NAACOS Summary of Key Elements of the June 2022 MedPAC Report

Overview: The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency that advises Congress on issues affecting Medicare, primarily payments to providers in the traditional fee-for-service (FFS) program and health plans participating in Medicare Advantage (MA). Although formally advising Congress, the Administration, including the Centers for Medicare & Medicaid Services (CMS), pays close attention to MedPAC's recommendations as well. The 17-member commission meets monthly between September and April and publishes two reports a year: March and June. MedPAC's June 2022 Report includes a chapter discussing potential approaches policymakers could take to streamline and harmonize Medicare's portfolio of alternative payment models (APMs). The full report is available here, and an executive summary is available here. A NAACOS Summary of the June 2021 Report that includes a chapter on ACOs and the Commission's recommendations on APMs is available here.

Summary: Streamlining and Harmonizing Medicare's APMs

In Chapter 1, the Commission provides specific suggestions to operationalize last year's recommendation that CMS reduce the number of APMs in Medicare. The Commission believes implementing the following suggestions would reduce the complexity and uncertainty that providers face when deciding to participate in an APM, increase provider participation in these models, and improve incentives for providers to furnish care more efficiently and improve quality.

1) Implement a foundational population-based payment approach that reduces the number of ACO model tracks from seven down to a smaller number of tracks that could each be geared toward provider organizations of different sizes and involve different degrees of financial risk
2) Move away from "rebasing" ACOs' spending benchmarks every few years based on actual spending, and instead rely on periodic administrative updates to benchmarks using a growth factor that is unrelated to ACOs' own spending performance and is known to ACOs in advance
3) Implement a national episode-based payment model for certain types of proven clinical episodes (e.g., hip and knee replacements) that will enhance savings and/or improve outcomes
4) Require certain providers to participate in the national episode-based payment model for all their fee-for-service (FFS) Medicare patients, including beneficiaries already attributed to an ACO
5) For beneficiaries concurrently attributed to the episode-based payment model and an ACO, allocate episode bonus payments so that (a) episode-based providers have an incentive to furnish efficient, high-quality care; (b) providers in ACOs have an incentive to refer their attributed patients to low-cost, high-quality episode-based providers; and (c) when combined, these incentives are not so large that they increase total Medicare spending

The number of population-based payment model tracks could be reduced

The Commission asserts that population-based payment models hold great promise and highlights studies that suggest ACOs have a history of producing modest but promising results. Health care providers seeking to enroll in a population-based payment model currently have seven options to choose

from (MSSP Basic Levels A-E; MSSP Enhanced; and GPDC/ACO REACH) with varying shared savings and loss rates.

The Commission favors a streamlined approach that would reduce the number of tracks available to health care providers interested in entering an ACO. The Commission also favors using more consistent parameters in these tracks so that potential participants would have fewer differences between tracks to consider. One approach to reducing model tracks would be to condense CMS's current offerings into three tracks geared toward provider organizations of different sizes, including:

1) **Small Provider Organizations:** Offer upside only with 50 percent shared savings
2) **Medium and Specialty Provider Organizations***:* Two-sided risk with 75 percent shared savings/loss
3) **Large Providers and Health Systems:** Two-sided risk with 100 percent shared savings/loss

The Commission also highlights that smaller organizations might be able to adopt necessary reforms to participate in more advanced APM models. Alternatively, the Commission also said that another way to reduce the number of ACO model tracks would be to offer a single track with shared savings and loss rates that varied based on ACO characteristics, such as their ability to take on financial risk.

Eliminating the periodic rebasing of ACO spending benchmarks could increase ACOs' incentives to lower spending

To give ACOs stronger incentives to lower their spending, the Commission believes that ACO benchmarks should be based on historic spending that would be trended forward to the current year using a growth factor. ACOs' spending benchmarks would be prospectively set one year at a time before the start of a performance year.

