Medicare accountable care organization (ACO) update

April 4, 2013

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Today’s presentation

- Background
- Description of ACO models in Medicare
- Strengths and weaknesses of ACOs vs. Medicare Advantage (MA) plans
- Discussion
Background

Motivation for ACOs
- Needed a mechanism to counteract the incentive for volume growth in FFS
- Reward improved quality
- MA incentives without capitated payment, limited networks, or claims processing

Two Medicare ACO models
- Pioneer
- Medicare shared savings program (MSSP)
ACOs’ place in the payment spectrum

**Pure FFS**
- Pay by service
- Silo-based
- Some VBP
- No risk

**ACO**
- Mixed payment: FFS payment
  +/− shared savings
- All Part A&B
- Quality incentive
- Limited risk

**MA**
- Pay for population
  - Full capitation
- All Part A&B
- Quality bonus
- Full risk

Payment and delivery system integration

VBP = value based purchasing
Current status: Pioneer ACO model

- Started January 1, 2012
- 32 ACOs in program, 860,000 beneficiaries
- Primary care physicians (PCPs) required as ACO members
- Beneficiaries assigned to ACOs based on PCP visits, informed by letter, can opt out of data sharing
- CMS provides claims data on assigned beneficiaries with monthly updates
Current status: Medicare shared savings program (MSSP)

- Three cohorts thus far:
  - April 1, 2012: 27 ACOs, 370,000 beneficiaries
  - July 1, 2012: 87 ACOs, 1.3 million beneficiaries
  - January 1, 2013: 106 ACOs, 1.6 million beneficiaries
- PCP members specified by ACO
- Beneficiaries assigned to ACOs based on PCP visits, informed by letter, can opt out of data
- Performance data quarterly
- 32 MSSP ACOs in advanced payment program
Medicare ACOs available in many states

Source: CMS press releases and fact sheets
Common features of Pioneer ACOs and shared savings ACOs

- An organization whose primary care providers are accountable for coordinating care for a population of 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
## Differences between Pioneer ACOs and shared savings ACOs

<table>
<thead>
<tr>
<th></th>
<th>Pioneer ACOs</th>
<th>Shared Savings ACOs</th>
</tr>
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<tbody>
<tr>
<td>Minimum population</td>
<td>15,000 (5,000 if rural)</td>
<td>5,000</td>
</tr>
<tr>
<td>Risk</td>
<td>Shared risk moving to partial capitation in third year plus two option years</td>
<td>Bonus only or shared risk</td>
</tr>
<tr>
<td>Total population (Medicare and non-Medicare)</td>
<td>50% of all revenues must be in ACO-like arrangement by end of second year</td>
<td>No requirement</td>
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<tr>
<td>Selection of ACOs</td>
<td>Competitive: Chosen by CMMI on experience and readiness</td>
<td>Any that meet program requirements</td>
</tr>
<tr>
<td>Share of savings</td>
<td>higher</td>
<td>lower</td>
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</table>
Payment in Pioneer ACOs

- Five different arrangements
  - Vary by share of savings, caps on share of gains and losses, minimum savings rate, share of risk
  - Build over time, higher limits in year 2
- Population based payment in year 3 only if savings $\geq 2\%$ in years 1 and 2
## Payment in shared savings ACOs

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Bonus only</th>
<th>Shared risk</th>
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</thead>
<tbody>
<tr>
<td>Number of ACOs</td>
<td>212</td>
<td>8</td>
</tr>
<tr>
<td>Maximum sharing rate (depends on quality score)</td>
<td>Up to 50%</td>
<td>Up to 60%</td>
</tr>
<tr>
<td>Minimum savings rate (MSR)</td>
<td>2% to 4% depends on size</td>
<td>2%</td>
</tr>
<tr>
<td>Performance payment limit</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>Shared savings</td>
<td>1st dollar once MSR is met</td>
<td>1st dollar once MSR is met</td>
</tr>
<tr>
<td>Shared loss rate</td>
<td>na</td>
<td>1 – final sharing rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limited to 5% yr1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7.5% yr2, 10% yr3</td>
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Issues of Commission concern

- Beneficiary issues
  - Prospective assignment and beneficiary notification
  - Opt-out provision
  - Incentives (lower cost-sharing, share of savings)
- Assignment on primary care provided by RHC, FQHCs and non-physician practitioners
- Establishing benchmarks and assessing performance based on service use
Strengths and weaknesses of ACOs and MA plans

- **MA plans**
  - **Strength:** More tools to control service use
  - **Weakness:** Higher overhead

- **ACOs**
  - **Strength:** Lower overhead (no enrollment, rate contracting, or claims processing)
  - **Weakness:** Fewer tools to control use
    - No ability to limit networks
    - No prior authorization
    - No control over beneficiary cost sharing (Medigap issues)
      - Could be addressed with a Medicare Select type product
Illustrative case: ACOs vs. MA plans’ comparative market advantage

Net savings relative to FFS cost

| Amount of identifiable excess service use in FFS |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| None            | 5%              | 10%             | 15%             | 20%             | 25%             |

ACO

MA plan

Note: Based on MA bids and conversations with ACOs, we have set up this illustrative example as showing a 2% additional overhead at an ACO and 10% at an MA plan. We assume ACOS can eliminate 20% of excess use and MA plans 60%. To overcome the higher overhead, both ACOs and MA plans will need to reduce excess utilization without harming outcomes.
ACOs are concentrated in markets with higher potential for managed care gains

### Average MA plan bid relative to FFS costs in 2013

<table>
<thead>
<tr>
<th>Market characteristic</th>
<th>MA bids 5% or more lower than FFS</th>
<th>MA bid within 5% of FFS</th>
<th>MA bid over 5% higher than FFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of beneficiaries</td>
<td>44%</td>
<td>34%</td>
<td>22%</td>
</tr>
<tr>
<td>% of potential ACO beneficiaries</td>
<td>61</td>
<td>28</td>
<td>10</td>
</tr>
<tr>
<td>Share of ACOs</td>
<td>54</td>
<td>35</td>
<td>11</td>
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Note: “Share of potential ACO beneficiaries” represents FFS beneficiaries in markets where we have identified one or more ACOs. MA bids represent average 2013 bids in the market as a percentage of FFS costs assuming the sustainable growth rate adjustments to physician payment rates are replaced with a rate freeze.
Discussion

- **Short-term issues:**
  - Beneficiary notification/opt-out
  - Assignment based on FQHC, RHC, non-physician practitioners
  - Medicare Select supplemental insurance and ACOs
  - Benchmarks and performance assessed on service use

- **Longer-term issues:**
  - Level the playing field for FFS / ACO / MA
    - Set common benchmarks
    - Common performance goals
  - Expect different payment models to succeed in different markets