Key Question Alternative Payment Models

Background

As of September 2023, more than 88 million individuals were enrolled in Medicaid and the Children's Health Insurance Program (CHIP).[1] There is increasing attention to the cost and value of care in the US healthcare system, and a historical focus on quality and safety. Based on historical trends, healthcare treatment costs are expected to increase significantly in the coming years.[2] Public and private payers are looking for methods to curb spending while maintaining or improving the quality, safety, and equitable access to care across the care continuum.[3] The rapid increase in healthcare spending in the US has led to the creation of novel payment models to ensure the sustainability of the healthcare system. Traditional fee-for-service (FFS) reimbursement models can incentivize the volume of care without accounting for the value and quality of that care.[4] Alternative payment models (APMs) attempt to attach reimbursement to value and quality.

Since the 1980s, the US Centers for Medicare & Medicaid Services (CMS) has driven payment reform using APMs to shift reimbursement away from (FFS) payments. The Centers for Medicare and Medicaid Services define an APM as a reimbursement strategy incentivizing health systems and providers to implement high-quality, cost-efficient care.[5] The Health Care Payment Learning & Action Network (HCP LAN) is a voluntary group of public and private healthcare leaders who provide thought leadership, strategic direction, and ongoing support to accelerate the adoption of alternative payment models (APMs) in the US.[6]

The [HCP LAN APM Framework](), is a common vocabulary and pathway for measuring success toward aspirational, national APM adoption goals. The framework classifies payment models in four categories and specifies core principles and design rules for value-based models. Category 3 and 4 models in the framework are considered advanced APMs and qualify for higher reimbursement from the CMS Quality Payment Program.[7] Currently, only 40% of health care dollars spent are in Category 3 & 4 APMs.[8] By 2030, The LAN aspires to see 100% of Medicare and 50% of Medicaid payments in AAPMs nationally.[9] Below are the key components of payment categories:

> **Category 1: Fee for service-** (traditional payment approach). Payments are based on volume of services and not linked to quality or efficiency.
>
> **Category 2: Fee for service- link to quality & value.** At least a portion of payments vary based on quality or efficiency (for example, pay for reporting or pay for performance).
>
> **Category 3**: **APMs Built on Fee-for-Service Architecture-** This approach blends the traditional Fee-for-Service payment approach with measures to improve care delivery, encourage coordination across the healthcare ecosystem, manage costs and ensure appropriate care while focusing on specific procedures, episodes of care or sets of service.[10]

Category 4: Population-Based Payment- A holistic approach to healthcare delivery, focusing on broader care coordination, prevention, and wellness across a defined population, rather than focusing on individual procedures or episodes of care. These payment structures contrast with Fee-for-Service (FFS) arrangements and are designed to encompass a broader scope of care.[10]

As adoption of APMs increase nationally by both public and private payers, models continue to evolve rapidly without strong evidence of effectiveness. The nominator, on behalf of the MMDN, is interested in evidence that APMs improve patient outcomes and control costs in Medicaid populations. They are also interested in whether the accrued savings can be shared with providers, and if the evidence supports the adoption of APMs, and if so, should one APM strategy be promoted over another. A new evidence review by AHRQ could help to close the knowledge gap among policymakers and providers about the effectiveness of Medicare and Medicaid APMs).

Key Questions

1. What is the evidence that alternative payment models improve patient outcomes for Medicaid patients?
2. Are shared savings in Medicaid value-based payments (alternative payment models) sufficient to support changes in care delivery models?

Table 1. Questions and PICOTS (population, intervention, comparator, outcome, timing and setting)

Questions	1. KQ1 and KQ2
Population	Adult Medicaid patients attributed to provider(s) participating in APM. Adult patients covered by Medicare FFS, Medicare Advantage and commercially insured.
Interventions	HCP-LAN Category 3 or 4 – APM models based shared savings; shared-savings/shared-risk; full capitation.
Comparators	Fee-for-service Medicaid; fee-for-service Medicare; commercially insured. ? category 2?
Outcomes	Total cost of care, hospitalizations, re-hospitalizations, ED visits; mental health metrics including follow-up after ED visits or hospitalizations; measures related to vaccinations, hypertension, and/or diabetes.

Abbreviations: APM=alternative payment model; ED=emergency department HCP-LAN=Health Care Payment Learning & Action Network; KQ=key question.

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