Under this proposed approach, the growth factor could be set using a single exogenous factor or be based on two components: (1) a price component and (2) a volume and intensity component, which are outlined below:

- The price component could reflect annual updates to Medicare's various FFS payment systems and fee schedules, including customary adjustments to reflect different Medicare payment rates in different geographic areas of the country. Annual increases to the price component of the growth factor could be weighted based on the relative mix of services used by an ACO's beneficiaries in their historical baseline period since Medicare's various payment systems' and fee schedules' payment rates increase at different speeds.

- The volume and intensity component could be set in several ways, such as by using CMS actuaries' projected growth rate for the volume and intensity of services in FFS Medicare (which includes the use of new technologies) or the projected growth in real national gross domestic product (GDP) and then discounting this factor by some percentage to generate savings for the Medicare program.

The Commission further highlights that the growth factor(s) used to trend forward historical spending to the current year should grow at a fast enough rate to ensure that ACOs have a chance to earn shared savings without compromising beneficiaries' care quality. It should also be developed to ensure that savings can be generated for the Medicare program. The Commission also suggests that growth factors used to trend benchmarks forward could be adjusted periodically if it underpredicted or overpredicted health care spending levels. In addition to rebasing benchmarks for ACOs, the Commission also suggests

that policymakers may want to reconsider CMS's current practice of including ACO shared savings payments in Medicare Advantage benchmarks since it results in CMS "double paying" for these bonuses and drives up Medicare spending.

Operating episode-based payment models concurrently with a population-based payment model
Over the last year the Commission has considered several options for how episode-based models and ACOs could continue to coexist in Medicare. Under the option supported by the Commission, Medicare would implement an episode-based payment model nationwide that would be mandatory for certain proven types of episodes and certain providers. In this approach, all FFS beneficiaries would be attributable to this model for the specified covered episodes (e.g., hip and knee replacement episodes)—regardless of whether the beneficiary was already attributed to an ACO under a population-based model and regardless of what type of ACO the beneficiary was in.

Concurrent with their existing attribution to an ACO, beneficiaries would be attributed to the episode-based payment model for the duration of their episode. At the same time, for episodes not covered by Medicare's model, ACOs would be free to develop and administer their own payment arrangements involving contracts with specialists and hospitals. The Commission favors this approach because it would ensure that every beneficiary would benefit from having an accountable entity focused on furnishing efficient, high-quality care during every covered episode.

The Commission believes that making the episode-based payment model mandatory would not only ensure that all relevant providers were included in the model, but it would also ensure that all relevant beneficiaries were included. That said, the Commission believes that selecting which types of episodes to include in Medicare's national episode-based model is important and includes the following general principles for CMS to consider going forward:

1) Whether an episode has attributes that facilitate the implementation of episode-based payment arrangements
2) Whether an episode has been found to generate gross savings and is expected to generate net savings without harming quality, or whether an episode has been found to improve quality without increasing gross spending and is expected to generate quality improvements without increasing net spending
3) Whether there are concerns that including a particular type of episode in the episode-based payment model will induce more episodes
4) Whether inclusion of the episode is anticipated to discourage participation in ACOs or other existing APMs
5) How care processes among different types of episodes interact with each other and with ACOs

Allocating savings and losses between two models
An important design consideration when integrating a Medicare-run episode-based payment model with a population-based payment model is how savings or losses generated during covered episodes should be allocated when beneficiaries are concurrently attributed to providers in both model types. The Commission asserts that, in principle, any bonus payments resulting from reducing episode costs should be allocated in such a way that:

1) Episode-based providers have an incentive to furnish efficient, high-quality care.
2) Providers in ACOs have an incentive to refer their attributed patients to low-cost, high-quality episode-based providers.

3) When combined, these incentives should not be so large that they increase total Medicare spending.

The chart below highlights two examples the Commission outlines for how savings could be allocated.

