Advising the Congress on Medicare issues

Accountable care organizations

David Glass, Jeff Stensland

April 9, 2009

MEDPAC

What is our definition of an ACO?

- A combination of a hospital, primary care physicians, and possibly specialists. Potential ACOs include:
  - Integrated delivery systems
  - Physician hospital organizations (PHO)
  - Hospital plus multispecialty groups
  - Hospital and independent practices
- Associated with a defined population of patients
- Accountable for total Medicare spending and quality of care for that patient population

ACO concept

- Physicians and a hospital have joint responsibility for the quality and cost of care delivered to a population of patients
- Bonus for high quality and low cost growth
  - Bonus is a percentage of FFS payments
  - High quality is meeting benchmarks (e.g. mortality, readmissions)
  - Cost growth is the rate of increase in overall Medicare spending per beneficiary assigned to ACO
- Possible penalty for low quality and high cost growth

Why Medicare may want ACOs

- Medicare needs mechanisms for controlling cost growth and improving quality
  - ACOs could help control volume growth by tying bonuses and penalties to overall Medicare spending
  - ACOs could help improve quality by tying bonuses and penalties to quality metrics
- Policy objectives
  - Delivery system reform; improve care coordination and collaboration
  - Tie provider payments to quality and resource use
  - Achieve a sustainable Medicare spending growth rate
  - Reduce regional variation

Last month: two paths

Voluntary model

- Providers volunteer to be ACO
- CMS assigns patients
- No patient lock-in
- Bonus and withhold
- Providers have to be organized

Mandatory model

- CMS assigns providers to virtual ACO
- CMS assigns patients
- No patient lock-in
- Bonus and withhold
- No organization needed, but creates an incentive for cooperation and integration

Tradeoff between volume and FFS rates

- Spending = FFS rates x volume
  - Voluntary: weaker volume incentive → high pressure on FFS rates
  - Mandatory: stronger volume incentive → less pressure on FFS rates
  - ACO providers still paid national FFS rates
- Would be preferable to eliminate unnecessary care (control volume) rather than use the blunt tool of low updates

This month: two variants of voluntary path

Voluntary bonus only model

- Providers volunteer to be ACO
- CMS assigns patients
- No patient lock-in
- Bonus only
- Providers have to be organized

