Expanding the use of value-based payment in Medicare

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Overview of the presentation

- The concept of value-based payment (VBP)
- The Commission’s prior work on Medicare payment
- Improving Medicare Advantage (MA) and accountable care organizations (ACOs) to promote VBP
- To what extent could VBP replace the traditional fee-for-service (FFS) program?
The concept of value-based payment

- Commissioners have expressed interest in expanding the use of value-based payment (VBP) in Medicare
- VBP aims to create stronger incentives to control overall costs than traditional fee-for-service (FFS) payment while maintaining or improving quality
- VBP is a broad concept instead of a specific policy; there are many ways to expand its use in Medicare
The Commission’s prior work on Medicare payment

- The Commission has a long-standing interest in moving Medicare away from the traditional FFS model
  - Reduce FFS incentives to use/deliver too many services
  - Make MA plans more efficient and improve data quality
  - Develop better ways to measure quality across sectors
- Our future work on VBP will follow the same fundamental principles that have long guided our work
MA and ACOs could provide a foundation for the broader use of value-based payment

- More than half of all Medicare beneficiaries are now enrolled in MA plans or assigned to ACOs.
- These programs have more incentive to control overall spending than traditional FFS due to use of capitation (MA) and shared savings (ACOs).
- Both programs need to be improved to better support the use of VBP.
Strengths and weaknesses in the current design of Medicare Advantage

- Compared to FFS, most MA plans can provide Medicare benefits at a lower cost and offer extra benefits.
- However, Medicare pays 1-2 percent more overall for MA.
- Added expense is due to rebates, quality bonuses, high benchmarks in some counties, and more intense coding.
- Changes to MA benchmarks and the quality bonus program could lower program spending and improve incentives to provide high-quality care.
Improvements to Medicare Advantage

- Commission recommendation to improve quality of encounter data
- Potential redesign of the quality bonus program
Strengths and weaknesses in the current design of accountable care organizations

- ACO model creates incentives to control overall spending that are absent in traditional FFS program
- However, ACO savings have been modest (roughly 1-2 percent in 2016, after 4 years of operation, not including the cost of shared savings payments)
- Program reforms could improve ACO performance but may not appreciably change overall savings
Improvements to ACOs

- Assign beneficiaries to ACOs on a prospective basis instead of a retrospective basis
- Waive certain regulatory requirements for ACOs that use prospective assignment and accept 2-sided risk
Strengths and weaknesses in the current design of traditional fee-for-service

- Beneficiaries have good access to care
- Administered prices can help constrain growth in spending
- Fee schedules used by many other health care payers
- However, no entity is responsible for overall costs, and beneficiaries and providers have incentives to use or deliver too many services
- Continued reforms to improve the program’s value could be considered
To what extent could VBP replace the traditional FFS program?

- Supporters of VBP often describe it as a way to “replace” or “eliminate” fee-for-service payment.
- It’s not clear what this would mean in Medicare, especially since MA and ACOs are closely linked to FFS.
- We developed four illustrative scenarios to highlight some of the issues that would be involved.
- Each scenario would expand the use of VBP, but they differ in how far they would go to replace the FFS program.
Scenario 1: Medicare continues to operate the traditional FFS program

- Closest scenario to the current Medicare program
  - Traditional FFS program continues to operate
  - Voluntary participation in MA (for plans and beneficiaries) and ACOs (for providers)
- Pursue improvements in all three delivery systems
- Potential FFS reforms include bundled payments, site-neutral payment policies, refinement of existing quality incentives and development of new incentives
Scenario 2: Medicare requires all FFS providers to participate in ACOs

- Traditional FFS would no longer be an option
  - Providers must join ACOs to receive FFS payments
  - Medicare assigns all FFS beneficiaries to ACOs
  - CMS continues to pay claims for ACOs using FFS rates
  - Beneficiaries can still enroll in MA plans
- Could affect any-willing-provider policy and may have implications for beneficiary choice
- Ensuring universal access to ACOs could require higher spending in some areas (as in MA)
Scenario 3: Medicare stops paying providers directly

- MA plans and ACOs pay providers for all services
- CMS continues producing FFS fee schedules
- Replacing FFS claims data would be difficult
  - Calculation of benchmarks and risk adjustment would be major challenges for administering the MA and ACO programs
  - Premium support could be used to set benchmarks
- ACOs effectively become capitated health plans; this raises the question of whether beneficiaries would need to actively enroll in ACOs
Scenario 4: Medicare stops producing the FFS fee schedules

- Identical to prior scenario except CMS would not produce fee schedules
- Complete elimination of FFS program would fragment Medicare’s purchasing power
- Providers could use their market power to force MA plans and ACOs to pay much higher rates
Some implications of our illustrative scenarios

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Beneficiary choice of any willing provider</th>
<th>Delivery model(s)</th>
<th>Implementation difficulty</th>
<th>Incremental costs/savings</th>
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</thead>
<tbody>
<tr>
<td>1: Medicare continues the traditional FFS program</td>
<td>Yes in FFS or ACO</td>
<td>Choice of FFS, MA, ACO</td>
<td>Low to moderate</td>
<td>Depends on changes to models</td>
</tr>
<tr>
<td>2: Medicare requires FFS providers to join ACOs</td>
<td>Could be limited</td>
<td>Choice of MA or ACO</td>
<td>Moderate</td>
<td>Depends on changes to models</td>
</tr>
<tr>
<td>3: Medicare stops paying providers directly</td>
<td>No</td>
<td>Capitated health plan</td>
<td>High</td>
<td>Depends on changes to models</td>
</tr>
<tr>
<td>4: Medicare stops producing the FFS fee schedules</td>
<td>No</td>
<td>Capitated health plan</td>
<td>High</td>
<td>Significant costs due to higher provider rates</td>
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</tbody>
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Note: FFS (fee-for-service), ACO (accountable care organization), MA (Medicare Advantage)
Discussion

- The Commission plans to prioritize work on VBP during the next meeting cycle.
- We would like your guidance on how VBP would affect each of Medicare’s delivery systems (traditional FFS, MA, and ACOs).
- We are particularly interested in your views on the illustrative scenarios and the extent to which VBP could replace traditional FFS coverage.