BIPARTISAN POLICY CENTER

Medicare Networks: A Proposal for the Future of ACOs

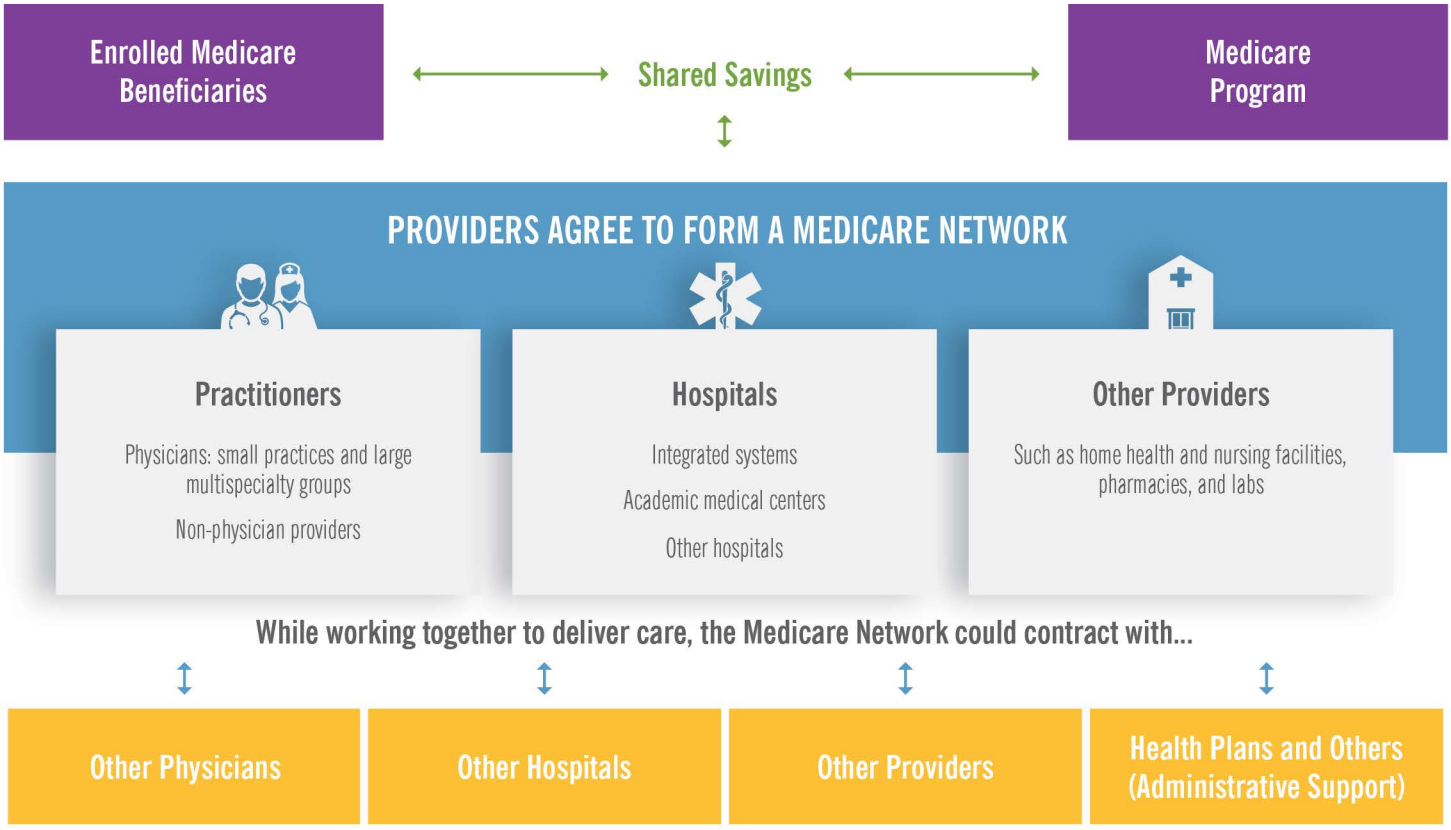
What are they?

Medicare Networks would be an enhanced, enrollment-based model for the future of accountable care organizations (ACOs). Similar to today's ACOs, Medicare Networks would be formed and led by health care providers who would be held responsible for the cost, quality, and coordination of care delivered to a defined group of beneficiaries. Unlike today's ACOs, beneficiaries would have the opportunity to select their Medicare Network and would have incentives to access care from Medicare Network providers. Networks could be paid entirely through the Medicare fee schedules or accept partial capitation, in which networks would receive a combination of a fixed per-beneficiary payment plus some payment through the fee schedules. Future fee-schedule updates would be reserved for providers who form or join a Medicare Network, which would be measured against regional benchmarks.

Key Features

Provider-formed and -led.

Medicare Networks would be formed by a group of providers who want to work together to deliver care. A network could include, for instance, small physician practices, large multispecialty physician groups, and hospitals. It might also include other providers, such as post-acute care facilities or mental/behavioral health providers.



