



Transitioning from Volume to Value:

Accelerating the Shift to Alternative Payment Models

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AUTHORS

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DELIVERY SYSTEM REFORM INITIATIVE

In April 2013, BPC issued *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, a report that laid out a comprehensive set of policy recommendations for lowering costs, improving quality, and reducing inefficiency across the health care system. As a continuation of that work, the Delivery System Reform Initiative's four co-chairs—former Senate Majority Leaders Tom Daschle and Bill Frist, former White House and Congressional Budget Office Director Dr. Alice Rivlin, and former Ranking Member of the House Ways and Means Committee Jim McCrery—are developing meaningful policy solutions to facilitate and accelerate the transition to a value-based health care system.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's (BPC) founders or its board of directors.

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Overview



In 2013, the Bipartisan Policy Center (BPC) issued a report, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, outlining recommendations to reform the nation's health care delivery system. The project's leaders—former Senate Majority Leaders Tom Daschle and Bill Frist, former Senator Pete Domenici, and former Congressional Budget Office Director Alice Rivlin—recommended detailed proposals designed to encourage patients and providers to move away from fee-for-service care to more efficient delivery models that promote better care coordination, improve quality of care, and slow cost growth. Over the last year, BPC's Health Project has engaged a broad range of stakeholders to update and revise those recommendations in order to accelerate the transition to

alternative payment models (APMs), within the context of the debate around physician payment reform. Congress and the Centers for Medicare and Medicaid Services (CMS) have adopted some of the recommendations. The resulting recommendations were published in four white papers issued in 2014 and early 2015:

1. *Transitioning from Volume to Value: Opportunities and Challenges for Health Care Delivery System Reform*, August 2014;
2. *Transitioning to Organized Systems of Care: Medical Homes, Payment Bundles, and the Role of Fee-for-Service*, January 2015;

3. *Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare, January 2015; and*
4. *Transitioning from Volume to Value: Consolidation and Alignment of Quality Measures, April 2015.*

This report provides an update on federal action since the release of those recommendations, an overview of the current status of accountable care organizations (ACOs) in Medicare, and a comparison of existing models with BPC's proposed changes. In addition, the report includes estimates of savings to the Medicare program associated with several policy recommendations, including modernization of the basic Medicare benefit, an expansion of differential updates (higher updates for providers that participate in APMs, lower updates for those that do not) to all Medicare providers, and changes in Medicare reimbursement for Part B drugs to more accurately reflect acquisition costs and to remove unintended, counterproductive incentives in the current formula.

Updates in Health Care Delivery Reform



In early 2015, both Congress and the Department of Health and Human Services (HHS) took steps to improve quality and lower health care costs. Congress enacted legislation to replace Medicare's sustainable growth rate (SGR) with a system of payment for health care providers that are paid under Medicare's Physician Fee Schedule.¹ In addition to the passage of the SGR legislation, HHS has set goals to increase value-based purchasing in Medicare. In January, the HHS Secretary announced that the agency will take steps to promote the transition to alternative payment models, by establishing new goals to increase value-based payments in Medicare to 50 percent of all payments by 2018.² As part of that effort, the CMS Center on Medicare and Medicaid Innovation (CMMI) announced

a Next Generation ACO, designed to build on lessons learned in the Medicare Shared Savings Program (MSSP) and the Pioneer ACO program, as well as continuing demonstrations of other payment models.³

Alternatives to fee-for-service (FFS) have proliferated in recent years as the federal and some state governments, private insurers, and employers seek increased value in the health care system. According to a recent study, there are more than 744 ACOs operating as of March 2015, with more than 400 of these participating in the MSSP or Pioneer program.⁴ While policymakers have taken action to encourage the formation of ACOs, private-sector payers have become increasingly concerned about the cost and quality of the

health care system, and businesses are utilizing ACOs as a delivery model for their employees. Today 132 private payers have at least one ACO contract.⁵

BPC reviewed implementation of ACOs in Medicare and offered near-term recommendations to improve this model, some of which were incorporated as part of CMMI's Next Generation ACO model. While this report focuses primarily on ACOs and the role they play as APMs in delivery system reform, BPC's previous white papers also examined the potential of other models of care—such as patient-centered medical homes (PCMHs), payment bundles, and revisions to fee-for-service—and recognizes that additional models may be developed over time.

In practice, ACOs have enjoyed modest successes, but at the same time, they have encountered significant challenges. Specifically, quality results were disappointing in many cases, and most ACOs generated modest or no savings—especially in the MSSP. Medicare's current ACO programs lack many of the features BPC proposed in 2013, such as giving providers clearer expectations, engaging beneficiaries directly with the ACOs, and establishing stronger incentives for both providers and beneficiaries to participate—features which could help improve the success of Medicare ACOs. The establishment of a clear and viable pathway from the status quo to greater amounts of responsibility and risk is one of the most significant and important challenges for the long-term success of ACOs as an APM.

ACOs: Early Results and Potential for Improved Quality and Lower Costs



Early Results

There has been considerable debate among policymakers as to the success of the ACO model. Critics have argued that the results have been poor, and media reports have focused on the ACOs that have dropped out of the Pioneer model. In interpreting these early results, it is important to note that the purpose of CMMI is to test models of care and then determine what works and what does not.

