



Advising the Congress on Medicare issues

An approach to streamline and harmonize Medicare's portfolio of alternative payment models

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Background and goals for today's discussion

- MedPAC's June 2021 report recommended CMS reduce the number of Medicare alternative payment models (APMs) it operates and design models to work better together
- At subsequent MedPAC meetings, commissioners have offered more specific suggestions
- This presentation attempts to summarize the main concepts commissioners have coalesced around this cycle
- Staff seek feedback on whether any revisions are needed before this material appears in MedPAC's June 2022 report

Population-based payment (accountable care organizations)

Commissioners favor reducing the number of population-based payment model tracks

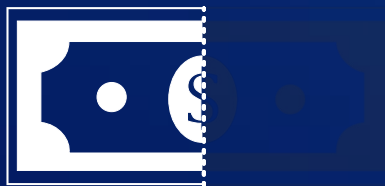
Track	Mechanism to guard against unwarranted shared savings or shared loss payments	Shared savings rate	Shared loss rate	Gain limit	Loss limit
Medicare Shared Savings Program					
Basic Track's Level A & B	Minimum savings rate coupled with a minimum quality standard	40%	Not applicable	10% of benchmark	Not applicable
Basic Track's Level C	Same as first row, plus a minimum loss rate	50%	30%	10% of benchmark	Lower of: 2% of revenue or 1% of benchmark
Basic Track's Level D	Same as second row	50%	30%	10% of benchmark	Lower of: 4% of revenue or 2% of benchmark
Basic Track's Level E	Same as second row	50%	30%	10% of benchmark	Lower of: 8% of revenue or 4% of benchmark
Enhanced Track	Same as second row	75%	40%–75% depending on ACO's quality	20% of benchmark	15% of benchmark
ACO REACH Model (formerly "Direct Contracting")					
Professional Option	5% quality withhold	50%	50%	For ACO spending that is >5% above/below the benchmark, savings/loss rates are: 35% for amounts 5-10% of benchmark; 15% for amounts 10-15% of benchmark; and 5% for amounts >15% of benchmark.	
Global Option	2% benchmark discount; 5% quality withhold	100%	100%	For ACO spending that is >25% above/below the benchmark, savings/loss rates are: 50% for amounts 25-35% of benchmark; 25% for amounts 35-50% of benchmark; and 10% for amounts >50% of benchmark.	

Illustrative example of a smaller set of population-based payment model tracks



Track 1

Groups of small organizations
(e.g., small independent
physician practices)



