

MedPAC June 2022 Report to Congress

Chapter 1: An approach to streamline and harmonize Medicare's portfolio of alternative payment models

CMS operates numerous alternative payment models (APMs) that providers in the fee-for-service (FFS) Medicare program can participate in. CMS's largest APM is the Medicare Shared Savings Program (MSSP), which is a population-based payment model. By holding providers accountable for cost and quality, APMs aim to give health care provider organizations a financial incentive to furnish a more efficient mix of services and improve the care they deliver. The occurrence of multiple APMs operating concurrently can create excessive complexity and may weaken incentives when Medicare beneficiaries are attributed to more than one model simultaneously and/or when providers participate in more than one APM at the same time.

In the MedPAC June 2022 Report to Congress, the Commission recommended that CMS reduce the number of Medicare APMs it operates and design models to work better together when combined. In this chapter, the MedPAC provided suggestions that are aimed at operationalizing their previous recommendation.

- Implement a foundational population-based payment approach that reduces the number of accountable care organization (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.
- Move away from “rebasings” 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.
- 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.
- 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.
- For beneficiaries concurrently attributed to the episode-based payment model and an ACO, allocate episode bonus payments so 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; and (3) when combined, these incentives are not so large that they increase total Medicare spending.

The Commission believes implementing these 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

Chapter 5: Improving the accuracy of Medicare Advantage payments by limiting the influence of outliers in CMS's risk-adjustment model

The Medicare program pays managed care plans that participate in Medicare Advantage (MA) a monthly capitated amount to provide Medicare-covered services to each of their enrollees. CMS adjusts the monthly capitated amounts for each enrollee using a risk score, which is a beneficiary-level index that indicates how costly an enrollee would have been expected to be in fee-for-service (FFS) Medicare relative to the national average FFS beneficiary. CMS generates the risk score for each enrollee using the CMS hierarchical condition category (HCC) model, a risk-adjustment model that uses demographic and medical information for FFS beneficiaries to predict the costliness of care. The purpose of risk adjustment is to accurately predict costs on average for a group of people with the same attributes that affect healthcare costs. The risk of financial loss incentivizes plans to manage their enrollees' conditions to keep costs down.

The HCC risk-adjustment model has largely been successful in serving its general purpose, but there is an ongoing concern that outliers are causing inaccuracies in the model. Outliers are beneficiaries who have the largest differences between actual medical costs and costs predicted by the model, and they cause biased model coefficients that result in risk-adjusted payments that are too high for some enrollees and too low for others. This undermines the accuracy of payment to plans.

To address this inaccuracy, the MedPAC Commission evaluated a modification that incorporates the principles of reinsurance and repayment to limit the influence of outliers in the estimation of the model's coefficients. The modification uses financial transfers to redistribute payments from plans whose enrollees incurred costs substantially below the model's prediction to plans whose enrollees incurred costs substantially above predicted costs. However, it is not feasible to complete these transfers for Medicare Advantage.

MedPAC's method for addressing outliers in the risk-adjustment model without requiring changes to the flow of funds from CMS to MA plans involved dividing their analytic sample into estimation and evaluation subsamples.

Using the estimation sample, MedPAC calculated the difference between the actual costs and the costs predicted by the standard CMS–HCC model for each FFS beneficiary in their analytic file. For beneficiaries with the largest underpredictions, they applied a loss limit by reducing the actual costs such that the total reduction in costs equaled 2 percent of all costs. For beneficiaries with the largest overpredictions, they applied a gain limit by increasing the actual costs such that the total increase in costs equaled 2 percent of all costs. The limits offset one another so that the adjustment to the cost data is revenue neutral. MedPAC then used the adjusted cost data (with loss and gain limits applied) to re-estimate the CMS–HCC model, thereby limiting the influence of outliers on the resulting coefficients with no impact on the flow of funds from CMS to MA plans.

