NAACOS Summary of Key Elements of the June 2020 MedPAC Report

Background and NAACOS' reaction: The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency that advises Congress on issues affecting Medicare, primarily payments to private health plans participating in Medicare and payments to providers in the traditional fee-for-service (FFS) program. The 17-member commission meets monthly between September and April and publishes two reports a year: March and June. In its June 2020 report, MedPAC devotes a great deal of attention to accountable care organizations (ACOs) and value-based payment more generally. Its opening chapter provides a high-level discussion about the need to move away from FFS and incentivize participation in "accountable entities." The full report is available here, and MedPAC's press release is here. MedPAC also devoted a chapter to ACOs in its June 2018 report, which NAACOS summarized here, as well as its June 2019 report, which is summarized here.

NAACOS is pleased to see such a devotion to the need to move to alternative payment models. MedPAC's encouragement of accountable entities backs the notion that ACOs and ACO-like models are the mechanism by which Medicare can move away from FFS payment to a payment system focused on value. ACOs, Medicare's largest and most successful payment model to date, play a critical role in that transition. We wholeheartedly agree with MedPAC that we need to accelerate the transition to value and are pleased to see MedPAC acknowledge that ACOs' savings has surpassed those achieved by a wide variety of care coordination models Medicare has tested. As they continue their work, NAACOS encourages MedPAC and policymakers to revisit policies such as increasing ACOs' shared savings rates, providing ACO investment opportunities, and extending the timeframe for ACOs to assume risk, which would all incentivize the creation of more ACOs and continued participation by existing ACOs.

"Realizing the promise of value-based payment in Medicare"
MedPAC opens its June report with a chapter that outlines broad principles and outlines the case to move Medicare's payment policies and delivery incentives to broaden the use of value-based payment. The commission generally describes value-based payment as paying for services to incentivize controlling overall costs while maintaining or improving quality. CMS should encourage "accountable entities," MedPAC writes, which are analogous to ACOs and would be responsible for accepting Medicare payments and accountability for the costs and overall health of a group of beneficiaries. MedPAC points to ACOs and Medicare Advantage (MA) as vehicles to broaden the use of value-based payment. However, both need improvement to realize their potential, the report adds. Medicare spending continues to increase and without changes to the program, spending growth could result in adverse and dramatic changes to Medicare.

ACOs, which serve about 23 percent of beneficiaries with Part A and B coverage, have generated around 1 percent to 2 percent savings, according to studies MedPAC points to. This falls in line with research NAACOS has commissioned. MA, which enrolls about 42 percent of beneficiaries with Part A and B coverage, increases Medicare spending overall because of rebates, quality bonuses, and submitting more diagnosis codes. MedPAC plans to conduct further analysis to identify specific policy changes that will

improve ACOs and ACO-like models but notes that simply creating additional ineffective ACOs or increasing funding for ACOs would not be effective.

Instead, MedPAC discusses two broad concepts that it plans to study further in the future:

- Provide ACOs with incentives to manage outpatient prescription drugs; and
- Increase beneficiary engagement such as through cost-sharing changes or other financial incentives for the patient.

MedPAC laid out two possible approaches to incorporate ACO accountability for Part D: (1) add Part D spending to ACOs' Part A and B benchmarks, allowing ACOs to share in savings for the combined medical and drug-spending benchmark, or (2) encourage ACOs to contract with Part D plans to reduce drug spending. MedPAC admits either would be challenging to implement. Medicare Part D is a separate benefit and already managed by plans with some financial responsibility for those costs. Also, projecting Part D benchmarks would be difficult given the various rebates and discounts needed to be taken into consideration. While CVS Caremark, one of the nation's largest pharmacy benefits providers, enthusiastically announced in 2014 that it would build partnerships with several Medicare ACOs, there's no published studies on the effectiveness of that work.

Figuring out how to make ACOs responsible for prescription drug costs has been a challenging issue, but it is one that NAACOS supports addressing in a thoughtful manner through testing voluntary models or initiatives for ACOs. We are working on recommendations that we look forward to sharing with MedPAC, Congress, and CMS. Appropriately integrating prescription drug costs into accountable care models is important for patient care and outcomes as well as generating savings for the Medicare Trust Fund.