Table 1 on the following page shows the differences in savings in both the MSSP and Pioneer model in year one, as well as Pioneer savings in year two.

Summary of BPC Recommendations

BPC's recommendations to address these challenges fell into four main categories. First, establish clear expectations for ACOs. Second, provide tools for ACOs to engage beneficiaries and providers in care coordination and to improve health outcome efforts. Third, establish a viable pathway for ACOs to assume two-sided risk. Finally, create differential payment-rate updates that incentivize provider participation in APMs with greater risk levels. Detailed recommendations are outlined in the following pages.

Table 1. Early Results for the Medicare Shared Savings Program and Pioneer ACOs⁶

Metric and Evaluation Period	MSSP ACOs	Medicare Pioneer ACOs	Year 2 (preliminary)
	Year 1	Year 1	
Total Net Savings to the Medicare Program	\$383 million	\$33 million	\$41 million
Number of ACOs Achieving Shared Savings	58 out of 220	13 out of 32	11 out of 23
Average Change in Per Capita Spending Relative to FFS*	-1.2% to -1.1%	-2.1% to -1.9%	
Average Change in Per Beneficiary Per Month Spending Relative to FFS**	Not Available	-\$35.62	-\$11.18
Performance on Quality Measures	Improvement on 30 of the 33 quality measures	All ACOs met the quality reporting requirements	Improvement on 28 of the 33 quality measures

Recommendation 1

Set clear expectations for ACOs

- Attribute beneficiaries prospectively across Medicare ACO programs, so ACO providers know in advance for which patients they are responsible. Allow beneficiaries to be attributed to an ACO based on non-physician primary care providers (e.g., nurse practitioners) visits.
- Likewise, set benchmarks prospectively across Medicare ACO programs, so financial targets are also known in advance.
- Reduce the number of quality measures, establishing a smaller set of measures for ACOs, which should be more focused on health outcomes (ultimately measured on the basis of the broader patient population) and patient satisfaction, not simply process measures.
- Allow partial shared-savings bonuses for ACOs that reduce spending and achieve significant, relative quality improvement, even if national standards are not met.

Recommendation 2

Provide ACOs with tools to engage patients and providers in care coordination

- ACOs should be able to establish provider networks; inclusion in an ACO's network should be considered a form of APM participation when ACO patients are served.
- Transition to a patient-choice model in which beneficiaries have the opportunity to make an active decision to designate an ACO and would have incentives for doing so.
- Waive certain Medicare regulations for ACOs assuming two-sided risk.

* This study looks at market-level trends in spending instead of ACO-level spending, so the results are not directly comparable to the numbers in the preceding rows.

** These results reflect data for all 32 Pioneer ACOs that participated in the program in 2012, including those that are no longer part of the program.

Recommendation 3

Establish a viable pathway to risk

- Offer ACOs a larger proportion of shared savings, and do not reset historical benchmarks.
- Beginning in 2018, implement a five-year transition from historical benchmarks to regional, risk-adjusted benchmarks.
- Set an expectation that all ACOs should eventually accept two-sided risk. Limit one-sided risk to two full three-year contract periods plus one partial contract period.
- Allow ACOs to ease into downside risk by making it easier to earn shared savings and by further limiting potential shared losses during a transition period.
- Offer more advanced payment models, such as partial capitation, for ACOs that demonstrate strong performance and preparedness for managing risk.

Recommendation 4

Incent more providers to participate in ACOs

- Provide incentives through the fee schedules for all Medicare providers to adopt APMs with increasing levels of risk. Transition to a permanent 5 percent differential between Medicare fee-schedule payment rates for APM participants at two-sided risk and for non-participants.
- Beginning in 2018, annual Medicare fee-schedule payment-rate updates should be adjusted so that:
 - Payment rates for Medicare providers not participating in APMs grow at a rate 1 percentage point slower than those participating in two-sided risk APMs; and

- Payment rates for Medicare providers participating in one-sided risk APMs grow at a rate 0.5 percentage points slower than those participating in two-sided risk APMs.*

- Facilitate access to start-up capital for rural and physician-led ACOs.

Some of BPC's Recommendations Reflected in the New Medicare Next Generation ACO Model

The structure of an ACO can be analyzed along a variety of dimensions, such as the methodology for assigning beneficiaries to an ACO and the amount of shared savings or losses that the ACO can accrue. The following bullets and Table 2 compare the MSSP and Pioneer ACOs with BPC's ACO recommendations and CMS's new Next Generation ACOs along a variety of dimensions.

- Both the MSSP and Pioneer ACO program assign ("attribute") beneficiaries to an ACO based on the beneficiary's utilization patterns, as reflected in claims data. The Pioneer ACO program also allows beneficiaries to voluntarily align themselves with an ACO to a limited extent. BPC has recommended that alignment be based on beneficiary choice, and CMS is putting further emphasis on voluntary alignment in its Next Generation ACO model.
- While the Pioneer ACO model includes limited beneficiary engagement through the voluntary alignment option, neither the MSSP nor the Pioneer program emphasize the role of beneficiary engagement. BPC has recommended that ACOs share savings with beneficiaries through reductions in premiums and cost-sharing for beneficiaries seeking care within the ACO network. BPC has also

* For additional information, see proposal description in the section below on options for reducing health costs and improving and simplifying delivery.

recommended that ACOs provide voluntarily aligned beneficiaries with access to a 24-hour nurse help line and extended primary care office hours. Under the Next Generation ACO model, CMS has proposed providing beneficiaries with a financial reward if beneficiaries seek a certain percentage of their care within their ACO's network.

