Developing a multi-track population-based payment model with administratively updated benchmarks

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Recap of October and November meetings

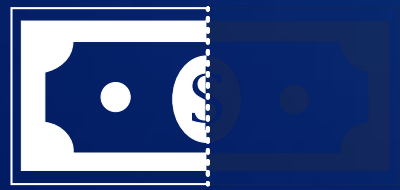
- October meeting:
  - Broad interest in centering CMS's APM strategy around a single multi-track, population-based payment model
  - Different tracks would be designed for different types of provider organizations, and involve different amounts of financial risk
- November meeting:
  - Broad interest in no longer "rebasing" ACO benchmarks every few years using ACO clinicians' latest spending data
  - Shift to only using annual administrative updates to benchmarks

Note: Alternative payment model (APM), accountable care organization (ACO).

Illustration of a multi-track, population-based payment model

Track 1

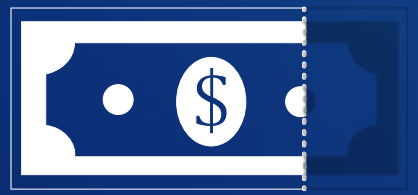
Groups of small organizations (e.g., small independent physician practices, small safety net providers, small rural providers)



50% SAVINGS

Track 2

Mid-sized organizations (e.g., multi-specialty physician practices with multiple locations, small community hospitals)



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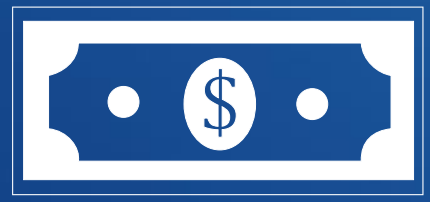
Track 3

Large organizations (e.g., health systems with multiple hospital campuses)



100% SAVINGS/LOSSES

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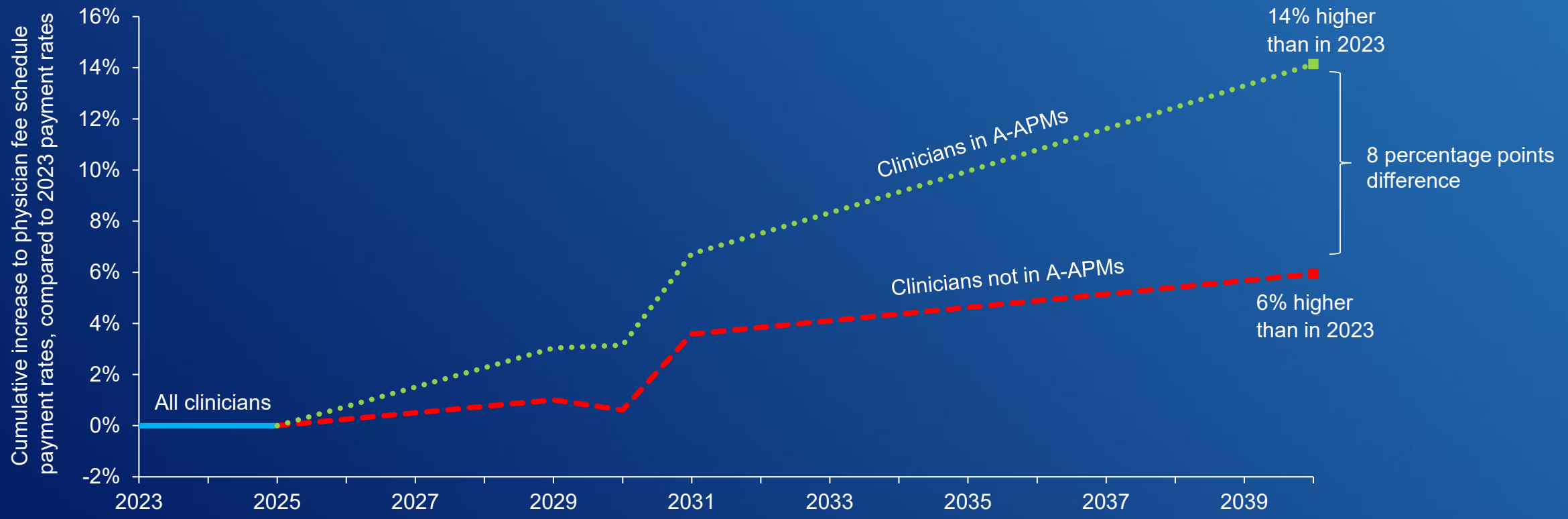
Implementation issues for consideration

