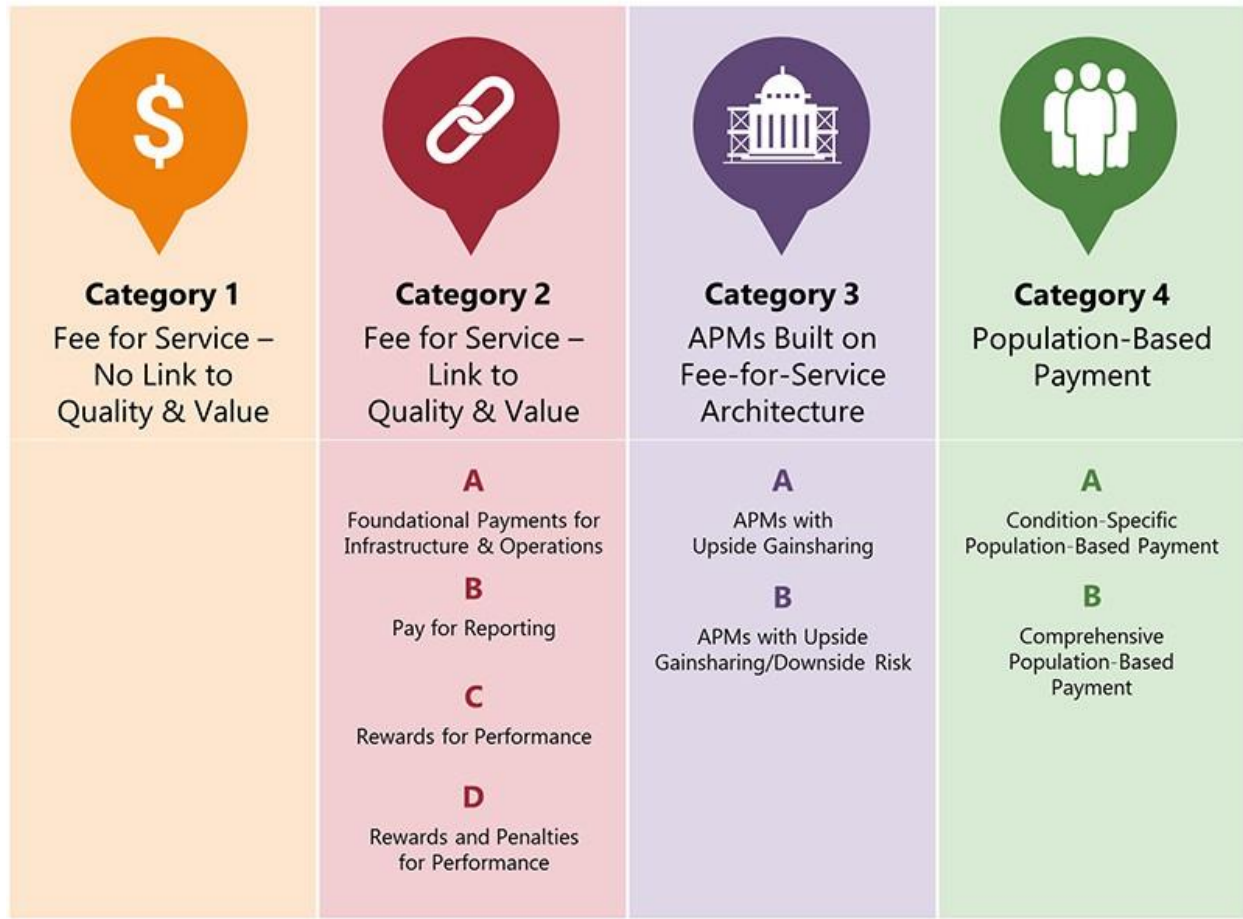
Most MAOs with whom CMS communicated indicated that they have incorporated a number of VBP arrangements in their contracts with providers. Many MAOs reported that they would prefer to engage in payment models in which the provider assumes full risk, and thus is accountable, for delivering high quality and cost effective care. MAOs indicated that they often enter into contracts with providers with the intention of moving those providers into more sophisticated risk-based payment arrangements over time, as they become feasible for and acceptable to both parties.

Payment Continuum

In terms of the Administration's Payment Taxonomy Framework detailed in the Introduction of this Report, this would mean transitioning providers from a Category 1 to a Category 4 payment model. Figure 1 below represents how the progression of payment approaches, from least risk (basic FFS) to the assumption of full risk (full risk capitation/population-based payment), aligns with this framework, following the discussion presented in the Introduction of this Report.

MAOs indicated that, ideally, providers participating in their VBP initiatives progress along the payment continuum, from one category of models to the next and, within a category, from one payment approach to the next, over time. The factors at play in this progression are detailed in Subsection B below.

Figure 1. Payment Continuum and Payment Taxonomy Framework ^{a, b}



Source: “Alternative Payment Model (APM) Framework Final White Paper”. Produced by the Healthcare Learning and Action Network. <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>

- a. Foundational payments for infrastructure and operations, pay for reporting, rewards for performance, and rewards and penalties for performance all represent the P4P payment approach.
- b. Upside gainsharing is another term for shared savings and downside risk is another term for shared risk.