- The MSSP model requires the primary care providers and specialists providing primary care services that participate in an ACO to align themselves with one ACO, and the Pioneer model has a similar requirement for primary care specialists. BPC recommended allowing certain providers to contract with ACOs as part of the ACO's preferred-provider network. CMS is offering a similar option under the Next Generation model.
- The amount of shared savings that an ACO may receive is based on comparing the ACO's actual fee-for-service payments for the performance year with the payment benchmark (or target) for the year. If the ACO's actual fee-for-service payments are sufficiently below the benchmark, and the ACO has met the required quality measures, the ACO qualifies for shared savings. Both the MSSP and Pioneer programs determine the benchmark retrospectively (after the performance year) and base the benchmark on the ACO's own historic Medicare spending. A retrospective benchmark means that the ACO does not know what its target is until the end of the year, while a historically based benchmark may make it difficult for ACOs in low-spending regions to achieve savings. BPC has recommended a prospective payment benchmark that accounts for regional factors and is risk-adjusted. Under the Next Generation model, the benchmark will be prospective and will still be

based on the ACO's own experience, but it will incorporate regional experience through the trending and discount methodologies.

- Under the MSSP program, ACO providers are still reimbursed at traditional Medicare fee-for-service payment rates, while under the Pioneer model, certain providers can opt for population-based payments in the later years of the ACO contract. BPC has recommended that ACOs have the option of payment through partial capitation, instead of just fee-for-service. CMS is offering four payment options under the Next Generation model, including a capitation option for select ACOs in the later years of the ACO contract.
- BPC has recommended increasing the maximum shared-savings and losses percentages from the current 50 percent (for one-sided-risk ACOs) and 60-75 percent (for two-sided risk ACOs) to up to 80 percent. The CMS Next Generation Model offers shared savings of up to 100 percent, depending on the track chosen.
- Under the MSSP, ACOs can enter the program under one-sided risk for the first contract period and then transition to two-sided risk for subsequent periods. However, CMS has proposed a policy of allowing MSSP ACOs to remain at one-sided risk for another contract period. On the other hand, BPC and others (including the Medicare Payment Advisory Commission or MedPAC), emphasize the need to move providers to two-sided risk arrangements. CMS's Next Generation Model offers only two-sided risk.
- Along with two-sided risk comes the possibility for certain types of regulatory flexibility. Under the Pioneer ACO model, ACOs may waive the three-day stay requirement for Medicare coverage of care in a skilled nursing facility. BPC recommended expanding this regulatory flexibility

to other ACOs that assume two-sided risk and including other types of flexibility, such as waiving the homebound requirement for home-health and waiving certain limits on in-network referrals. In the Next Generation Model, CMS will once again allow three-day-stay rule waivers, in addition to reducing some of the limitations on Medicare reimbursement for telehealth and home visits.

- Given the capital needed to establish an ACO, CMS developed an Advance Payment ACO Model for certain rural and small providers that are participating in the MSSP. Under this model, ACOs receive upfront and monthly payments to help with set-up costs, and then these payments are recouped later. However, take-up of this option has been limited. BPC recommended low-interest loans for rural ACOs and a federal loan guarantee program for small physician-led organizations. In the Next Generation Model, CMS offers a payment track that provides monthly “infrastructure payments” upfront that are later recouped. Table 2 on the following page illustrates key differences in ACO models.

Table 2. Comparison of Medicare Shared Savings Program ACOs, Medicare Pioneer ACOs, BPC Medicare Networks, and the Medicare Next Generation ACO

