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

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David Glass, Jeff Stensland, Katelyn Smalley
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**
- 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
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

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<tr>
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<th>Pioneer ACOs</th>
<th>Shared Savings ACOs</th>
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<tr>
<td><strong>Minimum population</strong></td>
<td>15,000 (5,000 if rural)</td>
<td>5,000</td>
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<td><strong>Risk</strong></td>
<td>Shared risk by the second year</td>
<td>Bonus only or shared risk</td>
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<td><strong>Total population</strong></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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<td><strong>Selection of ACOs</strong></td>
<td>Competitive: Chosen by CMMI on experience and readiness</td>
<td>Any that meet program requirements</td>
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<td><strong>Share of savings</strong></td>
<td>higher</td>
<td>lower</td>
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Medicare ACOs operational in many states

Source: CMS press releases and fact sheets
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)