Example 1	Example 2
CMS could use discounted target prices in the episode-based payment model and include any episode bonus payment in the ACO's annual spending tally. The ACO would realize shared savings payments based on the difference between the undiscounted episode price implicitly included in the ACO's annual spending benchmark and the discounted episode target price in the Medicare run model.	CMS could use undiscounted target prices in the episode-based payment model and divide any savings relative to the episode target price between episode-based providers, ACOs, and the Medicare program according to some predetermined percentages. For example, Medicare could retain 40 percent of the episode savings, episode-based providers could retain 30 percent, and ACOs could retain 30 percent.

The Commission also discusses the importance behind the methodology of determining benchmarks for episode target prices saying that consideration should be given to how episode target prices align and interact with ACOs' spending benchmarks in any new combined models.

For example, the Commission highlights that if target prices in the episode-based model exceed the amount of episode spending implicitly included in an ACO's benchmark, reductions in actual episode spending may result in bonus payments for episode providers but could still be higher than episode costs in an ACO's benchmark—leading the ACO to owe shared losses to CMS despite the reduced spending. Conversely, if episode target prices are set below the amount of episode spending implicitly included in an ACO's benchmark, the ACO may find itself collecting shared savings payments related to episodes even if episode-based providers do not reduce actual spending.

Summary: Addressing Part B Drug Costs
In Chapter 4, the Commission examines three alternative approaches to address high Part B drug costs, including:

1) Addressing uncertain clinical benefit and high launch prices of first-in-class drugs
2) Promoting price competition among drugs with therapeutic alternatives
3) Improving provider incentives under the ASP payment system

To address concerns about possible financial incentives associated with Medicare Part B's average sales price plus 6 percent payments, the Commission highlights that the add-on could be changed to a fixed dollar figure or a combination of the two models. The Commission says the impact on payments for Part B drugs would vary, with a fixed dollar limit on the add-on payment reducing payment for very expensive drugs, and the application of a fixed fee raising payments for relatively inexpensive drugs while decreasing payments for more expensive ones.

Summary: Improving the Accuracy of Medicare Advantage Payments
In Chapter 5, the Commission presents an option to address the influence of outliers in the CMS–Hierarchical Condition Category (HCC) risk adjustment model used to adjust payments to MA plans. To address inaccuracy introduced in the model by outliers, the Commission evaluated a modification to the CMS-HCC risk adjustment model that incorporates the principles of reinsurance and repayment by

redistributing a share of annual beneficiary costs in the FFS data used to estimate the risk-adjustment model coefficients.

The Commission found that the modification to reduce the effect of outliers in the standard CMS-HCC model improves the predictive power of the model. In addition, the Commission also found improvements in model performance for groups of beneficiaries for which the standard CMS-HCC model performs less well (i.e, those with very low and very high actual costs and those with very large underpredictions).

The Commission says the benefit of this approach to addressing large prediction errors is that it improves the performance of the CMS-HCC model without added burden on plans or beneficiaries to provide additional data. CMS would continue to use the existing risk-adjustment model that is familiar, straightforward, and easy to understand. In addition, this approach would not require any change to the flow of funds from CMS to MA plans.

Although the Commission feels this approach would improve model performance, substantial issues remain for MA risk adjustment, such as the financial benefit to plans for coding conditions more intensively compared to FFS clinicians' coding and payment inaccuracies among beneficiaries who are not among the largest overpredictions and underpredictions addressed in this analysis. The Commission intends to address these issues in future work.

Conclusion
NAACOS is pleased to see that MedPAC continues to dedicate attention to improving the ACO model and APMs. When it comes to better harmonizing episode-based models with population-based models like ACOs, MedPAC left a lot of detail up to CMS, opting instead to give some broad, high-level principles that make sure ACOs are helped not harmed by a new program. For example, they didn't address how to reconcile payments between ACOs and episodes. While NAACOS has some concerns about how mandatory episodes would interact with ACOs, we appreciate that MedPAC emphasized for CMS that allocating savings between models must be done in a way so incentives for the ACO to save and participate are considered.