Advising the Congress on Medicare issues

Medicare accountable care organizations (ACOs): Recent developments and future directions

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Today's presentation

- Background
- Recent developments
- Shorter-term opportunities
- Longer-term possibilities

Motivation for ACOs

- Needed a mechanism to counteract the incentive for volume growth in FFS
- Reward improved quality
- MA incentives without capitated payment or claims processing
- No limitation on beneficiary's choice of providers

ACOs' place in the payment spectrum

Pure FFS	ACO	MA
Pay by service	Mixed payment: FFS payment +/- shared savings	Pay for population Full capitation
Silo-based	All Part A&B	All Part A&B
Some VBP	Quality incentive	Quality bonus
No risk	Limited risk	Full risk

Payment and delivery system integration

VBP = value based purchasing

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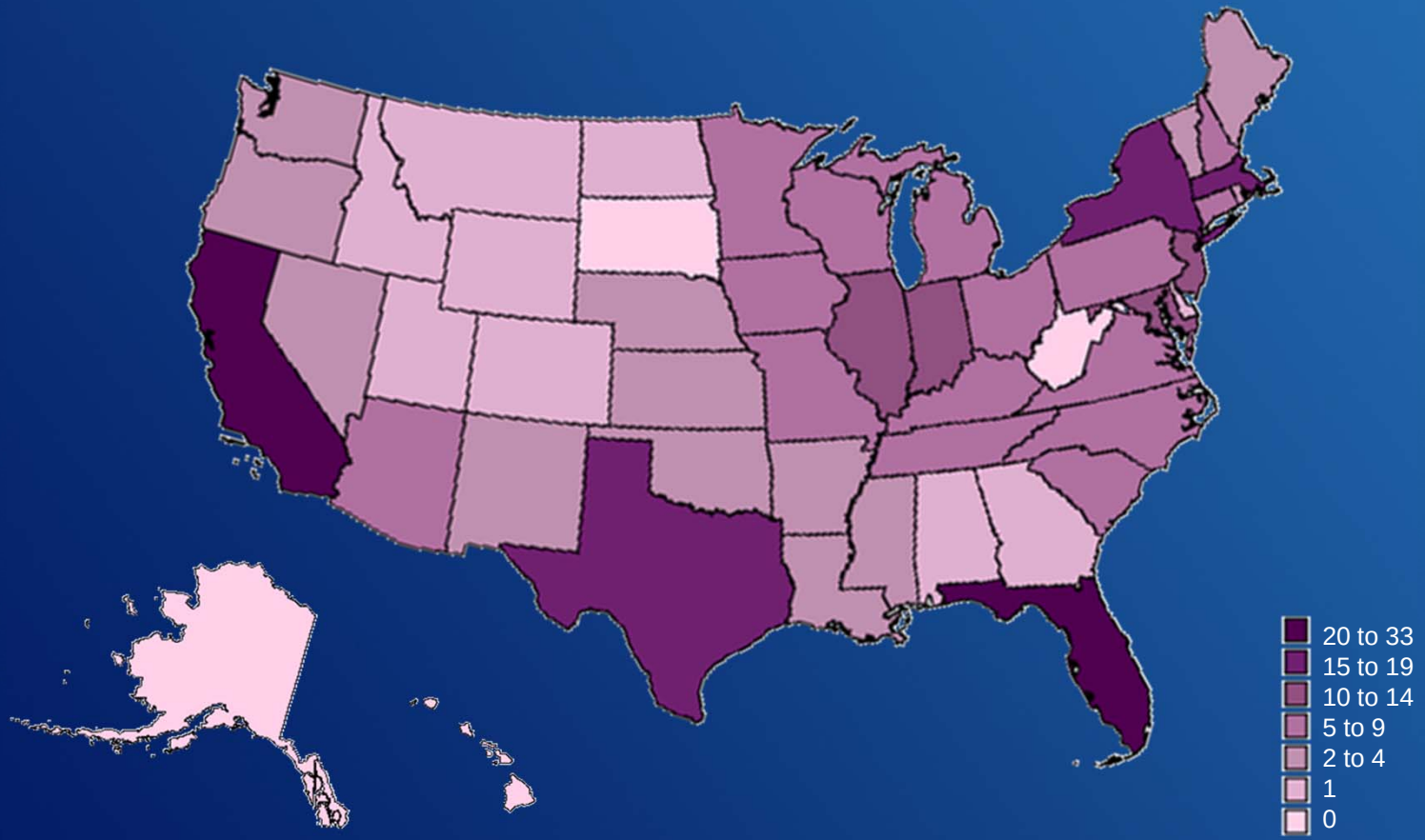
Medicare ACOs