MAO-Adopted Alternative Payment Models

In our attempts to learn more about the VBP initiatives and, more specifically, the APMs that have been adopted by MAOs, we found that MAOs and their network providers are engaged in payment models that can be classified under every category of the Administration’s Payment Taxonomy Framework and support payment approaches at all levels of the payment continuum. Most payments to MA providers are still tied to the basic FFS payment approach and many of the value-based arrangements that MAOs described were Category 2 (P4P) models. However, MAOs provided several examples of value-based arrangements that would be classified as APMs, or Category 3 and 4 models under the Administration’s Payment Taxonomy Framework, by virtue of their reliance on one of the four payment approaches at the end of the payment continuum. Many of the MAO-adopted APMs that were described, moreover, implemented the same APM

strategies currently promoted by CMS, as detailed in Section IV of this Report, and resembled, to varying degrees, the APMs currently in place under Medicare FFS.

MA APMs differ from Medicare FFS APMs primarily in that the quality measures and performance thresholds used to drive the quality component of APMs are different from those used under Medicare FFS initiatives. MAOs are incentivized to consider HEDIS and CMS Star Ratings metrics when developing APM quality and performance measures because, as explained in Section III-B of this report, the MAOs' performance on these measures impact their payments from CMS. However, the exact set of quality measures that MAOs use to shape their models are independently developed through contract negotiations with their network providers. Ultimately, the quality and performance metrics used by MAOs are influenced by CMS's metrics, but may also include additional measures not used by CMS for evaluating the performance of providers participating in Medicare FFS APMs.

B. Contracting and Collaborating with Providers

The provider contracting decisions of MAOs involve a number of factors, including the provider's location in the designated service area; competition with other MAOs for provider contracts; provider ability to offer the level of care required to serve an increased number of MA patients; and the provider's willingness to contract with the MAO. When asked about which APMs they use with which providers, MAOs indicated that relevant criteria include a provider's ability to perform well in areas of quality, cost efficiency, financial stability, physician engagement, and data analytic competency. For instance, in a full risk-based payment arrangement, if a provider exceeds budgeted costs, the provider must absorb the difference. Therefore, a provider's financial stability is a crucial element in determining his or her inclusion in a more sophisticated, risk-based payment arrangement.

Several MAOs indicated that they are interested in contracting with providers who demonstrate the potential to succeed in APMs. Some MAOs cite "like-mindedness" – whether a provider "buys in" to the MAO's care delivery and physician engagement models³⁸ – as an important factor to consider when selecting providers with whom to contract.

Contracting with Primary Care Providers and Specialists

Primary care is often viewed by plans as central to effective care coordination and overall improvement in population health. Thus, for most MAOs, primary care providers are the focus of APMs. MAOs generally hold primary care physicians more directly accountable for the overall medical costs of patients than they do specialty providers. Therefore, MAOs more often enter into risk-based APMs with primary care physicians, including capitated payment arrangements.

Feedback from the MAOs indicated that they engage specialists in APMs to varying degrees and usually through contracts with highly skilled and high-performing multi-specialty physician groups. The use of APMs involving specialists is generally seen as an opportunity to increase the cost effective management of enrollees with specific conditions. Joint replacement surgery is a

³⁸ A physician engagement model is a care delivery model that emphasizes ongoing collaboration between the MAO and the provider.

frequently cited area in which there are opportunities for efficiency. For example, in orthopedics, the bundling of payment for joint replacement surgery is a common method to reduce costs and increase efficiency. There are Medicare FFS bundled payment APMs that also focus on such procedures.

Provider Collaboration

The MAOs that participated in discussions with CMS universally indicated that collaboration between MAOs and providers is a fundamental component of APMs. Open and ongoing communication and data sharing between the MAO and provider is critical to tailoring the APM to meet desired results. For instance, some MAOs touted the value of provider feedback regarding appropriateness of quality measures. It is also not uncommon for MAOs and providers to meet regularly to discuss quality performance, challenges, and ways to improve performance. Regular communication allows the MAO to understand and address provider's needs. For example, one MAO discussed the use of an outreach team to meet regularly with providers to discuss performance data.

Thus, the contracts between MAOs and providers will often also address the type of support the MAO will offer providers to help them achieve the goals of their contracts. In addition to the support mechanisms described already, support from the MAO also takes the form of infrastructural support, including data and data analytics consultation. Most MAOs said they provide access to a variety of data (e.g., aggregate data and summary reports) on patient population characteristics and health outcomes. This information helps identify high risk patients and care gaps and enables the MAO and providers to more effectively manage their patient population. These resources are meant to assist providers in meeting the terms of their contracts as well as help improve population health management.