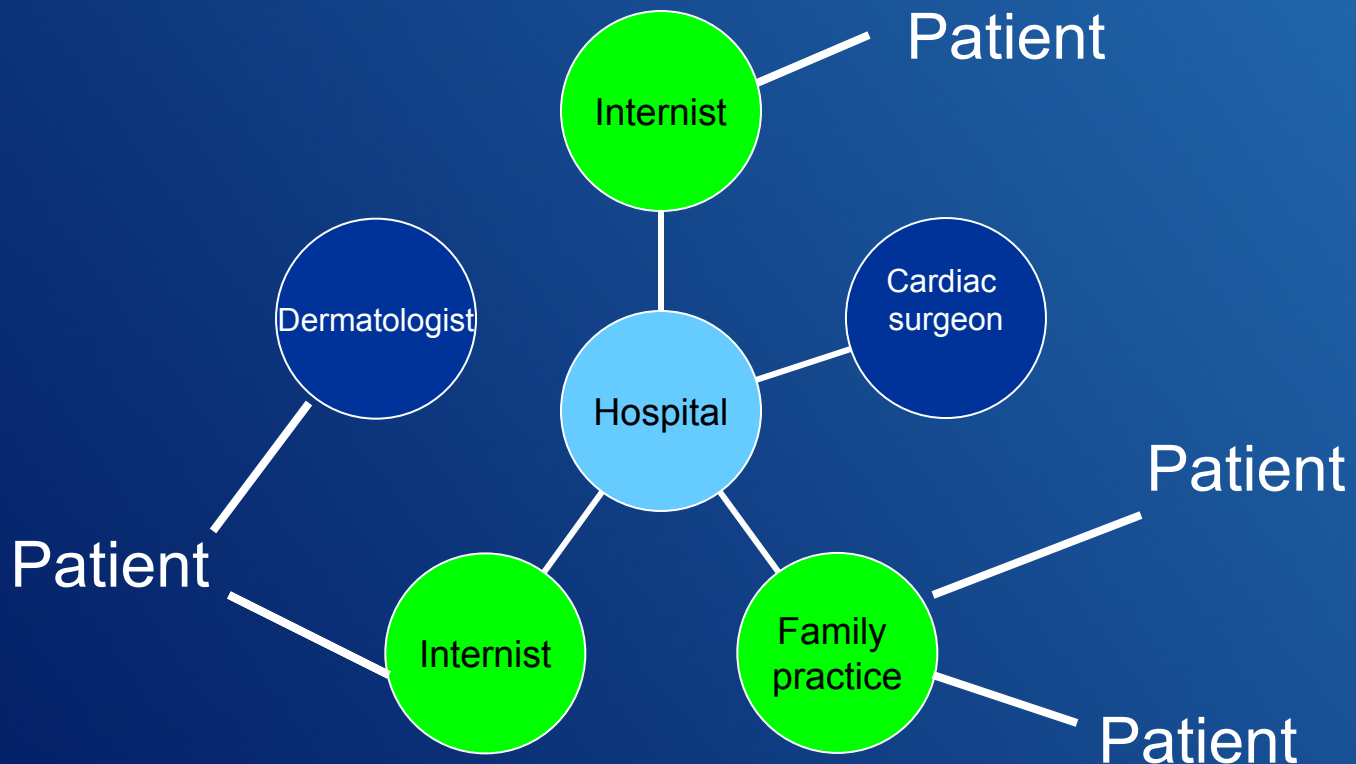
Voluntary ACO + Medigap SELECT model

- Providers volunteer to be ACO
- Patients enroll
- Lock-in by cost sharing
- Bonus and withhold
- Providers have to be organized

Voluntary ACO, bonus only model

- Physicians who use a common hospital volunteer with the hospital to be held jointly accountable for patients that are assigned by CMS
  - Some providers may be part of a common organization (e.g. an integrated delivery system)
  - Some providers may be independent practices
- CMS assigns patients to primary care physician based on claims, then to ACO based on the physician's hospital assignment

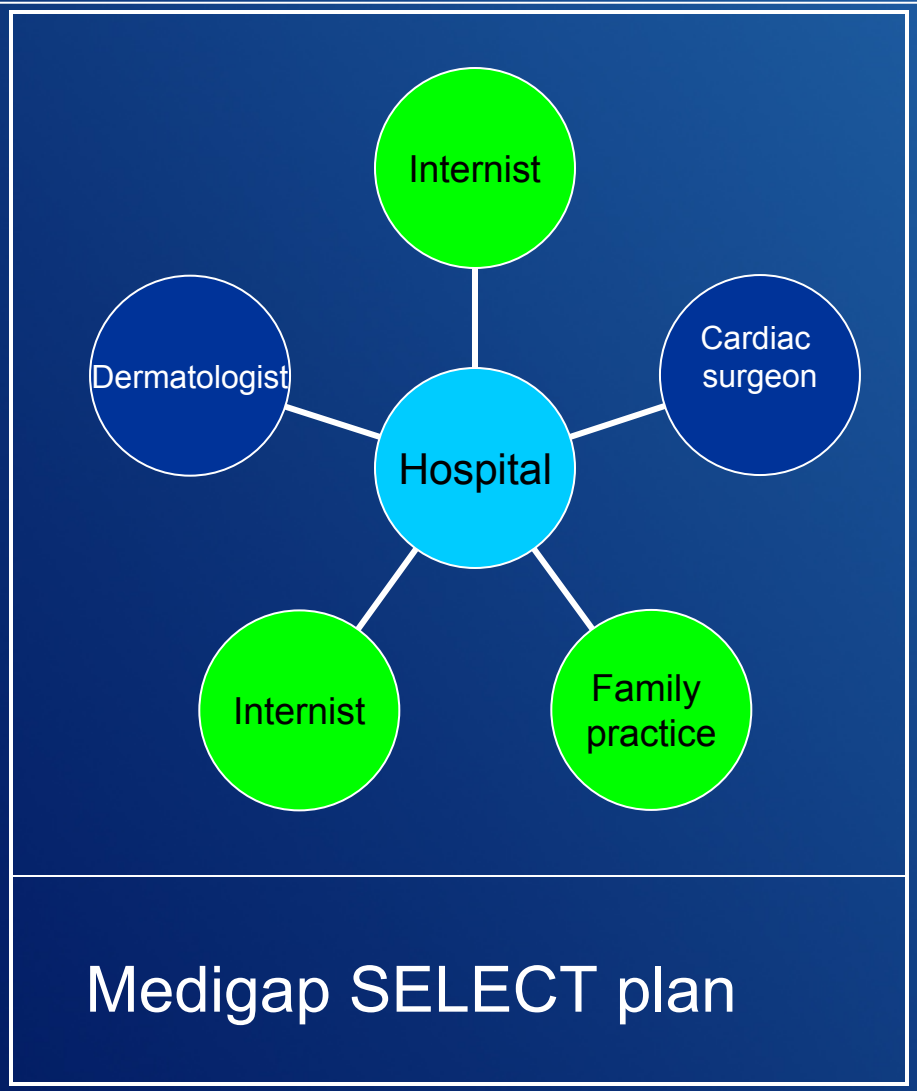
Voluntary ACO, bonus only model: Physicians organize ACO, patients assigned