- Options for incentivizing provider participation in the model
- How quickly providers should take on financial risk
- Addressing ways that random variation in spending could create unwarranted shared savings
- How to apply administratively set benchmarks to the model

Incentivizing provider participation

- Voluntary models often attract only those providers who expect to receive more Medicare revenue by participating
  - This selection bias can lead to a net increase in Medicare spending
- Tracks 2 and 3: May need to incentivize participation since not all providers may want to take on financial risk
- Track 1: May not need to incentivize participation because it's upside-only, so will be attractive to many

Under current law, clinicians in A-APMs will receive higher annual payment updates than clinicians not in A-APMs starting in 2026



Note: Advanced alternative payment models (A-APMs). Graph shows increases to payment rates in nominal terms. Graph does not show annual MIPS adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or annual 5 percent A-APM bonuses available through 2024, because these adjustments are one-time and not built into subsequent years' payment rates. Graph also does not show adjustments to ensure that changes to the fee schedule's work relative value units are budget neutral. In 2030, the size of the 2 percent sequester (reduction) to Medicare payment rates will increase, and then in 2031 it will expire—raising all clinicians' rates from then on.

Source: MedPAC analysis of the Medicare Access and CHIP Reauthorization Act of 2015, the Bipartisan Budget Act of 2018, the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Consolidated Appropriations Act, 2021, An Act to Prevent Across-the-Board Direct Spending Cuts, and for Other Purposes, and the Protecting Medicare and American Farmers from Sequester Cuts Act.

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Options for incentivizing provider participation

- Require that certain types/sizes of providers participate in certain tracks of the model
- Pay lower rates to clinicians not in the model, through:
  - Lower annual updates (e.g., 0.25%/year vs. 0.75%/year)
  - A flat reduction to payment rates (e.g., -5%)
- Waive certain Medicare requirements if in the model
- Offer technical assistance to clinicians in the model
- Other?

How quickly providers should take on financial risk

- Smaller providers could be allowed to participate in the upside-only Track 1 indefinitely, or they could eventually be encouraged to transition to a track with financial risk
  - Pushing smaller providers to take on financial risk could lead to provider consolidation
- Mid-to-large providers could be incentivized to participate in the model right away or could be given time to transition
  - Pushing larger providers to quickly enroll could lead to provider pushback

Addressing random variation among small ACOs

- Changes in expenditures (leading to shared savings/losses) can be generated by random variation rather than improvements in care
- Current models require ACOs have at least 5,000 beneficiaries, but there is evidence this threshold may not be sufficient
- Some models have minimum savings rate (MSR) that must be exceeded before ACO qualifies for shared savings payments

Framework for administratively determined benchmarks

- Benchmarks initially determined by historical Part A and Part B FFS spending for assigned beneficiaries
- Benchmarks updated annually using combination of administratively determined factors:
  - Actual changes in FFS prices
  - Projected growth in volume and intensity of FFS services
- Benchmarks include national and regional discount factors
  - A “within-region” adjustment could vary in size based on whether an ACO has high or low spending relative to their region

Note: Fee-for-service (FFS).

Example of benchmark growth rates and discount factors within a given region

ACO spending level within region	Actual growth in Medicare prices in region	Projected growth in volume and intensity (net of national discount factor)	"Within-region" discount factor	Net benchmark growth rate
Quintile 1 (low spending)	2%	2.5%	0%	4.5%
Quintile 2	2	2.5	-0.3	4.2
Quintile 3	2	2.5	-0.5	4.0
Quintile 4	2	2.5	-0.7	3.8
Quintile 5 (high spending)	2	2.5	-1.0	3.5

Note: All figures in table are illustrative and do not reflect actual growth rates. Discount factors could be set on a continuous scale to avoid "cliffs."

Considerations for administratively determined benchmarks

- Administratively determined growth rates not based on changes in actual spending, so addresses “ratchet” effect
- Variable regional discount rates could reduce spending variation within each region and between different regions
- Benchmark methodology needs to account for:
  - Changes in risk scores of ACOs’ beneficiary population
  - Unforeseen changes in spending due to new technology (e.g., expensive new drug) or exogenous event (e.g., pandemic)
  - Size of “wedge” between ACO’s benchmark and actual spending in region

Discussion

- Does illustrative three-track model reflect commissioner thinking about population-based payment model?
- Is the potential for shared savings large enough to incentivize participation -- if not, how should participation in the model be encouraged?
- Should ACOs in the upside-only track be required to move to a track with two-sided risk?
- What steps should be taken to minimize shared savings payments arising from random variation?
- Is the framework for updating benchmarks consistent with commissioner thinking?