Another frequently-used support mechanism is the embedding of a member of the MAO's care management staff in the provider practice to enhance care coordination or help the practice adopt new practice patterns associated with the performance thresholds upon which the practice will be evaluated. These staff offer providers hands-on support of clinical management activities or support in managing technological administrative functions (e.g., data analytics or access to coding consultant staff). MAOs may also offer providers access to EMRs, clinical integration, and health management software to support a number of financial, clinical, risk, and health management activities.

Movement along the Payment Continuum

Each provider and provider group is unique and payment arrangements, financial incentives, and MAO support must be tailored to the specific provider or provider group to be effective. MAOs will determine whether a provider is ready to transition to the next level of the continuum based on performance, technological capability, level of commitment to adhering to agreed-upon care management protocols, financial stability, and provider willingness and ability to enter into a higher level of risk based payment. According to MAOs, success in all of those areas is important. One MAO stated that even the most technologically-enabled practices will not achieve success if they do not engage physician leadership to make certain that a practice's providers take the initiative to meet medical cost targets and achieve quality goals. According to MAOs, success in these models requires complete provider buy-in.

Additionally, MAOs indicated that, in their experience, competition among providers in a service area and the level to which they have been exposed to VBP affect a provider's ability and willingness to participate in the "riskier" VBP arrangements, or APMs. In other words, providers in markets where VBP penetration is already high are more willing to engage in APMs with MA organizations and possibly assume a larger share of risk, for underperformance related to cost and quality of care, than providers in markets where VBP arrangements are less common.

C. Provider Resistance and Complaints

To better understand any difficulties experienced by MA providers in APM arrangements, we asked MAOs to discuss the nature of any provider resistance or complaints, which generally fall into the four categories described below.

Payment Amounts and Payment Timing

MAOs indicated that many providers are hesitant to enter into risk-based arrangements because of the possibility of lost revenue. Almost all APMs, regardless of payer, rely on outcomes-based payments, which, by definition, are contingent upon performance evaluation. Therefore, providers participating in APMs may be at risk of lower revenue than anticipated or limited cash flow because significant portions of the provider's payment are made as year-end bonus payments based on performance. Depending on the provider's reserves, such limits on cash flow may result in inadequate payments/revenue to support ongoing operations.

Nonetheless, based on CMS conversations with MAOs, it is clear that the industry is shifting away from reliance on a pure FFS payment approach and toward value-based ones. While some MAOs report resistance from providers because of revenue uncertainty, others report that providers have accepted and embraced the industry shift toward quality-based payment and use of APMs.

Quality and Other Performance Metrics

Feedback from MAOs indicated that quality metrics and benchmarks can be a point of disagreement between MAOs and providers. Some providers disagree on the quality metrics by which they should be evaluated or believe that certain benchmarks set by MAOs are too rigorous. Others express concern over the difficulty in continuously improving performance. MAOs acknowledge that there is a limit to how much improvement can be made and that it is challenging to find new ways to reward providers who consistently perform at the highest levels.

Data and Infrastructure

Some MAOs reported sharing a great deal of information with providers to support value based goals within alternative payment models. This information includes data concerning gaps in care, service utilization, and patient satisfaction. However, many providers in APMs express some frustration about being inundated with a multitude of data that does not provide the type of information they believe would be useful to them in improving care. Providers have told MAOs that they would prefer information from which they can obtain insight into factors that drive costs.

A few of the MAOs also indicated that providers value timely data. According to MAOs, the use of real time patient data allows the providers to engage in appropriate care planning and delivery.

For example, the use of current data allows providers to identify specific gaps in care that need to be addressed. However, incompatible EHR systems and lagged claims data do not always allow for the seamless exchange of data between plans and providers necessary to accomplish this.

The exchange of data is a fundamental component of many APMs. Therefore, the inability of MAOs and providers to share data across systems can be a significant barrier to the success of APMs. Many of these models require the constant flow of data between multiple parties (e.g., providers, sub-contracted providers, labs, hospitals, health care facilities, and MAOs). The incompatibility of data and communications between data systems creates additional burden for providers who must report and interpret multiple streams of data from the MAOs.

Participation in Multiple APMs of Varying Design

MAOs and other payers, including Medicare FFS, use APM arrangements to pay providers in order to improve quality and cost efficiency of care. The APM arrangements differ across payer types (e.g., public payer, MAOs, and commercial insurers) and by payer, including variation among MAOs. As a result, some MAOs acknowledged that providers have reported on the difficulty of managing multiple APM arrangements in which there are different specified metrics, benchmarks, data systems, and value-based care delivery models. Payers may even differ in the data requested and the data shared.

D. Challenges to Incorporating APMs in Medicare Advantage

The CMS recognizes that for a number of years, the commercial health insurance industry has been experimenting with APMs to reduce costs, increase efficiency, and improve the health outcomes of patients. Most MAOs also provide health care insurance products in the commercial industry. In our efforts to understand how to support continuing success of APMs in MA, we asked MAOs to discuss how the MA environment differed from the commercial environment in terms of APMs, describing, particularly, any challenges that are specific to MA. MAOs noted a number of challenges faced when operating APMs in the MA industry, as discussed below.

