Medicare's Shared Savings Program for ACOs

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MEDPAC

PPACA definition of an ACO

- An organization whose primary care providers are accountable for coordinating care for at least 5,000 Medicare beneficiaries
  - Having a hospital or specialists in the ACO is optional
  - Patients assigned to ACO using primary care claims
- Required capabilities:
  - Distribute bonuses
  - Define processes to promote evidence-based medicine
  - Report on quality and cost measures
  - Be patient-centered
- The beneficiary can still choose any provider inside or outside of the ACO

Building on last month's discussion

- Informing patients of a primary care provider's decision to join an ACO
- Quality metrics in general
- Size and random variation
- Benchmarks and historical spending
- Two-sided risk model in addition to a high-threshold bonus-only model

How assignment works

- Assignment is to be based on utilization of primary care services
- Beneficiaries do not enroll, they are assigned
  - First, a provider chooses to join an ACO
  - Second, CMS assigns patients to the provider
- If the patient is informed in advance, then assignment must be prospective

Inform beneficiaries when primary care provider joins ACO, beneficiary can opt out

- Fulfills beneficiary right to be informed
- Avoids equivalent of “managed care backlash”
- Gets patient engaged in care management
- “Opt out” means either choose a different provider or data doesn’t count in ACO evaluation
- The default is stay in ACO, participate in care management

ACOs create an opportunity to synchronize a small set of quality metrics

- Small set of output oriented measures for example:
  - Emergency department use
  - Potentially preventable admission rates
  - In–hospital mortality rates (possibly patient safety measures)
  - Readmission rates
  - Patient satisfaction and health status
- Work across all payers

How much random variation is there?

	Pools of 5,000 beneficiaries		Pools of 10,000 beneficiaries		Pools of 20,000 beneficiaries	
	10th %	90th %	10th %	90th %	10th %	90th %
Difference between 2006 to 2007 growth in spending per capita and national average growth rate	-3.6%	4.0%	-3.1%	3.0%	-2.1	2.1%

Source: MedPAC analysis of 2006 and 2007 from the CMS Beneficiary annual summary file. Variation in spending for 1000 random pools of beneficiaries (for each size category) who were enrolled and alive on January 1, 2006 and January 2, 2007.

Result: CMS needs to require a savings "threshold" to prevent excessive bonuses for random variation

Small ACOs will have problems measuring efficiency and managing care

- CMS must limit bonuses paid for random variation in costs and quality, will require large thresholds in bonus-only model for small ACOs
- Small ACOs may not be equipped to manage the full spectrum of care
- CMS could require persistent savings over years

Benchmarks should not be purely based on historical spending

- Growth allowance set to projected absolute amount of growth in national FFS per capita expenditures
- Represents higher percentage of growth for lower–spending ACOs
- But, does it penalize for past good behavior?
- Could set higher target for lower spending, lower target for higher spending—but, don't want to discourage ACOs in higher spending areas

Setting ACO-specific Medicare spending targets

	National	ACO spending		
	average	low	average	high
Base spending	$10,000	$7,000	$10,000	$12,000
$ target growth	500	500	500	500
Target spending	$10,500	$7,500	$10,500	$12,500
Resulting growth allowance	5.0%	6.3%	5.0%	4.2%

Assumption: Wage index = 1

Adjusting target growth amount by historical spending

	National average	ACO spending		
		low	average	high
Base spending	$10,000	$7,000	$10,000	$12,000
$ target growth	500	600	500	400
Target spending	$10,500	$7,600	$10,500	$12,400
Resulting growth allowance	5.0%	8.6%	5.0%	3.3%

Assumption: Wage index = 1

Weak incentives in bonus-only model

- Two types of incentives
  - Strong group incentives to reduce FFS revenue of providers outside of the ACO
  - Weak group incentive to reduce ACO's own revenue
- Will only cut their own FFS revenue if there is a strong possibility of a large enough bonus
- Why is the bonus uncertain?
  - Must meet threshold—threshold may be large for small ACOs
  - Random variation can offset savings, resulting in no bonus

Two-sided risk model

- Symmetric upside and downside risk
- Risk corridors to protect ACOs from large swings (e.g. a limit of 4 or 5%)
- No threshold—bonus for first dollar savings
- Downside protection
- Possible extensions
  - waivers from some regulations
  - waiver of some cost-sharing for beneficiaries

Summary

- Informing the beneficiary
- A small set of quality measures
- Limitations of small ACOs
- Benchmarks reflecting levels of use
- Two-sided risk model with corridors as an alternative to a high-threshold bonus-only model