Parameter	Medicare Shared Savings Program (active)	Medicare Pioneer ACO (active)	BPC Medicare Networks (proposed April 2013)	BPC Recommendations (proposed January 2015)	Medicare Next Gen ACO (proposed, Round 1 applications due June 2015)
Beneficiary Attribution	Retrospective; claims-based	Prospective; claims-based; limited voluntary alignment	Beneficiary choice	Prospective to start, with a transition to beneficiary choice	Prospective; claims-based, augmented by beneficiary choice
Beneficiary Engagement	None	None	Shared savings with beneficiaries via reductions in premiums and cost-sharing	Cost-sharing waivers for primary care, 24-hour nurse line, extended office hours; only available to beneficiaries who have actively chosen an ACO, not those who were attributed	CMS-distributed “Coordinated Care Reward”
ACO Membership Type	Primary care providers and specialists providing primary care services are exclusive to ACO	Primary care specialists are exclusive to ACO	Core members (exclusive to ACO) or part of provider network	Core member (exclusive to ACO) or part of provider network	Core members (exclusive to ACO) or part of provider network (preferred providers/suppliers)
Payment Benchmark	Retrospective; based on historic experience	Retrospective; based on historic experience, with locality adjustment to adjust for regional differences; risk-adjusted	Historic experience initially, with 5-year transition to regionally based and risk-adjusted	Prospective; do not rebase historical benchmarks between contract periods; 5-year transition from historically based to regionally based, risk-adjusted; allow for upward adjustments in cases of significant changes to Medicare payment policy	Prospective; 1-year historic baseline trended by a regional projected trend; risk-adjusted. Incorporates a discount based on quality and efficiency (comparison with regional and national trends), with goal of rewarding both attainment and improvement
Payment Mechanism	FFS rates only	FFS-only or population-based (reduced FFS + per beneficiary per month payment)	FFS (with full updates only for providers participating in APMs) or partial capitation	FFS (with full updates only for providers participating in APMs) or partial capitation	Four choices: 1. FFS-only 2. FFS + additional PBPM infrastructure payment 3. Population-based (same as Pioneer) 4. Capitation, in which the ACO receives monthly PBPM capitation payments and is responsible for paying claims for ACO providers (not available until PY2)

Table 2. Continued

Parameter	Medicare Shared Savings Program (active)	Medicare Pioneer ACO (active)	BPC Medicare Networks (proposed April 2013)	BPC Recommendations (proposed January 2015)	Medicare Next Gen ACO (proposed, Round 1 applications due June 2015)
Shared-Savings Percentage	<p>For 1-sided risk: 50% after reaching the minimum savings rate (varies based on ACO size), and capped at 10% of target</p> <p>For 2-sided risk: 60% shared savings after reaching minimum savings rate (set at 2%), and capped at 15% of target; cap on shared losses increases over time from 5% in year 1 to 10% in year 3, and then stays at 10%</p>	Shared savings and losses of up to 60-75%, after reaching the minimum savings/losses rate (1-2%)	60% of savings, above minimum savings rates of 2%; total shared savings capped at 15% of target; 60% of losses if average per beneficiary spending is more than 2% above target; total shared losses capped at 10% of target	Shared savings of up to 80%; limit shared losses, particularly for initial years under full risk	<p>Two options, both with a 15% savings/loss cap:</p> <p>1) first-dollar shared savings and losses of 80%-85% (increases over 5-year contract period), or</p> <p>2) first-dollar shared savings and losses of up to 100%</p>
Risk Sharing	Either: 1-sided with transition to 2-sided in second agreement period, or 2-sided from the start	2-sided	2-sided	2-sided risk (with transition for those that have started with 1-sided risk)	2-sided
Quality Measures	33 quality measures, across four quality domains: Patient / Caregiver Experience, Care Coordination / Patient Safety, Preventive Health, and At-Risk Population	Same as MSSP	Not specified	Reduce number of measures and increase focus on outcomes (vs. process)	Same as MSSP minus the electronic health records (EHR) measure
Regulatory Flexibility	No	Waiver of 3-day stay rule	Not specified	Waiver of 3-day stay rule, waiver of homebound requirement for home-health, waiver of certain limits on referrals	Waiver of 3-day stay rule, modification of telehealth requirements, and change to supervisory requirements for post-discharge home visits
Access to Capital	Certain smaller practices and rural entities can opt into the Advance Payment ACO Model (participation has been limited)	Not specified	Low-interest loans for rural ACOs and a federal loan guarantee program for physician-led organizations	Low-interest loans for rural ACOs and a federal loan guarantee program for physician-led organizations	Infrastructure payment option (discussed above)
Role of Medicare Part D Spending	Not included in benchmark	Not included in benchmark	Option to partner with select Part D plans	Not specified	May include eventually

Additional BPC Findings and Recommendations



BPC recognizes that there is significant variation in the structure of medical practices across the country and that ACOs may not be the optimal model in all geographic areas or for all provider groups, at least in the near term. To address this variation, BPC made recommendations on additional payment mechanisms, including changes in Medicare fee-for-service, patient-centered medical homes, and in bundled payments. Importantly, BPC also recognizes the critical role that quality measures play in the transition to new models of reimbursement. Summaries of those recommendations are included in the following pages.

Medical Homes, Payment Bundles, and the Role of Fee-for-Service

While there have been significant steps to move away from fee-for-service, many providers throughout the country have not, and in some areas APM adoption is especially low. In those areas, it is important to incentivize provider migration to organized systems of care while recognizing that some providers may ultimately remain in the fee-for-service system, even if less financially attractive. Higher Medicare reimbursement for APM participation, including PCMHs, bundled payments, and ACOs, relative to fee-for-service, will accelerate the transition to new, organized systems of care.

Undervalued Codes in the Physician Fee Schedule—CMS should continue to devote resources to identifying and revaluing incorrectly valued codes under the physician fee schedule, prioritizing the rebasing of the value of services in a way that does not add to federal spending.

Upside-risk PCMHs—The upside-risk PCMH model should be considered an APM eligible for higher fee-schedule payment-rate updates as MACRA is implemented by CMS; recognizing it as a useful mechanism will improve the patient experience and accelerate the transition away from fee-for-service.

