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MEDICARE

Voluntary and Mandatory Episode-Based Payment Models and Their Participants

GAO Highlights

Highlights of GAO-19-156, a report to Ranking Member, Committee on Finance, U.S. Senate

Why GAO Did This Study

In 2017, expenditures for health care services provided through traditional Medicare totaled approximately $394 billion and were expected to grow to $730 billion by 2027. This 85 percent increase is expected to be driven by multiple factors, including increases in the number of services provided per beneficiary. In an effort to slow this growth and improve the quality of care provided to beneficiaries, CMS is testing alternatives to traditional Medicare, such as episode-based payment models. Under episode-based payment models, providers such as hospitals or physician group practices are held accountable for the cost and quality of the services provided to Medicare beneficiaries during a defined episode of care.

GAO was asked to review the episode-based payment models developed by CMS. This report (1) describes the characteristics of the providers that participated in these models and (2) compares the relative advantages of voluntary versus mandatory episode-based payment models, as identified by stakeholders.

GAO analyzed CMS data on participants and other providers and reviewed CMS's evaluations of the models. GAO also interviewed multiple stakeholders, including officials from CMS, its contractors, selected providers and organizations representing providers, as well as Medicare experts.

The Department of Health and Human Services provided technical comments on a draft of this report. GAO incorporated these comments as appropriate.

View GAO-19-156. For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov.

What GAO Found

As of February 2018, the Centers for Medicare & Medicaid Services (CMS) had tested, or was in the process of testing, six episode-based payment models as alternatives to traditional Medicare. In these models, rather than pay providers largely based on the volume and complexity of each individual service, CMS establishes a target payment amount to cover the costs of all the services Medicare beneficiaries may receive during a defined "episode of care" initiated by a health care event, such as a surgical hospitalization. Providers can earn additional payments if they treat beneficiaries for less than the target amount and meet certain quality metrics; in some models, providers may be penalized for expenditures that exceed the target amount or if the care provided does not meet quality goals. Provider participation in all but one of the six models being tested is entirely voluntary (i.e., eligible providers may choose to participate in the model and generally have an option to leave the model before testing ends), with participation in the remaining model mandatory for some providers (i.e., eligible providers must participate and cannot leave the model before testing ends).

According to CMS data and reports that GAO reviewed, providers participating in the six episode-based payment models typically had more beds or larger practices, had higher episode volume, and were more often located in urban areas compared to all providers that participated in traditional Medicare. Stakeholders—participants, experts, and provider groups—that GAO interviewed noted that the likelihood for financial gain under voluntary models can influence providers' decisions to participate in the models.

Stakeholders also identified relative advantages of voluntary versus mandatory episode-based payment models. In general, stakeholders reported that voluntary models largely benefit providers. For example, these models tend to have more generous terms and providers can choose to participate in only those models where they are likely to be successful. On the other hand, mandatory models are more likely to give CMS generalizable evaluation results.

Relative Advantages of Voluntary versus Mandatory Episode-Based Payment Models Identified by Stakeholders

Voluntary	Mandatory
Participants often have more favorable terms of participation (e.g., types of model incentives and degrees of risk required) than in mandatory models, as CMS has an incentive to make the model attractive so providers willingly participate.	CMS and its evaluation contractors are able to evaluate the performance of participants that are more representative of different types of providers and as such, the model's evaluation results are more generalizable.
Participants have the ability to self-select models and episodes where they have identified opportunities to successfully implement care redesign and earn performance bonuses.	CMS can test models with greater financial risks and penalties because providers are required to participate.
CMS and its evaluation contractors are able to test novel concepts in care redesign with early adopters that are interested in performing well under the model. This allows CMS to assess the feasibility of a model before additional testing.	CMS can encourage transition from traditional Medicare to value-based care models among providers that may be reluctant to make the change on their own.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) model evaluation reports and interviews with participants, experts, and provider groups.