There were other, more general ideas raised in the report. MedPAC recommends adoption of a new MA "value incentive program," which it explains further in another chapter. MedPAC suggested paying hospitals under a global budget to cover all of their inpatient and outpatient services, which currently is done in Maryland. The commission also discussed the notion of "downstream" payment arrangements used by MA plans and ACOs to pay their individual providers. While policymakers have typically stayed away from specifying the mechanisms those entities use to pay participating providers, it is a key concept of the Innovation Center's Direct Contracting Model. MedPAC suggests CMS could give accountable entities stronger incentives to control costs and therefore use payment arrangements different from traditional Medicare fees to reimburse providers, since it would be challenging for CMS to develop requirements. Medicare could also reduce FFS payment rates for providers not part of an accountable entity. None of the concepts were discussed in detail in the chapter. Lastly, MedPAC asserts that the development of new care delivery models from the CMS Innovation Center needs to accelerate.

Changes to MSSP Assignment

In the report's second chapter, MedPAC recommends the Medicare Shared Savings Program (MSSP) base patient assignment at the national provider identifier (NPI) level, as opposed to the taxpayer identification number (TIN) as it is today. Such a move would more accurately reflect where beneficiaries receive their care, MedPAC states, since low-cost patients could enter an ACO or high-cost patients exit without a change in the benchmark under TIN-based assignment. For purposes of calculating benchmarks and performance-year assignment, each clinician's NPI would be associated with only one ACO. Additionally, MedPAC says the move will generate $50 million annually in savings to Medicare due to reduced shared savings payments to ACOs.

MedPAC fears ACO savings could be eroded or offset by adverse patient selection. For example, ACOs could have high-cost clinicians bill under an ACO's TIN in a benchmark year, then remove those high-cost

clinicians from a participating TIN during the performance year to make it easier for the ACO to generate savings. Similar shifts could occur with high-cost beneficiaries between benchmark and performance years if ACO providers bill for high-cost patients under different TINs. The report states that it does not believe there's widespread adverse selection in MSSP, but the current system is set up in a way that could allow it. MedPAC expresses two potential concerns: (1) ACOs could still send high-cost patients to certain clinicians not participating in an ACO to remove spending not found in benchmark years, and (2) NPIs could move mid-year, creating the need to remove Medicare claims from outside an ACO's market if the move was to another geographic area.

NAACOS has previously supported a TIN-NPI level assignment approach, which is used in the Next Generation ACO and Direct Contracting Models. A TIN-NPI approach provides benefits such as increased accuracy between benchmark and performance year spending and an ability for ACOs to decide on their ACO providers more strategically. However, MedPAC stated that a TIN-NPI approach does not resolve issues of unwarranted shared savings because low-cost providers could still be moved between different TINs and in and out of an ACO.

As it did in the 2019 June report, MedPAC raised concerns about the use of annual wellness visits (AWVs) to retain low-cost beneficiaries. Without citing evidence of this occurring, MedPAC notes that ACOs could use AWVs as a way to have patients with historically low spending attributed to their ACO, while avoiding high-cost patients by not offering them an AWV. They note patients who receive an AWV tend to have lower historical spending. While AWVs could be for care coordination and improvements on MSSP quality measures, ACOs also conduct AWVs more than traditional FFS, and patients with AWVs later in the year tended to have relatively low spending. MedPAC pointed to research published last year which showed AWVs did not result in lower Medicare spending and had no effect on appropriate screening rates, emergency department visits, or hospitalization rates.

Citing NAACOS's work among others, MedPAC acknowledges that ACOs have resulted in savings between 1 percent and 2 percent for Medicare. While MedPAC calls these savings "modest," the commission acknowledges that these savings are greater than those from other care coordination demonstrations. ACOs with commercial insurers, such as Massachusetts' Alternative Quality Contract, have generated larger savings, but that may be expected as a commercial insurer, since it has tools Medicare doesn't, such as prior authorization and networks of lower-cost, higher-quality providers. MedPAC offers several high-level ideas to increase ACO savings, including increasing beneficiaries' incentives to engage with ACOs, increasing hospitals' incentive to reduce unnecessary service use, and increasing specialist engagement with ACOs.

Conclusion and Next Steps

While MedPAC technically advises Congress on Medicare payment policy, its recommendation on NPI-level attribution in MSSP could be adopted by CMS without congressional action. However, it's unclear if either Congress or CMS will accept MedPAC's recommendation. Either way, changes to MSSP assignment would go through CMS rulemaking, which provides an opportunity for stakeholder input. NAACOS is eager to work with MedPAC as it develops its recommendations on value-based care and plans to follow-up on the commission's recommendations with our own thoughts.