Population

MAOs indicated that the higher utilization and complexity of services among the Medicare population is a key difference between MA and the commercial populations. As the MA beneficiary population is comprised of aged and disabled individuals, more resources are required to provide the higher frequency and complexity of care they need than with the population of beneficiaries in the commercial environment. Although Medicare payments to MA plans are risk-adjusted to offset the higher level of care needed by their enrollees compared to the average Medicare beneficiary, MAOs report that compared to enrollees in their commercial plans, the MA enrollees have characteristics that make it more difficult to achieve cost savings in MA.

Star Ratings

Several MAOs discussed the challenges of aligning their value-based care models with their efforts to improve their Star Rating. The MAOs acknowledged that Star Ratings drive many of their business decisions. MAOs consider Star Rating metrics and the benchmarks established by CMS in their decisions about measuring the performance of providers that contract with the MAO and

when designing care models and developing other performance benchmarks for providers participating in their APMs. MAOs contend that because the Star Rating cut points are not known by MAOs until late in the contract year, it is difficult for MAOs and providers to establish specific performance metrics based on achievement of a specific Star Rating.

Regulatory Requirements

When operating APMs in the MA program, MAOs encounter challenges associated with certain regulatory requirements. For example, CMS regulation 42 CFR 422.256(b)(4) states that CMS will approve a bid only if the “benefits package and plan costs represented by the bid are substantially different from the MA organization’s other bid submissions [...]. [E]ach bid must be significantly different from other plans of its plan type with respect to premiums, benefits, or cost sharing structure.”

In essence, an MAO may not offer two plans that are not “meaningfully different” from each other in the same service area. The purpose of the meaningful difference evaluation is to address the potentially large number of available plan options in certain areas and to make sure beneficiaries can easily identify the differences between plans – in terms of cost-sharing, benefits, etc. – and determine which plan best fits their needs. Some MAOs contend that this provision constrains their ability to innovate with high value provider networks because CMS’s evaluation does not consider variations in provider network in determining one plan’s difference from another. One MAO representative discussed its inability to provide a particular plan as a “high value network” HMO because, based on CMS’s criteria, it was too similar to another HMO being offered by the organization in the same area.³⁹

E. Next Steps

The CMS has gleaned important information as a result of its discussions with MAOs. However, in order to gauge the proportion of MA payments that are linked to quality and to gain a complete understanding of the scope of value-based contracting activities within the MA program, beginning CY 2016, CMS will collect information regarding the adoption of APMs by MAOs as part of the annual Part C reporting requirements. Specifically, CMS will ask MAOs to report on the number of providers and the proportion of payments made to providers through APMs. This information will provide CMS with data to perform quantitative analysis concerning the extent of the integration of APMs into MA. In its Announcement of Calendar Year 2017 MA Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (published April 4, 2016), CMS also sought further comments from the industry regarding challenges and concerns associated with the use of APMs in MA. The CMS is also leading further outreach through the LAN to assess commercial payer adoption of alternative payment models this fall.

³⁹ However, we would note that a measure of “high value networks” has not been quantified by these MAOs and there is not yet an agreement on the standards a network must meet to be defined as “high value.”

VI. Feasibility of Integrating APMs into the MA Program

The MA program today effectively functions as a value-based purchasing (VBP) arrangement between CMS and MAOs. Payments to private insurers that contract with CMS to provide Medicare benefits are population-based and increasingly tied to quality performance, driven by ACA requirements linking a plan's MA benchmark and rebate percentage to its quality rating. However, these links to quality do not directly impact an MAO's contracting arrangements with providers.

CMS's ability to directly incorporate APMs at the provider-payment level in the MA program is limited by current law and program structure. Medicare is a purchaser of services offered by MAOs under MA, not the direct payer to providers, except in very limited circumstances. The non-interference clause strictly constrains CMS's ability to dictate the payment terms between MAOs and contracted providers. Therefore, under current law, CMS is prohibited from requiring, or directly conditioning payment on, an MAO's use of APM strategies and payment structures in the payment arrangements with its contracted providers. However, CMS maintains some limited regulatory flexibility, such as discretion through 1115A authority, as discussed below.

As noted in the previous section, MAOs have, to varying degrees, voluntarily implemented VBP arrangements, including APMs, to better align incentives for contracted providers with the value-based incentives the insurers face under the MA program. This reflects an indirect incentive for MAOs to adopt APMs that already exists under the MA program.

In this section, we explore several more direct potential approaches for expanding the use of APMs in MA, including extending Medicare FFS APMs to MA and mechanisms to encourage the use of APMs by MAOs, and consider these approaches in the context of the current statutory framework.

A. Integrating Existing Medicare APMs

As discussed in Section IV, CMS is currently modeling APMs for Medicare FFS providers. We considered whether CMS could expand existing arrangements, as well as the payment models identified in section 101(e)(2) of MACRA, to include MA providers and concluded that we cannot.

Some Medicare FFS APMs administered by CMS, such as the APMs under the Medicare Shared Savings Program, cannot be expanded to MA because, by statute, they are explicitly limited in application to payments made under Medicare Parts A and B, thereby directly excluding MA payments, which are made under Part C.