The Commission then used the evaluation sample to evaluate the effect of this method of limiting overpredictions and underpredictions. They used two measures of overall fit, the R² and the Cumming's prediction measure, both of which estimate how well predicted costs reflect actual costs. MedPAC found that this modification to the standard CMS–HCC model improved the R² from 0.13 to 0.19. They also assessed the predictive ratio, which is the aggregate costs for the group predicted by the risk-adjustment model divided by the aggregate actual costs for the group. MedPAC considered groups of beneficiaries for

which the standard CMS–HCC model typically does not perform as well and found improvements in model performance.

Improving the accuracy of MA risk adjustment is a goal for the Commission. This approach would help accomplish that goal without any additional burden on plans or beneficiaries to provide additional data. More work is needed to understand how this approach can integrate with other improvements to risk adjustment for MA plans. The Commission intends to address these issues in future work.

Chapter 6 Aligning Fee-For-Service Payments Across Ambulatory Settings

Medicare payment rates often differ for the same service among ambulatory settings, including hospital outpatient departments (HOPDs), ambulatory surgical centers (ASCs), and freestanding physician offices. These payment differences can result in care being provided in the settings with the highest payment rate, which increases total Medicare spending and beneficiary cost sharing without significant improvements in patient outcomes. The MedPAC Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting. However, there are important distinctions between ambulatory settings. Some services can only be safely provided in HOPDs, and hospitals incur costs to maintain standby capacity for handling emergencies and to comply with additional regulatory requirements that ASCs and freestanding offices do not have. There are also differences in how services are packaged into payments across the different place of service settings, so identifying payment rate differences must be done with careful analysis.

In order to evaluate whether an ambulatory service should continue to have different payment rates in the three settings or whether it would be appropriate to align the payment rates more closely across the three settings, the MedPAC Commission analyzed the ambulatory payment classifications (APCs) used in the outpatient prospective payment system (OPPS) to pay for services provided in HOPDs.

The Commission found the following:

- There were 57 APCs identified where it would be reasonable to align payment rates across the three ambulatory care settings with those of the physician fee schedule (PFS).
 - The physician office is the most frequent site of service for these specific APCs, indicating that freestanding offices are a safe and appropriate setting for these services and that PFS payment rates are adequate to ensure beneficiaries' access to care.
- There were 11 APCs for which ASCs have the largest volume among the three ambulatory settings.
 - It would be appropriate to align the OPPS payment rates with those paid in the ASC setting, while continuing to use the PFS payment rate when the service is provided in a freestanding office.
- Finally, for 101 APCs, including emergency department (ED) visits, the HOPD is the most frequent setting, or the services cannot be provided in settings other than HOPDs. For these APCs, each setting should continue to have a different payment rate, with generally higher payments for HOPDs.

As policymakers consider how to align these payment rates, they must ensure that hospitals continue to receive sufficient financial support to maintain standby emergency capacity. To maintain this support, the APCs for ED visits, critical care visits, and trauma care visits could be reclassified from standard APCs to

comprehensive APCs (C-APCs), which are an advanced form of APC in which all services (with a few exceptions) that appear on the same claim are packaged together into a single payment unit. By changing payment for these services from standard APCs to C-APCs, higher payment rates for the provision of services during these visits would be maintained, appropriately reflecting the hospital-level costs of items and services provided.

If these payment changes were taken as program savings, Medicare program spending in 2019 would have declined by \$6.6 billion and beneficiary cost-sharing obligations by \$1.7 billion. Across all hospitals, a site-neutral policy would have reduced overall Medicare revenue by 4.1 percent and beneficiary OPPS cost sharing by 13.2 percent.

Current law determines that CMS would have to fully offset the lower Medicare spending and beneficiary cost sharing from aligning ambulatory payment rates by increasing the OPPS payments for all other nonaligned APCs to maintain budget neutrality. In response to concerns regarding effects of budget neutrality adjustment, policymakers could consider an alternative to the budget-neutrality policy that would explicitly target hospitals that serve a high share of low-income beneficiaries to limit the loss of Medicare revenue for these hospitals. Over time, the payment rate alignment policy would produce savings for the Medicare program and lower cost sharing for beneficiaries under either the budget-neutrality policy or the stop-loss policy because incentives to shift services from the lower-cost physician office and ASC settings to the higher-cost HOPD setting would be mitigated.