Bundled Payments

- CMS should prioritize the establishment of bundled payments for episodes of care that have a statistically meaningful clustering of costs, providers, utilization, and patient characteristics.
- Bundles should be developed as both an alternative to fee-for-service reimbursement and a mechanism for engaging specialists in ACOs.
- Providers should receive differential updates in fee-schedule payment rates as they adopt more advanced payment and delivery models, so that bundled-payment participants would over time access higher fee-schedule payment rates than those not participating in APMs.
- Transition from a benchmark based on provider-specific, historical experience at the beginning of the contract toward a community-experience benchmark. Updates based on historical experience should not be rebased for experience under bundled payment.
- Prospective versus Retrospective Payment: CMS should offer more options for prospectively paid bundles, while retaining retrospective bundles as a default payment mechanism.

Consolidation and Alignment of Quality Measures

Effective quality measures are imperative to accountability in organized systems of care, especially where performance affects the ability of the provider to share in savings or determines whether a provider avoids penalties or receives bonus payments. The issue however is that, simply put, there are too many quality measures currently used in both public and private programs. The current U.S. health care system has alignment initiatives and programs that are attempting to consolidate measures in order to move toward a value-based health care system, and there has been some measurable success. However, we are still far from reaching the goal of simplifying providers' experiences while maximizing benefits to beneficiaries and payers.

Often, the roles and responsibilities of organizations, such as health plans and accrediting bodies, are ill defined in the area of quality reporting, leading to confusion and inefficiencies. This lack of clarity can place an unnecessary administrative burden on health care providers, forcing them to use resources to report on redundant, conflicting, or irrelevant metrics. Moreover, these inefficiencies with the current disjointed reporting system do little to address the more critical goals of allowing providers to objectively assess their own performances and strive to improve the quality and safety of care. Repairing this current, dysfunctional system will require a cooperative effort among all quality stakeholders, a clear vision with defined priorities, and a willingness to work toward common goals, such as simplifying the provider's experience while maximizing benefits to the beneficiaries and payers. BPC recommended the following:

- Private-sector stakeholders, in coordination with CMS should identify core measures for use across payers and delivery systems.
- Measures should be converted into a rating system

that can be understood by consumers. This translation should be done by the same private stakeholder group in coordination with CMS and with strong involvement of consumer groups. For example, CMS could use a system similar to (a revised and improved) Medicare's star rating system.

- The identification of core measures will require the continued endorsement of measures and recommended selection by a national standards-setting organization as well as identifying and prioritizing key measure gaps to fill. CMS and Congress should continue to support this effort.
- CMS should promulgate core measures as part of the Physician Quality Reporting System (PQRS) and other reporting initiatives, and should apply them across reimbursement models. As measures are promulgated, providers should be relieved of other reporting requirements.
- States that implement core measures in Medicaid (including pediatric measures) should receive an increase in Federal Medical Assistance Percentage (FMAP) (1 percent) for the first two years of implementation for claims made by plans or providers reporting core measures to the states. States must use these measures in lieu of other duplicative measures to receive enhanced matching.

Options for Reducing Health Costs and Improving and Simplifying Delivery



While BPC's 2013 cost-containment report included estimates of federal savings from policy recommendations, not all of the proposals were modeled for financial impacts on the Medicare program. Over the past year, BPC has worked to produce additional details and savings estimates for proposals to improve the accuracy of and eliminate counterproductive incentives within reimbursement for Medicare Part B drugs, to simplify and modernize Medicare benefits, and to extend differential payment updates to health care providers that are not paid under Medicare's physician fee schedule, such as hospitals, which would create stronger incentives for these providers to participate in APMs.

Reform Medicare Part B Drug Payment To More Accurately Reflect Actual Ingredient Costs And Remove Counterproductive Incentives

Payment for provider-administered drugs covered by Part B of Medicare should be reformed to establish neutral incentives for providers to prescribe and administer the most appropriate, high-quality treatment options, and to more accurately reflect ingredient costs. Current law pays providers more (over and above reimbursement for ingredient costs) when administering more expensive drugs. These reforms would address inappropriate incentives and result in savings for both beneficiaries—in

the form of reduced cost-sharing and supplemental insurance premiums—and for the Medicare program.

Background

Part B of the Medicare program covers drugs that are administered to Medicare beneficiaries by a physician or non-physician health professional—as opposed to Part D prescription-drug plans. Provider-administered drugs include common treatments for many cancers, macular degeneration, and other conditions. Medicare does not pay pharmaceutical manufacturers or wholesalers directly for Part B drugs. For beneficiaries in traditional Medicare, providers generally purchase these drugs themselves and then are reimbursed by the Medicare program.* This reimbursement is not based on what an individual provider actually paid for a particular Part B drug, but it is set at 106 percent of the average sales price (ASP) of the drug across all providers. CMS collects data from manufacturers, including information about the net sales prices paid (i.e., including rebates), to determine this average. The ASP plus 6 percent reimbursement is meant to cover the cost of the ingredient and any handling costs. Research from the Congressional Budget Office has found that capital costs associated with inventory are small to the point of being negligible and that handling costs are largely unrelated to ingredient cost. Providers are paid separately through the Medicare physician fee schedule to cover the cost of administering the drug to a patient, which includes the provider’s time, practice expense, and any equipment involved.