Other Medicare FFS APMs do not explicitly exclude payments made under Part C. We do not believe, however, that these arrangements could be expanded to include MA for two reasons. First, whereas providers in the existing Medicare APMs are paid directly by CMS for services furnished to FFS enrollees, only MAOs, as per section 1851(i)(2) of the Act, are entitled to receive payment from CMS for the vast majority of services furnished to individuals enrolled in MA plans.⁴⁰

⁴⁰ See section 1851(i)(2) of the Act, which provides that only a MAO shall be entitled to receive payments from the Secretary for services furnished to its MA enrollees, subject to sections 1853(a)(4), 1853(e), 1853(g), 1853(h), 1857(f)(2), 1858(h), 1886(d)(11), and 1886(h)(3)(D). See also footnote 22 above.

Second, as noted above, under the non-interference clause, CMS is expressly prohibited from requiring MAOs to contract with certain providers or from specifying the payment terms between MAOs and their network providers. Therefore, while certain Medicare FFS APMs, such as the Comprehensive Primary Care and the Comprehensive Primary Care Plus initiatives, involve the participation of other payers, including MAOs, the other payer participation is strictly voluntary and no dollars flow between CMS and the participating private insurer.

Given the central role of MAOs in the administration of the MA program, the remainder of this Report will focus on methods that would leverage MAOs' contracts with, and payments to, providers as the mechanism by which APMs could potentially be expanded in MA.

B. Encouraging MAOs to Adopt APMs

The further integration of APMs in the MA program would require establishing a direct, explicit incentive for MAOs to adopt APMs by conditioning a reward to an MAO on its adoption of an APM. MAOs could be encouraged to adopt APMs by: (1) modifying existing financial incentives under MA to encourage APM adoption and/or (2) establishing new incentives or mandates under the MA program for the same.

Incentive Qualification and Non-Interference

Under a scenario where the Medicare program adopted financial incentives for MAOs that committed to APM adoption, an MAO would qualify for an incentive, such as a bonus payment, based on the degree to which it integrates APMs into its offerings, or, in other words, the level of APM adoption by an MA plan in any given year. Therefore, a key question related to the development of an incentives-based initiative to encourage APM adoption by MAOs is what types of value-based contract arrangements between MAOs and providers constitute APMs. In resolving this question, policymakers can consider desired APM strategies and initiatives from among those currently promoted by Medicare (enumerated in Section IV), as well as desired characteristics that APMs introduced by MAOs should possess.

Under the current statutory framework, the non-interference clause restricts Medicare's ability to explicitly require an MAO – i.e., condition additional payments to the MAO – to adopt a particular provider payment arrangement. Therefore, for Medicare to reward MAOs for the adoption of value-based provider payment arrangements that Medicare deems constitute APMs would likely require a change in law.

Incentive Options

Recognizing the constraints presented by the non-interference clause, CMS does not have the ability to make significant changes in the MA program to directly reward, or incentivize, MAOs to adopt APMs across their plan offerings. However, listed below are some of the financial and non-financial, mechanisms affecting payments to MA plans, which, if adjusted through a change in law or, in some case, a change in current program rules, could be used to incentivize plan behavior. Such mechanisms could also potentially be considered as part of a future model test authorized under section 1115A of the Act, which permits CMS to waive legal requirements to test innovative approaches to reduce costs and/or improve quality of care within Medicare.

Financial Incentives under MA Payment Rules

Each of the mechanisms listed below builds on existing payment systems under MA (described in Section III-B of this report) and, if changes were made, could be considered as a method for varying the payment a plan receives per Medicare beneficiary based on its success in incorporating APMs.

- (1) **Applicable Percentage:** An MA plan’s applicable percentage could be adjusted, thereby tying the county benchmark rate against which MA plans bid, to APM adoption.
- (2) **Quality Bonus Payment Percentage:** The applicable percentage quality increase, currently five percent, which plans receive for achieving at least a four-star rating could be adjusted.
- (3) **MA Rebate Percentages:** A plan’s rebate percentage, which is the portion of the difference between a plan’s bid and benchmark that constitutes the beneficiary rebate amount could be adjusted.
- (4) **Benchmark Caps:** For plans with high levels of APM adoption, the statutory cap keeping the total calculated benchmark amount below pre-ACA levels, as discussed in Section III-B, could be lifted or raised.
- (5) **Star Ratings:** Multiple approaches could be taken to using Star Ratings to drive APM adoption, including tying measures or the overall rating to APM adoption. Note that the Star Ratings have a payment consequence, as described in Section III-B of this Report.
- (6) **Additional Subsidies:** Additional subsidies could be offered to plans that have high levels of APM adoption. As with beneficiary rebates, plans could be required to use such subsidy amounts to provide and cover additional non-Medicare benefits or to buy-down beneficiary premiums.