50% SAVINGS



Track 2

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

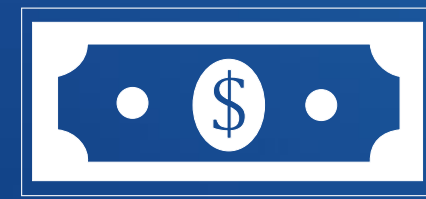


75% SAVINGS/LOSSES



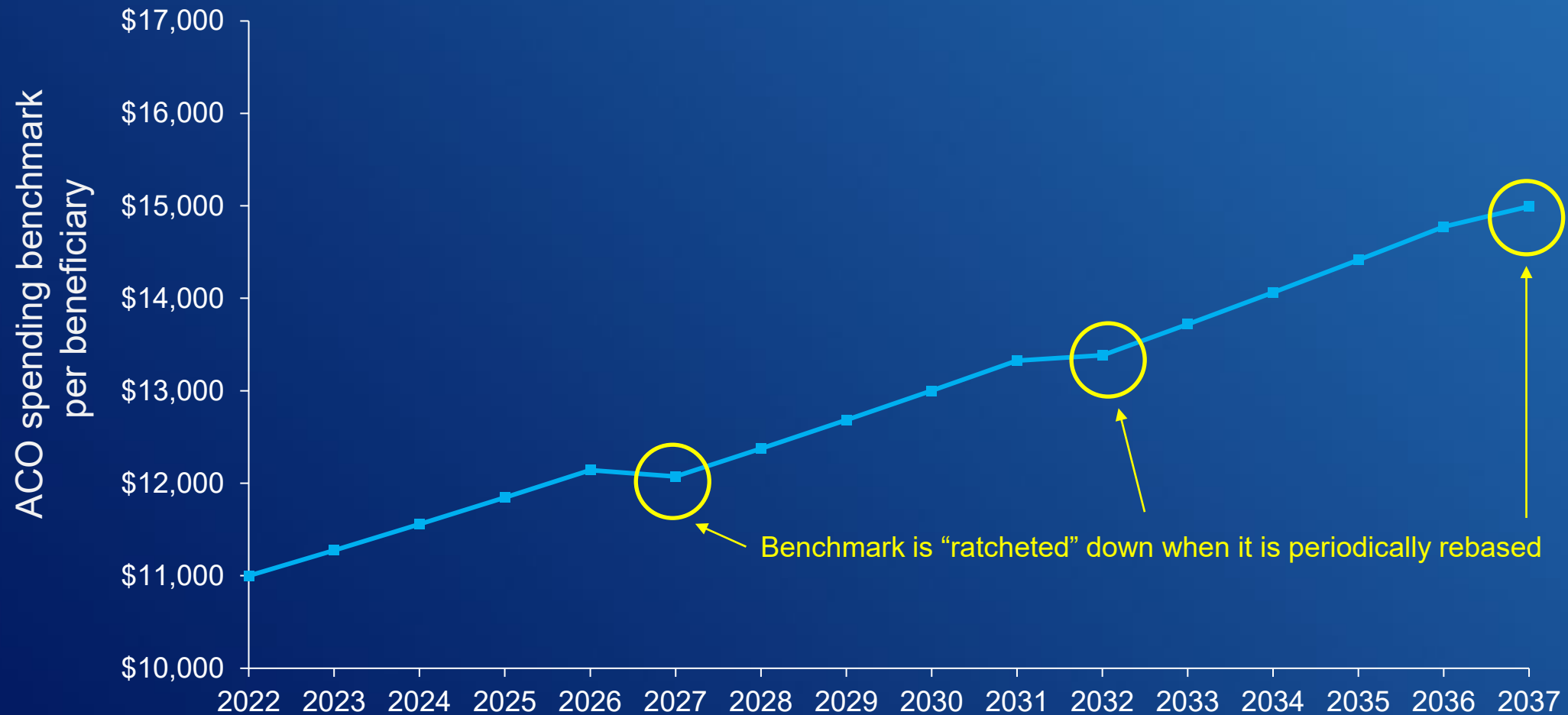
Track 3

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

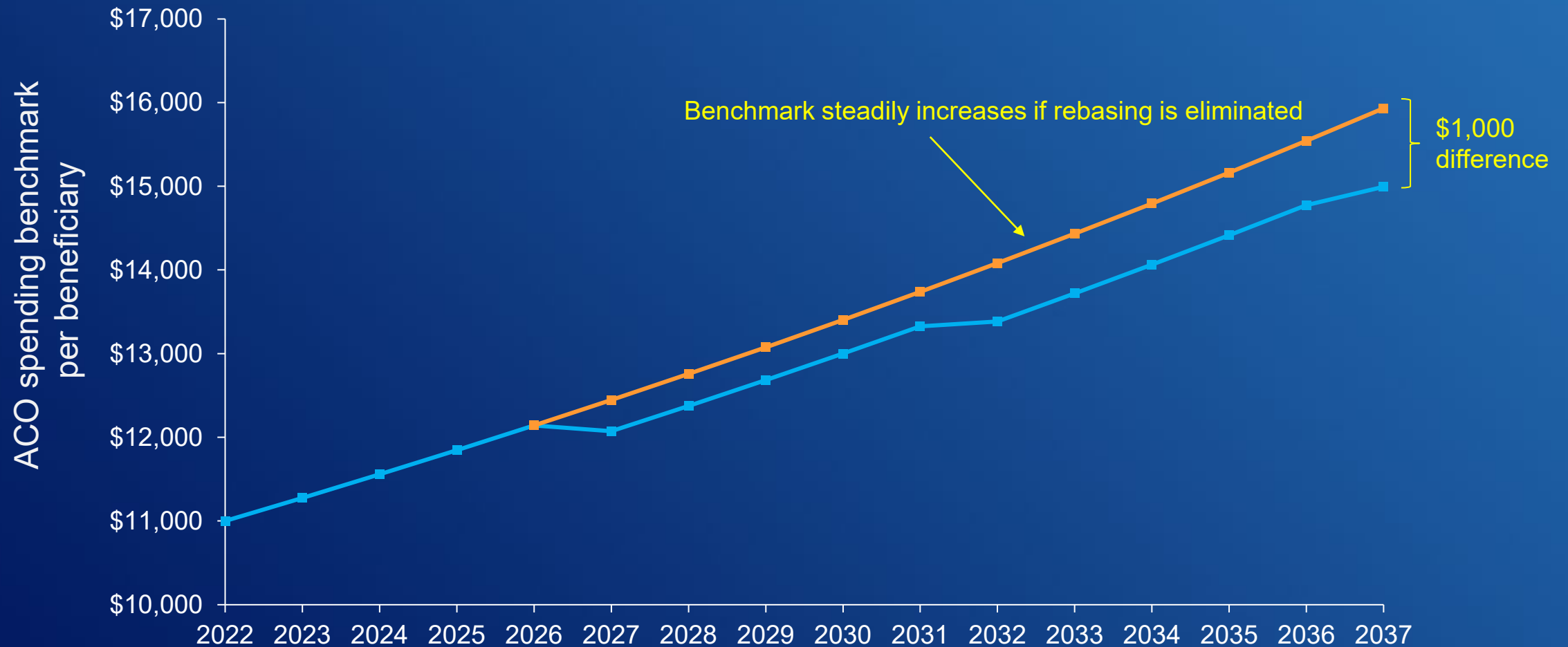


100% SAVINGS/LOSSES

Commissioners favor eliminating the periodic “rebasing” of an ACO’s spending benchmark



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Commissioners favor using an exogenous growth factor to trend forward ACO spending benchmarks

- ACO spending benchmarks would be set using historical spending data that is trended forward each year using exogenous growth factor(s) unrelated to ACO spending
- For example:
 - Medicare updates to payment rates; and
 - Projected growth in volume & intensity of services in FFS Medicare
- Growth factor would need to be discounted by some percentage to generate savings for the Medicare program

Episode-based payment

Commissioners favor operating a national episode-based payment model concurrently with ACOs

- Medicare would implement a nation-wide episode-based payment model for certain types of episodes
- All FFS beneficiaries who trigger a covered episode would be attributed to Medicare's model
 - Beneficiaries in an ACO would be concurrently attributed to both models during the episode period
- ACOs could design and implement their own episode-based payment arrangements for types of episodes not covered by Medicare's model

Chair's suggested factors for CMS to consider when selecting episodes for Medicare's model

1. Whether an episode has attributes that facilitate implementation of episode-based payment
2. Whether an episode-based approach has been found to generate savings and quality improvements above what an ACO would achieve on its own
3. Whether there are concerns that including an episode in the model will increase volume of the episode

Chair's suggested factors for CMS to consider when selecting episodes for Medicare's model (continued)

4. Whether inclusion of an episode in the model is anticipated to discourage participation in ACOs
5. How care processes among different types of episodes (e.g., surgical episodes and chronic conditions) interact with each other and with ACOs
6. Whether including an episode would be expected to reduce health care disparities

Potential set of principles for allocating savings and losses between ACOs and providers in episode model

- Bonus payments (or repayments) resulting from changes in spending during covered episodes should be allocated in a way that:
 - Episode-based providers have an incentive to furnish efficient, high-quality care, and
 - Providers in ACOs have an incentive to refer patients to low-cost episode-based providers, and
 - When combined, these incentives should not increase total Medicare spending

Discussion

- Staff seek feedback on the concepts presented here and whether they accurately reflect commissioner preferences for improving CMS's portfolio of APMs
- Chapter will appear in June 2022 report to the Congress