Voluntary ACO + Medigap SELECT model

- Physicians and hospital organize into an ACO and volunteer to be held jointly accountable for patients
- Patients choose to join ACO and buy affiliated Medigap SELECT supplemental plan which has lower premium and differential cost sharing
  - low cost sharing for using providers in the ACO
  - full Medicare cost sharing for using non-ACO providers without referral (ACO is gatekeeper)

Physicians organize, patients enroll in ACO and Medigap SELECT plan



enroll Patient 1

enroll Patient 2

Patient 3

Patient 4

enroll Patient 5

MEDPAC

Key challenges to the ACO + Medigap SELECT model

- Share of each physician's patients enrolling may be small
  - Requires more physicians in an ACO pool to reach 5,000 member threshold
  - Dilutes incentive to change individual practice patterns
  - More difficult to reach consensus on constraining capacity
- Complexity of Medigap regulations

Contrasting today's ACO options

Option	Voluntary ACO bonus only	Voluntary ACO + Medigap SELECT
Patient	CMS assigns	Beneficiary enrolls in ACO and Medigap SELECT plan
Share of patients	Large	Depends on enrollment (could focus on Medigap SELECT patients)
Lock-in	None	Copays for out of network care, ACO is gatekeeper
Incentive	Bonus only	Bonus and withhold
Funding	Shared saving + FFS restraint	Shared savings and withholds
Challenge	Requires reducing FFS rates to fund the bonus (shared savings may be small)	Small share of each practice's patients may join (weakens incentives)

Strengths and weakness of different models

	Mandatory ACO	Voluntary Bonus only ACO	Voluntary ACO + Medigap SELECT	MA – PSO
Strengths	▪ Rewards value ▪ Patients can use any physician ▪ Limited financial risk for providers ▪ No organization required	▪ Rewards value ▪ Patients can use any physician ▪ No financial risk for providers	▪ Rewards value ▪ Stronger patient management ▪ Patients enroll for lower premiums ▪ Limited financial risk for providers	▪ Strongest patient mgmt. ▪ Patients enroll for lower cost sharing ▪ Greatest incentives for efficiency
Weakness	▪ Lack of control over patients ▪ Provider resistance to accountability for care outside their control	▪ Lack of control over patients ▪ Cost control incentive dependent on bonus size ▪ Bonus depends on reducing FFS updates	▪ Limited enrollment ▪ ACO enrollees may be a small share of practice's patients – limits incentives	▪ Must negotiate prices ▪ Must pay claims ▪ Full Insurance risk ▪ Few exist

MEDPAC

ACO issues for discussion

- Mandatory or voluntary?
- If voluntary: bonus and withhold or bonus only?
- Voluntary bonus only model:
  - Will bonus be large enough to change practice decisions?
  - Will FFS rates be adequately constrained?
- Voluntary ACO + Medigap SELECT:
  - Will enough beneficiaries join?
  - Will special enrollment provisions be necessary?

Issues for all options:

- Should CMS or ACO allocate the bonus?
- Will private payers implement either option?
- Synchronize ACO spending targets with improved MA updates?