POLITICS & REGULATION

Why a new Medicare ACO model is exciting value-based care groups

The new model builds upon prior demonstrations and expands the realm of who might participate in value-based care, experts said. (MH Illustration/iStock)

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Key Takeaways

- The Trump administration in December announced the launch of the Long-term Enhanced Accountable Care Organization Design model, or LEAD, next year.
- Accountable care organizations and value-based care groups say LEAD's features offer up long-term financial predictability.
- The model also makes it easier for a wider array of participants to explore value-based care, observers said.

A new model from the Center for Medicare and Medicaid Innovation could expand value-based care to more healthcare organizations.

The Trump administration in December announced it would launch the Long-term Enhanced Accountable Care Organization Design model, or LEAD, next year.

Industry groups say LEAD's features offer long-term financial predictability and make it easier for a wider array of participants to explore value-based care opportunities.

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LEAD is a 10-year voluntary, capitated ACO model that will run through 2036. The demonstration succeeds ACO Realizing Equity, Access and Community Health, or ACO REACH, which sunsets in December.

LEAD features two risk-sharing options determining ACOs' financial accountability. Under the global risk track, participants are liable for 100% of losses relative to a performance benchmark but eligible to retain 100% of savings. The professional risk track allows participants to evenly split losses and savings with the government.

LEAD's benchmarking formula, its bundled payment options and its efforts to engage high-cost healthcare providers could make value-based care opportunities more attractive to a wider swathe of the healthcare industry.

Benchmark changes

LEAD's benchmarking strategy builds on the methodologies used for ACO REACH and the Medicare Shared Savings Program program. But it also establishes new policies strengthening incentives for organizations to participate, CMMI said in a March 31 request for applications.

For starters, LEAD participants will not undergo rebasing, which resets financial benchmarks based on an ACO's past performance, for the duration of the 10-year model.

One side effect of rebasing is that high-savings ACOs must meet benchmarks that are increasingly hard to exceed. This "ratchet effect" has long been the subject of consternation among participants in the Shared Savings program and other models. The organizations have said it jeopardizes long-term participation by reducing incentives for ACOs to produce savings.

Addressing the ratchet effect is a clear instance of CMMI listening to industry concerns, particularly among ACO REACH participants that had begun to be affected by

those pressures, said Valinda Rutledge, executive vice president of policy and advocacy for the trade organization America's Physician Groups.

Incorporating this and other feedback into LEAD helps alleviate the likelihood that high performers in the model drop out because of benchmarking pressures that undercut their success, Rutledge said.

CMMI is also establishing guardrails for a benchmark component known as the Accountable Care Prospective Trend, a forward-looking factor meant to help estimate Medicare cost growth. But Medicare costs have been difficult to predict in the years since the COVID-19 pandemic began, said Aisha Pittman, senior vice president of government affairs at the National Association of ACOs.

LEAD proactively sets upper and lower limits on ACPT estimations. Pittman called the move a highly positive step that will likely help provide financial predictability for participants.

High-cost tweaks

Most new ACOs joining a model have tended to operate more efficiently relative to their local peers, said Sean Cavanaugh, chief policy officer of Bethesda, Maryland-based Aledade and head of the Aledade Policy Institute.

Higher-cost providers have historically sat out, he said.

CMS' goal to increase value-based care participation — and begin getting high spenders to reduce their costs — resulted in two key model features specific to high-cost participants, Cavanaugh said.

LEAD sets a lower amount of money high-cost ACOs must pay back to CMS before they can begin receiving their shared savings, known as the "discount."

It also offers high-cost participants a monthly capitated payment they can invest in care coordination and other infrastructure that will help them perform well in LEAD.

"When you add those two things together, that's a real advantage for high-cost ACOs to come into this model," Cavanaugh said.

Risk adjustment

LEAD will also feature two risk-adjustment models to help account for patient costs: one for ACOs' general populations and a concurrent one for high-needs populations.

This gives participants more flexibility to care for high-needs individuals without creating separate tracks for ACOs caring for these enrollees, said Jennifer Podulka, senior vice president of federal policy for America's Physician Groups.

Bundled payments

One feature of LEAD, CMS-Administered Care Arrangements, offers ACOs more opportunity to engage specialists while building on demonstrations such as the Bundled Payments for Care Improvement model.

CARAs are voluntary, episode-based, two-sided risk arrangements between ACOs and outside specialists. They effectively enable ACOs to contract with specialists based on episodes of care.

CMS will offer ACOs data and pricing information on certain care episodes to help them develop relationships with specialists and bring down costs.

The CARAs are meant to address "a critical gap where specialists drive significant healthcare costs but remain largely outside accountability frameworks," CMS says in its request for applications.

The CARAs will give LEAD ACOs more negotiating ability with specialists, Pittman said.

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