- An organization accountable for cost and quality for a population of Medicare beneficiaries
  - Must have primary care in ACO (hospitals/specialists optional)
  - Beneficiaries assigned to ACO using primary care claims
- The beneficiary can still choose any provider inside or outside of the ACO
- Providers inside and outside ACO are paid FFS rates
- ACOs can share in savings with Medicare; then pass them on to its providers
- Two Medicare ACO models
  - Pioneer ACO demonstration
  - Medicare shared savings program (MSSP)

Differences between Pioneer and Medicare shared savings program

	Pioneer ACOs	Shared Savings ACOs
Minimum population	15,000 (5,000 if rural)	5,000
Risk	Shared risk by the second year	Bonus only or shared risk
Total population (Medicare and non-Medicare)	50% of all revenues must be in ACO-like arrangement by end of second year	No requirement
Selection of ACOs	Competitive: Chosen by CMMI on experience and readiness	Any that meet program requirements
Share of savings	higher	lower

Medicare ACOs operational in many states



Source: CMS press releases and fact sheets

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Medicare ACOs current status

- 220 MSSP ACOs and 23 Pioneer ACOs
- ACOs disproportionately located in higher-spending areas
- Half are physician groups without hospitals
- Serving both rural areas and metropolitan areas

Pioneer ACO model: CMS reported first year results

- Started January 1, 2012 with 32 ACOs
  - 13 achieved shared savings*
  - 2 had shared losses
  - 17 either below threshold for sharing or not at risk for losses in first year
- 9 of 32 ACOs withdrew in July 2013
  - 23 staying in Pioneer demonstration
  - 7 applying to be in MSSP
  - 2 likely will not be Medicare ACOs

* Shared savings are given if expenditures < benchmark and difference greater than minimum sharing rate

Pioneer first-year observations

- ACOs report incentives are large enough to induce efforts to manage care and improve relationships across silos
- Quality targets can be reported and some quality goals achieved
- CMS reports program savings
  - Pioneer growth in spending per beneficiary = 0.3%
  - Comparison growth in spending per similar beneficiaries nationwide = 0.8%
  - Program savings = 0.5%

Pioneer first-year issues

- CMS reports program savings and variation in performance. Would like to know:
  - How much is random variation?
  - Will benchmarking need to be refined?
- What is required for overall savings?
  - Program savings reported to be 0.5%
  - ACOs report the cost of running an ACO 1% to 2%
  - From provider's perspective, is this sustainable?
  - How large do savings need to grow to justify the costs?
  - Will savings increase over time?

Near-term options for refining the ACO programs

- Three-year MSSP contracts begin to expire in 2015
- Possible refinements:
  - Assignment on primary care provided by RHCs, FQHCs and non-physician practitioners
  - Establishing benchmarks and assessing performance based on service use
  - Beneficiary issues
  - Quality issues

Beneficiary incentives

- Lower cost-sharing in network
  - Could increase engagement with ACO
  - Supplemental insurance could eliminate effect
- Medicare Select ACO supplemental plan concepts
  - Lower cost-sharing for primary care in ACO
  - Beneficiary would need to buy Select plan
  - Increase loyalty to ACO primary care providers
  - Ability to attest into ACO through Select plan?

Quality issues

- Focus on outcomes, refine scoring
- Should FFS quality incentives continue into ACO?
  - Could reinforce incentives
  - Could be duplicative or unnecessary
  - Does not happen in MA
- Quality design differs among FFS, ACO, and MA
  - Different metrics
  - Population or provider basis

Longer-term issue: common platform

Should there be a level playing field across traditional FFS, ACOs, and MA? If so,

- Need to harmonize benchmarks
  - ACO: Beneficiaries' historical experience, actual trend
  - MA: Local FFS baseline, projected trend
    - Benchmark from 95 to 115% of local FFS
    - Bidding and rebates
- Need to harmonize risk adjustment
  - ACO historical baseline/categorical change
  - MA hierarchical condition categories (HCC)

Discussion: shorter-term issues

- Beneficiary notification and opt-out
- Lower cost-sharing in ACO
  - Medicare Select ACO supplemental
  - Other approaches?
- Spending or service use
- Moving toward common quality measures for FFS,ACOs, and MA

Discussion: Longer-term issues

- Spending benchmark: Improvement over historical (ACO method) or local FFS level (MA method)
- Benchmark computation: retrospective vs. prospective
  - Retrospective (ACO method) uses actual trend. It is more precise, but the benchmark is not known until the performance year is over.
  - Projected trend (MA method) is less precise but the benchmark is known at the start of the performance year.
- Risk adjustment
  - Historical spending/categorical (ACO method)
  - HCC (MA method)