MILLIMAN ISSUE BRIEF

Population-based payments (PBPs) open door for ACOs to more effectively manage care

Noah Champagne, FSA, MAAA
Jason McEwen, FSA, MAAA

Milliman

Accountable care organizations (ACOs) are regularly searching for new tools to better manage care and more effectively provide services to Medicare beneficiaries. Historically, Medicare ACOs have been largely unable to utilize two key care management tools: preferred networks and preferred pricing. However, the Next Generation ACO model introduced a provider payment mechanism called population-based payments (PBPs) that allows ACOs to negotiate provider payment rates and may allow more effective management of resource use.

The Centers for Medicare and Medicaid Services (CMS) introduced the Next Generation ACO model (NextGen) in 2016 to offer a higher-risk/higher-reward shared savings program targeted at more mature ACOs that may have greater abilities to control costs. Due to the high level of risk associated with the NextGen model, participants need to generate sufficient returns in order to justify the risk of the program. The NextGen model includes PBPs, a concept not present in the Medicare Shared Savings Program (MSSP). PBPs allow NextGen ACO participants to generate additional returns to both offset care management infrastructure costs as well as provide more value to its beneficiaries.

The PBP mechanism sees CMS pay participating providers a predefined percentage of the typical fee-for-service (FFS) rates for a claim, while paying the ACO the remaining portion of the claim[1]. The ACO is then responsible for paying the portion of the claim payment it received to the provider according to their contractual arrangement. If the ACO is able to negotiate a payment structure with these participating providers that ends up being lower-cost than the FFS rates for the same claims, then the ACO can generate additional income from the arrangement. This potential additional revenue will allow ACOs to provide greater value to their beneficiaries (through reinvestment) as well as further manage utilization and costs.

The NextGen program is small in size in comparison to the MSSP and, as such, PBP use is currently limited. However, CMS has shown the propensity to implement methodologies and policies introduced in the NextGen program into the MSSP (e.g., capped risk adjustment). Therefore, while PBPs are currently limited to a few NextGen participants, CMS could potentially incorporate PBPs into the MSSP or other risk-sharing programs in the future.

Payment mechanisms

The NextGen program tests the effectiveness of a few alternative payment mechanisms in facilitating investments in infrastructure and care coordination to improve health outcomes.[2] As of 2017, NextGen participants can elect to use one of the following four payment mechanisms in a given performance year:

1. Normal FFS payment.
2. Normal FFS payment plus monthly infrastructure payment.
3. Population-based payments (PBPs)
4. All-inclusive population-based payments (AIPBP)

The first two payment mechanisms both involve CMS paying FFS claims directly to the provider who is submitting the claims. Under the second payment mechanism the ACO also receives a monthly payment (infrastructure payment), which must be repaid at the end of the performance year.

However, the third and fourth payment mechanisms differ from the first two in that a portion (or all in the case of the AIPBP) of the FFS claims payments for specific providers are paid by CMS to the ACO instead of directly to the participating provider. The ACO is then responsible for paying participating providers the remainder of the claims payments owed, according to their contractual agreements. Any providers within the ACO that do not wish to participate in this agreement will continue to receive FFS payments directly from CMS.

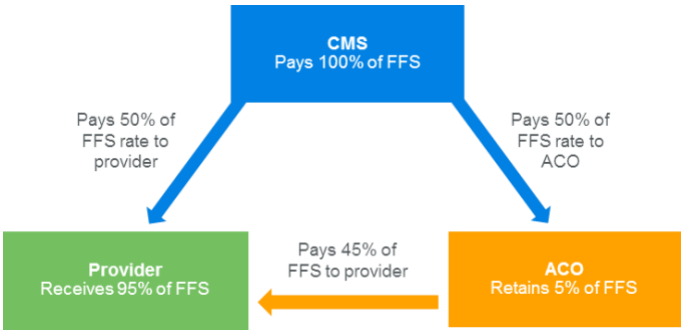
An example of a PBP arrangement is shown in Figure 1. In this example the provider has agreed to receive 50% of its traditional FFS payment directly from CMS. The ACO has negotiated with this provider to pay only 45% of FFS for the remaining 50% it would have received from CMS. As such, the provider will be paid 95% of traditional FFS while the ACO will retain 5%. It is important to note that these contractual arrangements do not impact the calculation of savings

[1] Operationally, CMS provides the ACO with the estimated total claims amount each month, and this amount is later reconciled based on actual utilization.