Even if non-interference were not a factor, the statute also restricts CMS’s ability to make certain payment adjustments administratively. Of the options listed above, only the Star Ratings adjustments are levers that could potentially be implemented administratively by CMS to account for APM adoption, but, again, only if the non-interference prohibition were not applicable.

Non-Financial Incentives under MA Payment Rules

Non-financial incentives could take the form of regulatory relief, targeted to either removing barriers limiting the adoption of APMs in MA or motivating the affected parties.

- (1) **Meaningful Difference:** Flexibility to MAOs in regards to the “meaningful difference” provision for plans with a satisfactory level of APM adoption could be provided. As noted earlier in Section V of this report, some MAOs have identified this provision as a challenge when attempting to innovate with high value provider networks.

Meaningful difference regulatory standards were established to provide beneficiaries with a more manageable selection of Medicare Advantage plans in a given market. For that reason, CMS has been reluctant to modify meaningful difference standards for purposes of provider networks to date. As stated in the Announcement of Calendar Year 2017 MA Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter (published

April 4, 2016), provider network differences have been excluded from CMS meaningful difference criteria because having a provider in one plan and not the other is not a change in benefit coverage. In addition, plan providers can change throughout the year (e.g., terminate their provider contract or close their practice to new members), so it is not necessarily accurate or transparent to a beneficiary making a plan choice for the year to identify provider network composition as a plan difference that meets the regulation requirement.

- (2) **Network Adequacy:** The current network adequacy requirements also pose a challenge for MAOs seeking to implement APMs that rely on an exclusive, narrow network of high value providers. Flexibility could be provided to a plan in regards to network standards in order to enhance the MAO's ability to offer an APM-driven product. However, consideration would need to be given to the impact on beneficiaries, including those living in rural areas, of modifications to these rules, which were established to support beneficiary access to services.
- (3) **Enrollment Period:** A Special Enrollment Period (SEP) could be established to allow Medicare beneficiaries to enroll at any point in the benefit year in plans deemed successful in APM incorporation, like the current SEP for enrollment in plans with a five-star quality rating.

CMS has the authority under section 1851(e)(4)(D) of the Act to establish a SEP administratively if it determines that such an enrollment opportunity is necessary due to "exceptional conditions."

Policymakers could also consider additional rules-based incentives in the future based on feedback from MAOs as they continue to adopt APMs and identify challenges created by regulatory requirements under the MA program.

Financial Incentive Design

To some extent, the success of any attempt to more directly encourage APMs in MA which focuses on financial incentives will be a factor of the specific design of the financial incentive(s) selected. An important policy consideration in this regard is how large any payment adjustment must be to adequately motivate MAOs to take action.

Broadly speaking, policymakers would need to consider the size of the additional compensation MAOs will require in order to alter their contract structures. Plans will face administrative burdens if new contracts with providers need to be negotiated and administered. Some MAOs will face barriers in certain markets that will make it more difficult or costly for them to adopt APMs, such as a small market share overall or few patients treated by individual providers. At the margins, some MAOs – likely those with limited prior exposure to APMs – will require a large financial incentive to adopt APMs, while others – likely those with relatively extensive experience with APMs – will respond to small, or smaller, financial incentives.

Additionally, both providers and MAOs new to VBP arrangements may require greater total funding initially, until the efficiency gains anticipated from VBP are evident for both sides. Estimates of cost considerations can provide a point of reference for determining how large any APM incentives would need to be. Over time, as APMs spread, providers become more efficient, and MAOs learn to manage risk more effectively, it could be possible for policymakers to reduce payment levels accordingly.

Finally, as noted above, conditioning financial incentive payments to the MAO on the adoption of an APM – in other words, requiring a particular provider payment structure from the MAO for it to qualify for payment (or increases in payment) – triggers the non-interference provision. This consideration must be accounted for when considering a financial incentive and any financial incentive design.

MACRA and “Other Payer” Arrangements

MACRA created a new incentive for providers to engage in value-based contracting with all payers, including Medicare. Specifically, MACRA offers a bonus payment to providers who have entered certain types of value-based payment arrangements (“Advanced APMs”) with federal and other payers. Under this arrangement, qualifying APM participants, or “QPs,” will receive a lump sum bonus payment totaling five percent of their Medicare Part B payments for covered professional services beginning in 2019 (performance period 2017) for meeting a specified threshold of participation in Advanced APMs. Beginning in 2021 (performance period 2019), providers who do not meet the QP threshold through Medicare Part B alone may meet the QP threshold through their participation in Advanced APMs with other payers, such as Medicaid and commercial payers.

Of note to the discussion at hand, this “All-Payer Combination Option” for becoming a QP is applicable to the payment arrangement between providers and MAOs under MA. Therefore, a provider can qualify for the APM incentive payment established by MACRA through, in part, participation in an Advanced APM with MAOs. In essence, the “All-Payers Combination Option” creates a new incentive for providers to engage with MAOs in establishing certain types of value-based arrangements.