The current Medicare Part B drug payment methodology, based upon ASP, replaced the previous system based on average wholesale prices (AWP), which were “list” prices that did not reflect prices charged in the market, excluded rebates paid to

providers, and as a result substantially overstated actual (net) acquisition costs. While basing reimbursements on ASP represents a vast improvement over basing payments on AWP, opportunities for refinement remain. Paying ASP plus 6 percent can distort incentives for providers when there is a choice among medically appropriate treatments for a particular condition. Providers who prescribe and administer lower-cost treatment options are paid less by the existing payment formula. Additionally, some types of providers are systematically overpaid for their ingredient costs, and others are systematically underpaid.

Improve The Calculation of ASP So It Better Reflects Actual Provider Costs For Ingredients

Because providers must negotiate their own agreements to procure drugs that are covered by Medicare Part B, the actual price paid varies among providers. Some provider types, such as hospital outpatient departments, systematically pay less than other provider types, such as physicians’ offices. Additionally, CMS publishes ASPs with a two-quarter lag; in the first two full quarters, the gross price for a new drug (i.e., excluding discounts and rebates), known as wholesale acquisition cost (WAC), is the basis for reimbursement. Only after the second full quarter is reimbursement based on the net (ASP) price. In addition, some manufacturers have adopted a strategy (such as for newly launched “me too” drugs) of increasing discounts each quarter, so that the ASP used for reimbursement systematically lags the current (actual) market price.

* Private Medicare Advantage plans are free to develop their own payment arrangements with providers for provider-administered drugs.

Recommendation 1

Authorize the Secretary of HHS to create separate ASPs for provider types with systematically different drug-acquisition costs.

For example, if hospital outpatient departments acquire particular Part B drugs at meaningfully lower costs than physicians' offices, the Medicare program would create separate ASPs for those drugs. Such a policy would prevent providers with systematically lower acquisition costs from receiving windfalls, while also protecting providers with systematically higher acquisition costs from losing money when acquiring these drugs.

Recommendation 2

Authorize the Secretary to incorporate projections of pricing trends into the ASP calculation in those instances when she determines a systematic tendency for a published ASP to lag the current market price.

In those instances, the Medicare program would forecast expected ASPs (based on projected trends) and use the projected amounts as the basis for reimbursing those Part B drugs.

Reimburse providers for ingredient costs plus a flat add-on payment by category of drug.

Providers should be reimbursed 100 percent of ASP to cover the ingredient costs, but the 6 percent add-on should no longer provide incentives to prescribe higher-cost treatment options or disincentives to prescribe lower-cost therapeutic alternatives. These distortionary incentives caused by the 6 percent add-on payment could be addressed by improving the calculation of ASP (as described above) and establishing a flat add-on payment that does not vary with ingredient cost within a diagnostic and therapeutic category. An example of a diagnostic/therapeutic category would be anti-neoplastic (chemotherapy) drugs used to treat colon cancer.

Recommendation 3

Reimburse providers for Part B drugs with 100 percent of ASP plus a flat add-on payment per diagnosis and therapeutic class. The new flat add-on payment would be set equal to the average 6 percent add-on amount based on the most recent actual data.

Reimbursements for drug-ingredient costs would be unchanged. If there is no change in prescribing behavior, the policy would be budget neutral. If providers migrate toward lower-cost drugs, the add-on payments would be higher than they would have been under current law, but the savings on ingredient costs would be much larger and would result in overall savings for beneficiaries and the Medicare program.

Flat add-on payments will be established for all drugs prescribed first for a particular diagnosis (such as a type of cancer), and then for each therapeutic class within a diagnosis, if applicable. For example, for a cancer diagnosis, some Part B drugs will be administered to treat the cancer, and others will be administered to treat side effects; each of these would have a separate, flat add-on payment. This equalization of the add-on payments will result in higher add-on reimbursements for providers that utilize lower-cost treatment options and lower add-on reimbursements for providers that utilize higher-cost treatment options. For example, if a costly drug and a much less expensive drug are both clinically appropriate, a physician's choice should be based on what is best for the patient, and the reimbursement incentives should be neutral among the options. If the proposed policy results in a shift in provider prescribing behavior toward lower-cost Part B drugs for a particular diagnosis, there will be cost-savings for beneficiaries and the Medicare program. Acumen, LLC has analyzed this recommendation and estimates it would yield \$3.9 billion in deficit reduction between FY2016 and FY2025 and \$9.8 billion in deficit reduction between FY2016 and FY2035.

Recommendation 4

The Part B add-on payment for new drugs would be based on the existing flat payment amounts for the particular diagnosis and therapeutic class.

Reimbursements for drug-ingredient costs would be unchanged, but the add-on amount for new drugs (i.e., those in the first two full quarters) would no longer reflect 6 percent of WAC. The existing flat add-on payment for the relevant diagnosis and therapeutic class would likely be lower than an add-on payment based on 6 percent of WAC, resulting in cost-savings to beneficiaries and the Medicare program.

