AMA AMERICAN MEDICAL ASSOCIATION

Advancing value-based care with alternative payment models

Background

For 20 years, there has been bipartisan interest in advancing the movement to value-based care in Medicare by implementing alternative payment models (APMs) for physician services as a means of improving the quality and coordination of patient care and reducing Medicare spending growth. Value-based care ties payment amounts for services provided to patients to the results that are delivered, such as the quality, and cost of care. APMs are a key approach to achieving value-based care by providing incentive payments to deliver high-quality and cost-efficient care for a clinical condition, a care episode, or a patient population. There are various types of APMs, including accountable care organizations (ACOs), bundled payment models, primary care medical homes, and others.

- The Bush Administration initiated the first demonstration projects of Medicare bundled payments and primary care medical homes. Bundled payments involve a single payment or budget for all services related to an episode of care, such as a surgical procedure or management of a chronic condition. Primary care medical homes involve monthly payments for comprehensive management of all of a patient's primary care services and coordination of other services needed by the patient.
- The 2010 creation of the Center for Medicare & Medicaid Innovation (CMMI) and the Medicare Shared Savings Program (MSSP) aimed to provide a significant boost to Medicare APMs. CMMI was established to test new APMs and the MSSP allowed for the development of Medicare ACOs in which medical practices and hospitals or health systems work together to coordinate all care for a defined patient population.
- In 2015, with too few APMs for physician services available, Congress included an APM pathway and six years of incentive payments in the Medicare Access and CHIP Reauthorization Act (MACRA). Congress recognized that to be successful, APMs need to be designed by physicians working on the front lines of care, so MACRA included the Physician-focused Payment Model Advisory Committee (PTAC) to review and recommend stakeholder-designed APM proposals.

Present day

To date, there are far fewer opportunities for physicians to participate in Medicare APMs than Congress envisioned under MACRA. While the goal was to provide opportunities for the majority of physicians to transition into APMs, CMMI models implemented to date often have steep financial risk requirements, lack funding needed to successfully redesign care delivery, and are usually only available in selected regions. In addition, because these APMs must demonstrate savings for Medicare within a short timeframe, they are often terminated instead of being improved and expanded nationwide. In a report on practices in rural or underserved areas, the Government Accountability Office noted that many lack the capital to finance the upfront costs of transitioning to an APM and face challenges acquiring or conducting data analysis necessary for participation. There is also no nationwide primary care medical home model in Medicare, despite multiple Medicare demonstrations of this model, so patients insured by Medicare are not benefiting from the improvements in preventive care, health care quality, and management of chronic conditions that medical homes can provide.

Despite the many stakeholder-developed APMs recommended by the PTAC, no Medicare APMs have been adopted to help specialists improve care for patients with chronic diseases like rheumatoid arthritis, heart failure, chronic obstructive pulmonary disease, or inflammatory bowel disease, or patients who would benefit from innovations in surgical care. Instead of keeping patients healthier and preventing hospitalizations, the CMMI-developed APMs have largely focused on services provided to patients after they have already been admitted to the hospital or begun treatment such as chemotherapy. As a consequence, Medicare patients, especially those outside of the hospital setting, are missing out on the benefits of APMs, including more timely and accurate diagnosis, improved patient-physician shared decision making about treatment plans, preoperative rehabilitation, as well as savings from enhanced care coordination and smarter choices about when to use biologics and other therapies.

One result has been that the APM incentive payments provided under MACRA to support physicians transitioning to APMs have reached far fewer physicians than had been forecast. In addition, MACRA requires increasing threshold percentages of APM participation for physicians to qualify for the APM incentive payments, but most APM participants cannot attain the higher thresholds.

Legislation needed

Many years after MACRA's passage, it has become evident that changes are needed to realize the robust pathway to APMs that Congress envisioned. These critical changes will help improve patient outcomes and reduce unnecessary Medicare spending. Specifically, Congress needs to:

- Reauthorize crucial incentive payments to increase physician participation in Advanced APMs, which expired at the end of 2024.
- Make participation thresholds for earning the incentive payments more flexible and realistic, reversing abrupt increases that took effect in 2025.
- Update criteria for adopting and expanding Medicare APMs. Criteria for achieving Medicare savings within a short time span have led multiple medical home and other models to be terminated and limited adoption of specialty models. Meaningful pathways are needed for APM proposals developed by stakeholders to be implemented in Medicare.

The Preserving Patient Access to Accountable Care Act

With strong support from the American Medical Association and other key physician stakeholders, a bipartisan group of legislators has introduced bipartisan legislation, H.R. 786/S. 1460, the Preserving Patient Access to Accountable Care Act, that would restore 3.53% APM incentive payments and retain the 50% revenue threshold through the 2027 payment year. The AMA applauded the bill's introduction by Reps. Darin LaHood (R-Ill.), Suzan DelBene (D-Wash.), Neal Dunn, MD (R-Fla.), and Kim Schrier, MD (D-Wash).