Value-Based Insurance Design Model

The CMS continues to explore innovations in health plan design under MA using section 1115A authority. The Medicare Advantage Value-Based Insurance Design (VBID) model is borne out of that effort and provides an opportunity for MA plans to offer supplemental benefits or reduced cost sharing to enrollees with CMS-specified chronic conditions, focused on the services that are of highest clinical value to them. Eligible MA plans participating in the VBID model, which will begin January 1, 2017 and run for five years, can offer a more favorable benefit design to targeted enrollees; however, targeted enrollees can never receive fewer benefits or have to pay higher cost-sharing than other enrollees as a result of the VBID model. The model serves an example of how CMS can test alternative payment structures in the MA program using section 1115A authority.

VII. Potential Value Based Modifier to MAOs

Section 101(e)(6) of MACRA requires CMS to evaluate the feasibility of including a value-based modifier (VBM) in the MA payment system and whether such a modifier should be budget neutral. Under the Medicare FFS Physician VBM (Physician VBM) initiative, an individual physician’s Medicare Physician Fee Schedule payments are adjusted upward or downward depending on his or her performance across a set of quality and cost measures.⁴¹ Each provider’s standardized domain scores are factors of the average provider-level results in a given performance year; provider cost and quality performance are classified as low, average, or high relative to the average performance. In the manner illustrated by Table 9 below, Medicare FFS providers with a quality classification that is high relative to costs (known as “high value providers”) can be rewarded with positive, per-claim payment adjustments, and Medicare FFS providers with a quality classification that is low relative to costs (known as “low value providers”) can be subjected to downward, per-claim payment adjustments.⁴²

Table 9. Physician VBM Adjustments^{a, b}

	Low quality	Average quality	High quality
Low cost	0%	+1.0X	+2.0X
Average cost	-1.0%	0%	+1.0X
High cost	-2.0%	-1.0%	0%

- c. The parameter X is set annually by CMS to make the VBM adjustments budget neutral.
- d. Note that the values in the table above were used in the first year (2015) of the VBM and applied to large group practices. Other group practices and physicians are held harmless from downward adjustments, receiving only either an upward or neutral adjustment.

A change in statute would be necessary for this program and its principles to be extended to MA given that it constitutes a payment adjustment which is not within the scope of the administrative changes to MA payments that CMS is authorized to make under sections 1853 and 1854 of the Act. Further, given that CMS directly controls only plan payments, not provider payments, under MA, an MA VBM initiative should be focused primarily on plan performance. The main consideration when developing a VBM for MA, therefore, relates to measuring value created at the plan level.

A. Establishing a VBM at the Plan Level

The CMS could evaluate MA plans with regards to value creation in one of two ways, both of which are consistent with the principles of the Medicare FFS VBM program. While the first option

⁴¹ In 2016, the measures used to determine provider performance for VBM purposes fall into six quality domains and two cost domains. The quality domains are: (1) effective clinical care; (2) person- and caregiver-centered experience and outcomes; (3) community/population health; (4) patient safety; (5) communication and care coordination; and (6) efficiency and cost reduction. The two cost domains are: (1) per capita costs for all attributed beneficiaries and (2) per capita costs for beneficiaries with specific conditions.

⁴² Additional information about the Physician VBM, which has been sunset beginning in 2019 due to MACRA, is available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>.

discussed allows MAOs flexibility in the method by which to generate value in beneficiary care management, the second option presented incentivizes MAOs to create value in a specific manner that aligns with the intent of the Physician VBM program.

Evaluate MA Plans like Physicians under VBM Initiative

An MA VBM initiative, like the Physician VBM program, could focus on performance across a set of quality and cost domains. Instead of assessing quality and cost of care provided by each physician or physician group as under the Physician VBM program, however, CMS would evaluate the care provided by all providers of each MA plan under an MA VBM initiative. A high value plan, therefore, could be defined much like a high value provider is under the Physician VBM program – one with high quality performance relative to low or average cost performance.

Plan performance in regards to quality is already measured under MA through the Star Rating system. As detailed in Section III-B of this Report, CMS assigns each MA plan a Star Rating indicating the quality of care the plan provides to its enrollees, as evaluated through HEDIS, CAHPS, and other measures. For the sake of consistency and ease of implementation, one option would be to rely on the quality score obtained through the Star Rating system for the purposes of the quality classification under an MA VBM. Plan cost or efficiency, on the other hand, is not currently measured in a way that would support an MA VBM initiative. Therefore, an MA VBM initiative would require the development of such a methodology.

Contracting with High Value Providers

An alternative approach would be to modify payments based on the extent to which MAOs engage in value-creating activities. One meaningful way that MAOs can create value in beneficiary care management is by contracting with high value providers, or the same category of physicians rewarded with a positive payment adjustment under the Medicare FFS Physician VBM program. As a result, a high value plan could potentially be defined as one offering its enrollees significant access to high value providers.

Access in this context can be measured either as the number of high value providers included in a plan's network or the percentage of the plan's network comprised of high value providers. Policymakers could also consider provider distance standards or the share of all enrollee utilization being performed by high value providers when measuring the level of access to high value providers offered under an MA plan.