Internal governance process.

Like today's Medicare Shared Savings Program (MSSP) and Pioneer ACOs, each Medicare Network would have an internal governance process, such as a board of directors elected by the member providers. Each network would agree on how to work together, how to share any savings, and how to distribute any losses. In the Bipartisan Policy Center's envisioned Medicare Networks, providers could have two kinds of relationships with a Medicare Network.

Some providers could be members involved in the governance of the Medicare Network (i.e., contracting with the Centers for Medicare and Medicaid Services, determining how to use any shared savings, and making business decisions related to the network).

Other providers might choose to contract with one or more Medicare Networks to provide services for their enrollees but would not be a member involved in the network governance.

Transition to regional spending targets.
Initially, each Medicare Network would have a unique spending target based on the historical spending of enrolled beneficiaries; over time, Medicare Networks would transition to regional spending targets based on per-beneficiary spending. The new spending targets would be risk-adjusted and would encourage inefficient providers to improve their performance relative to others within their region. Additionally, all Medicare Networks would be required to transition to two-sided risk over time (included, for example, as part of Medicare legislation), meaning that, in addition to potentially sharing in any savings, providers would be responsible for absorbing a portion of any excess spending over the target.

Higher-payment-rate updates for providers in Medicare Networks.
Physician-Fee-Schedule Providers. Physicians who participate in Medicare Networks (either as a member involved in governance or as part of a provider network) would receive updates based on the Medicare Economic Index minus a productivity adjustment (a measure of the annual increase in the cost to operate a practice). Physicians who do not participate in Medicare Networks or other alternative payment models would receive current law updates, which are significantly lower.

All Other Medicare Providers. For a period of six years, current law updates would be reserved for those participating in Medicare Networks. Providers who participate only in the fee-for-service portion of traditional Medicare would be protected from payment-rate reductions; however, their payment rates would be frozen during that period. Any Medicare-covered services delivered in the context of a Medicare Network would be reimbursed by the Centers for Medicare and Medicaid Services at the higher (non-frozen) rate.

Enrollment-based model.
Beneficiaries could choose to enroll in a Medicare Network and could take advantage of the coordinated nature of in-network care. Medicare Networks would provide the beneficiaries with the opportunity to directly engage with a coordinated system of care, unlike the current ACO structure where beneficiaries are passively assigned to an ACO based on claims data and many times are not aware they are part of the program.

Shared savings with beneficiaries.
Beneficiaries who enroll in a Medicare Network would be guaranteed at least a $60 annual discount on their Medicare premium for the first three years, after which the discount would depend on network performance. If a network meets quality goals and generates savings, a portion of the Medicare program's share of the savings would be redirected to reduce the monthly premium for enrollees of that network. Cost-sharing would be based on the traditional Medicare benefit design; however, enrollees would benefit from reduced cost-sharing (in the form of lower copayments or coinsurance) for services from in-network providers, but would pay higher cost-sharing to receive service from out-of-network providers. Medicare Networks would be required to meet standards for network adequacy and consumer protection.

Key Differences between Existing Medicare ACOs and Proposed Medicare Networks

Existing Medicare Accountable Care Organizations	Medicare Networks
Weak incentives for providers to participate.	Stronger incentives for providers to participate—full payment updates reserved for care delivered within Medicare Networks.
Paid through the Medicare payment schedules, with opportunities for different payment methods limited to demonstrations.	Could be paid entirely through the Medicare payment schedules or could accept partial capitation.
Providers can share in savings without taking any risk (one-sided risk).	Providers would share in both savings and excess cost growth (two-sided risk).
No patient engagement—beneficiaries are automatically assigned and have no incentive to access care delivered within the ACO.	Patients would be engaged from the beginning – patients in traditional Medicare could choose to enroll in a Medicare Network and enrollees would pay lower cost-sharing for in-network care, higher cost-sharing for out-of-network care.
Beneficiaries do not share in savings.	For consistently high-performing Medicare Networks, a portion of the savings would be devoted to a premium rebate for enrollees.

The concept for Medicare Networks is part of a comprehensive approach to health care delivery system improvement first proposed by the Bipartisan Policy Center (BPC) in April 2013, which also includes a modernization of Medicare's benefit design (bipartisanpolicy.org/benmod), a reformed, competitively priced Medicare Advantage program, and reforms to the tax treatment of employer-sponsored health insurance, among other proposals. BPC's Delivery System Reform Initiative has built upon this system-wide approach to dive deeper into alternative models of care and what is needed to successfully transition to models that improve the care experience and reduce health care costs.

To learn more, please see A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment at: *http://bipartisanpolicy.org/library/health-care-cost-containment/* and Transitioning to Organized Systems of Care: Near-Term Recommendations to Improve Accountable Care Organizations in Medicare at: *bipartisanpolicy.org/aco-medicare*

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