Medicare Benefit Modernization Proposal

A number of policymakers have recommended improving, simplifying, and modernizing Medicare's benefit package. Beneficiary advocates have raised concerns about this approach, concerned that beneficiaries would see higher out-of-pocket costs, which may result in barriers to access for low- and middle-income beneficiaries. BPC proposals for benefit modernization include the following recommendations:

Recommendation 1

Replace the outdated system of deductibles and co-insurance in order to strengthen the Medicare benefit, reducing the need for supplemental coverage, and allowing many beneficiaries to save money.

- Provide financial protection from the costs of a catastrophic illness by establishing an annual cost-sharing cap of \$5,400. This cap would cover cost-sharing for both Part A (hospital/facility care) and Part B (physician/medical care).
- Maintain preventive services and annual wellness visits with no beneficiary cost-sharing.

- Consistent with most insurance benefit designs, physicians' office visits would be subject to copayment, but the combined deductible would not apply.
- Medicare ACOs could waive primary-care office-visit copayments for assigned beneficiaries.
- Aggregate beneficiary cost-sharing amount would remain unchanged program-wide.

Recommendation 2

Revise Medicare supplemental coverage to address incentives for overuse of services and support development of APMs.

Under current law, which includes the passage of the MACRA, Medigap plans sold to newly eligible Medicare beneficiaries beginning in 2020 will be prohibited from covering the Part B deductible (\$147 per year in 2015). Under the BPC proposal, all supplemental plans, including Medigap, employer-sponsored plans, and TRICARE-for-Life, would be prohibited from covering first-dollar beneficiary cost-sharing.

Recommendation 3

Expand cost-sharing assistance to beneficiaries up to 150 percent of poverty.*

Currently, help with cost-sharing is available for Medicare beneficiaries with income below 100 percent of the federal poverty level (FPL), but not for those with incomes just above the poverty level. This new assistance would reduce cost-sharing by 50 percent for beneficiaries between 100 percent and 135 percent of FPL, and 25 percent for those between 135 percent and 150 percent of FPL.

* This new low-income assistance would be federally funded and administered. There would be no resource test, and those who file an income-tax return and meet income-eligibility guidelines would be automatically enrolled.

Recommendation 4

Reduce subsidies for higher-income beneficiaries.

The vast majority of Medicare beneficiaries pay Part B and D premiums equal to 25 percent of program costs or less, and about 10 percent of beneficiaries pay more. Under the BPC proposal, about 20 percent of Medicare beneficiaries would pay higher, income-related premiums.

As a result, BPC's benefit redesign reduces overall costs for beneficiaries, producing savings for the Medicare program and taxpayers, and adopting a modern insurance design that gives beneficiaries, as well as providers, a stake in appropriate utilization. Most importantly, these reforms seek to provide beneficiaries protection against the costs of catastrophic illness through a simpler and more up-to-date benefit structure. Acumen, LLC estimates that this package of Medicare benefit modernization proposals would yield \$40 billion in deficit reduction between FY2016 and FY2025 and \$150.6 billion in deficit reduction between FY2016 and FY2035.

Extend Differential Updates to All Medicare Providers

Summary of Proposal

BPC proposes two changes to Medicare payment policy that would expand upon the reforms included in MACRA. Under these proposed reforms, all Medicare providers, not only physician-fee-schedule providers, would have stronger incentives for APM participation and would assume greater levels of risk.

Differential updates for physician-fee-schedule providers would be implemented in 2018, five years earlier than the schedule enacted in MACRA. Three levels of updates would apply. Physician-fee-schedule providers who do not participate in any APMs (fee-for-service-only) would receive 0 percent annual fee-schedule payment-rate updates; those participating in one-sided risk APMs

(such as PCMHs and one-sided risk ACOs) would receive 0.5 percent annual fee-schedule payment-rate updates; and those participating in two-sided risk APMs (such as payment bundles or ACOs that are at two-sided risk, or on their way to two-sided risk within the three-year contract period) would receive 1 percent fee-schedule payment-rate updates. After five years of differential updates, the fee-schedule payment rates for physician-fee-schedule providers at two-sided risk would be permanently approximately 5 percent higher than those not participating in APMs. From 2023 on, all physician-fee-schedule providers would receive updates based on the Medicare Economic Index going forward.

Additionally, differential updates would be extended to non-physician fee-schedule providers (all other Medicare fee schedules, such as those for hospitals and post-acute care providers) by reducing payment rate updates for non-physician Medicare providers that do not participate in two-sided risk APMs. For five years, beginning in 2018, current law updates for non-physician-fee-schedule providers would be reduced by 1 percentage point for those not participating in APMs; reduced by a 0.5 percentage point for those participating in one-sided risk APMs (one-sided risk ACOs); and no reduction for those participating in two-sided risk APMs (such as two-sided risk ACOs or payment bundles). From 2023 on, normal payment updates would apply to all providers, so there would be a permanent approximately 5 percent differential between the payment rates for all Medicare providers participating in two-sided risk APMs and those providers not participating in APMs.