[2] CMS. Next Generation ACO Model: Request for Applications. Retrieved September 30, 2018, from https://innovation.cms.gov/Files/x/nextgenacorfa.pdf.

compared to the NextGen benchmark, as CMS is still paying out 100% of the FFS rate for each claim.

FIGURE 1: EXAMPLE OF A POPULATION-BASED PAYMENT ARRANGEMENT



The PBP payment mechanism (mechanism 3) allows specific providers (as indicated by the NextGen ACO) to receive a reduced FFS payment from CMS (anywhere from a 1% to a 99% reduction). The percentage received can vary by provider. CMS will pay the ACO the remaining portion of the FFS payment in estimated monthly installments, with a reconciliation at the end of the year.

Similarly, the AIPBP payment mechanism (mechanism 4) allows the entirety of CMS's FFS payment for the specified providers to be paid to the ACO. The ACO is then responsible for paying participating providers according to their contractual arrangements with the ACO, which may include metrics beyond service volume (e.g., quality measures).

Strategy for additional ACO revenue

Both the PBP and the AIPBP payment mechanisms allow the ACO to receive FFS payments from CMS and then pay providers for all or part of services rendered, based on contractual arrangements between the ACO and the participating providers. This gives the ACO the flexibility to enter into a contract with providers to pay less than FFS payment rates and retain any differences. These arrangements would also allow for ACOs to enter into capitation or other payment arrangements that are dependent on quality or cost metrics, which may result in additional revenue for the ACOs. The ACO may only be able to successfully negotiate these types of arrangements with a subset of their provider roster.

NextGen ACOs can leverage their relationships with primary care providers and other referring physicians to secure favorable payment arrangements with downstream providers as well as improve the efficiency of care.

For example, a cardiologist might be willing to agree to be paid 90% of Medicare FFS rates for all of the NextGen ACO's members if the ACO PCPs agree to refer their cardiology cases to that specific cardiologist, when appropriate. This may provide the cardiologist with additional customers while allowing the ACO to retain 10% of all cardiology claims performed by that specific provider.

Experience with Medicare Advantage (MA) has shown that providers are willing to accept a reimbursement rate lower than 100% of traditional Medicare FFS. A study performed in 2017 by Trish, Ginsburg, and Gascue reviewed claims data from 2007 through 2012 and found that the average MA reimbursement for common physician services varied between 91.3% and 100.2% of traditional Medicare FFS payments.[3] As beneficiaries are not restricted to only utilizing in-network providers in an ACO, the contracted savings realized by the ACO may not reach the levels found in MA.

Current NextGen ACOs should approach providers within their ACOs to discuss renegotiating the payment arrangement for NextGen beneficiaries. Providers that have a high amount of regional competition and may be struggling to keep their facilities at capacity would be ideal partners for this type of arrangement (e.g., SNFs, radiology centers, labs, ambulatory surgical centers, etc.). Additionally, an ACO's providers may accept a lower overall reimbursement rate in exchange for more favorable terms in receiving shared savings. ACO's should also consider other factors when entering contractual arrangements, such as quality of care, coding patterns, and other medical management considerations. For NextGen ACOs struggling to achieve satisfactory returns from the program, this type of arrangement could be a valuable lifeline that allows the ACO to continue to invest in care management with the goal of achieving savings in the NextGen program.

Conclusion

PBPs provide ACOs with an alternative funding mechanism that can be used to improve overall care management with the goal of achieving higher savings. While this payment mechanism currently is restricted to the NextGen program, the introduction of this key managed care tool is an indication that CMS is interested in providing ACOs with additional mechanisms to manage care delivery in order to improve their overall value and effectiveness. If the population-based payment (PBP) mechanism proves successful in the NextGen environment, CMS could introduce a similar flexibility to the MSSP or other risk-sharing programs.

CONTACT
Noah Champagne
noah.champagne@milliman.com

Jason McEwen
jason.mcewen@milliman.com

[3] Trish, E., Ginsburg, P., & Gascue, L. (September 2017). Physician reimbursement in Medicare Advantage compared with traditional Medicare and commercial health insurance. JAMA Internal Medicine. Retrieved September 30, 2018, from https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643349.