Critical to this approach for evaluating the value creation by MAOs is the identification of high value providers. The CMS currently only has mechanisms in place to identify high value Medicare FFS providers. Given that only a subset of all providers that contract with MAOs are also Medicare FFS providers, some high value MA providers would be left unidentified under the existing mechanisms. Therefore, to realize the full impact of an MA VBM initiative, CMS would need to establish a methodology for measuring the quality and cost performance of non-Medicare FFS MA providers, or "MA-exclusive providers," and thereby establish a mechanism for identifying high value MA-exclusive providers.

Current law limits CMS's authority to implement such an approach, as the non-interference clause restricts CMS from requiring MAOs contract with particular providers and thereby restricts CMS

from potentially rewarding MAOs for contracting with MA-exclusive providers determined to be high value. Even if non-interference were not a factor, the statute also restricts CMS's ability to create additional payments for MAOs administratively.

B. Financial Incentive Options and Budget Neutrality

Once plan performance is classified as low, average, or high relative to the average performance across all plans, Medicare could adjust plan payments through an MA VBM as they are adjusted currently for provider payments through the Physician VBM. As detailed by Table 9 above, this would mean the capitated monthly plan payments could increase or decrease by a certain factor percentage to achieve budget neutrality. Specifically, like under the Medicare FFS Physician VBM program, to ensure budget neutrality in the face of uncertainty regarding the number of plans that will be deemed "high value" or "low-value," a variable parameter could be included under an MA VBM initiative to adjust the maximum upward or downward adjustment by a factor that reflects available end-of-year funding.

Alternatively, policymakers could consider various other financial incentive options by which to adjust plan payments under an MA VBM initiative. The different options for financial incentives and incentive designs under an MA VBM initiative are the same as those discussed in the context of encouraging APM adoption by MAOs in Section VI-B above. Moreover, just like MA APM incentive payments, a VBM adjustment applied to MA plan payments could always be designed to achieve budget neutrality, if desired, by capping any positive performance bonuses at an amount that includes program savings linked to the initiative and/or reductions in base MA payments resulting from negative VBM adjustments applied.

Finally, even when the non-interference clause is not relevant, the statute also restricts CMS's ability to make certain payment adjustments administratively.

C. Additional Considerations

Adapting the Physician VBM to MA by rewarding plan-level performance as described above would not directly address the extent to which an MAO's financial arrangements with health care providers included APMs. Under this approach, an MA plan that achieved efficiencies without featuring APMs would still receive a positive adjustment, while a plan that widely adopted APMs without reaping efficiency gains would be subject to a negative MA VBM adjustment.

Furthermore, any MA VBM initiative will have significant implications for MA operations. Identification of specific operational issues and strategies will need to be developed on an ongoing basis, as the design and policy characteristics of an MA VBM initiative are solidified.

A key consideration, however, is whether a VBM adjustment is needed or appropriate for MA. Given the competition among insurers for beneficiaries and the fact that MA payments are fully capitated for all covered services, MAOs already have a strong financial incentive to provide care in a cost effective manner. Moreover, with the passage of the ACA, plan payments are adjusted, as described in Section III-B of this report, based on quality performance. An MA VBM adjustment would only be creating similar incentives.

VIII. Conclusion

APMs, in general, enable provider-centric care reform and aim to stimulate and sustain value-creating innovation in care delivery through changes in how providers are paid. Under the MA payment system, the reward structure for providers is determined by MAOs through private negotiations with prospective network providers, independent of CMS. Thus, under current law, MAOs must be the primary drivers for integrating APMs into the MA program.

The MA program currently supports the voluntary use of APMs by MAOs. Under the status quo, the MA program – given its reliance on capitated, population-based payments that are adjusted for quality, emphasis on care coordination through HMO and PPO plans, and promotion of market competition among participating insurers – intrinsically incentivizes MAOs to create cost efficiencies without compromising the quality of care furnished to their beneficiaries. This will become increasingly true as ACA requirements take further effect.

As discussed in Section V of this Report, we found that MAOs have started to pay providers under VBP arrangements, including APMs, so as to align provider incentives with those of the MAO. This suggests that an indirect incentive for MAOs to adopt APMs already exists under the MA program.

As a result, further integrating APMs in MA, which MACRA requires the Secretary to explore, would mean establishing a direct, explicit incentive for MAOs to adopt APMs, potentially with the goals of: (1) accelerating the shift by MAOs toward APMs and delivery systems that support them, and (2) aligning MAOs with Medicare FFS APM strategies and delivery system reform objectives.

However, current statute includes limits on how CMS can incentivize MAOs to adopt APMs. While this Report identifies various potential incentive mechanisms, the implementation of most, if not all, would require statutory and/or regulatory changes. Above all, the non-interference clause precludes both requirements for APM adoption and conditioning payments (rewards and direct incentives) to MAOs on contracting with high value providers through a VBM. However, CMS maintains limited regulatory discretion and is potentially able to waive certain constraints using 1115A authority.

Appendix – MACRA APMs and HHS Payment Reform Visual