Providers participating in ACOs, either as members or as part of an ACO's network, would receive the higher payment rate when providing services to a beneficiary who has been attributed to or voluntarily enrolled in the ACO. Services to beneficiaries who

are not attributed and did not opt-in would not be eligible for the higher rate. CMS should adjust ACO benchmarks upward so providers adopting APMs are not penalized through the shared-savings calculation for these differential updates. Acumen, LLC estimates that these two policy changes would yield \$122.5 billion in deficit reduction between FY2016 and FY2025 and \$376.7 billion in deficit reduction between FY2016 and FY2035.

Table 3. Estimated Cost-Savings from BPC Delivery System Reform Proposals

(Billions of dollars, by fiscal year) All estimates from Acumen, LLC unless otherwise noted.

Medicare	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016-2025	2016-2035
1. Reform Medicare Part B Drug Payment	-0.1	-0.3	-0.4	-0.4	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-3.9	-9.8
2. Medicare Benefit Modernization (Total)	0.0	-2.1	-3.0	-3.3	-3.8	-4.4	-4.8	-5.5	-6.3	-6.8	-40.0	-150.6
a. Supplemental Coverage	0.0	-4.6	-6.4	-6.8	-7.1	-7.6	-8.0	-8.5	-9.0	-9.5	-67.7	-185.8
b. Low-Income Assistance	0.0	5.8	8.0	8.3	8.7	9.1	9.6	10.2	10.7	11.1	81.5	218.3
c. Expansion of Income-Related Premiums	0.0	-3.3	-4.6	-4.9	-5.3	-5.9	-6.4	-7.1	-7.9	-8.5	-53.9	-183.1
3. Extend Differential Updates to All Medicare Providers	0.0	0.0	0.8	0.0	-0.9	-8.4	-19.0	-26.8	-34.5	-33.8	-122.5	-376.7
Federal Budget Deficit Reduction	-0.1	-2.4	-2.6	-3.7	-5.1	-13.2	-24.3	-32.7	-41.2	-41.1	-166.4	-537.1

Conclusion: Continuing Challenges



As outlined above, a number of steps have been taken within the last year in both the public and private sectors to advance delivery system reform. Additional action can and should be taken to accelerate change. BPC's Health Project will continue efforts to develop policy solutions in delivery reform. In addition to promoting further changes to APMs as outlined in the four white papers, other issues can and should be addressed to improve quality and slow cost growth in the health care system. BPC will continue its efforts in these and other areas, including:

The Role of Patients—Current models of care too often fail to enlist patients and their families. New models of care should engage patients to best understand their goals, including decisions

for those living with advanced illness. This will require rewarding systems of care that include individual patient assessments and the development of care plans, particularly for patients with multiple chronic conditions and who need assistance with one or more activities of daily living. While some providers successfully engage patients, others do not. Patients need more information on their options in care delivery, settings, and services. Moreover, patients would benefit from meaningful price and quality information. This information must be provided in a format that is useful to consumers.

Market Consolidation—To ensure adequate competition in individual health care markets, more work should be done to

assure that market consolidation promotes efficiency rather than driving up prices. Some states have begun to take action to make information available, but federal and state laws make it difficult for researchers, patients, and consumers to understand whether market consolidation is done for the purposes of better integrating care and reducing costs or for consolidating market share and increasing costs.

Consistency Across Payers—Organized delivery systems contract with multiple payers, including Medicare, Medicaid, and commercial payers, each of whom have different contract requirements that often do not align. Quality measures and contracting and reporting requirements should be broadly consistent across payers to best to reduce administrative burdens and improve care.

Constrained Budgets for Innovation—In the current budget environment, the longevity of CMS’s ability to continue to test models should be assured. With available resources, CMS needs to be able to accurately evaluate models of care and participants’ performances in those models in order to scale and spread successful models nationally.

End Notes

¹ Pub. Law 114-10, the Medicare Access and CHIP Reauthorization Act. Available at: <https://www.congress.gov/114/bills/hr2/BILLS-114hr2enr.pdf>.

² “Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value,” Department of Health and Human Services, January 26, 2015. Available at: <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>.

³ Details available at: <http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>.

⁴ David Muhlestein, “Growth And Dispersion Of Accountable Care Organizations In 2015,” Leavitt Partners analysis, Health Affairs, March 31, 2015. Available at: <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>; CMS, “Fast Facts: All Medicare Shared Savings Program (Shared Savings Program) ACOs and Pioneer ACOs,” April 2015, available at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCCombinedFastFacts.pdf>

⁵ David Muhlestein, “Growth And Dispersion Of Accountable Care Organizations In 2015,” Leavitt Partners analysis, Health Affairs, March 31, 2015. Available at: <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>.

⁶ Sources: CMS, “Pioneer Accountable Care Organizations succeed in improving care, lowering costs,” July 2013, available at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html>; CMS, “Medicare ACOs continue to succeed in improving care, lowering cost growth,” November 2014, available at: <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-11-10.html>; HHS Office of the Actuary, “Certification of Pioneer Model Savings,” April 2015, available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Pioneer-Certification-2015-04-10.pdf>; L&M Policy Research, “Evaluation of CMMI Accountable Care Organization Initiatives: Pioneer ACO Evaluation Findings from Performance Years One and Two,” March 2015, available at: <http://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf>.







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