



*Advising the Congress on Medicare issues*

# Accountable care organizations

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# Motivation for ACOs

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- Medicare volume growth unsustainable
- Quality uneven
- Lack of care coordination
- Need a mechanism to
  - counteract the incentive for volume growth in the FFS system
  - reward improved quality

# Direction for payment and delivery system reform to improve value

## Current FFS payment systems

Physician  
Inpatient  
Outpatient  
LTCH  
IRF  
Psychiatric  
SNF  
Home health  
DME  
Lab  
Hospice  
ESRD



## Recommended tools

Comparative effectiveness  
Reporting resource use  
Pay for performance  
Individual services  
“bundled” within a payment system  
Gainsharing  
Creating pressure for efficiency through updates



## Potential system changes

Pay across settings and across time  
For example:  
•Medical home  
•Payments “bundled” across existing payment systems  
•Accountable care organization (e.g. PGP demo)



# What is an ACO?

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- A group of physicians (and possibly a hospital)
- ACOs responsible for quality and overall annual Medicare spending for their patients
- Potential payment design
  - Physicians are paid FFS rates, less a withhold
  - Bonuses for meeting resource use and quality targets over the course of a year
  - Penalties for failing to meet both resource use and quality targets

# How do ACOs complement medical homes and bundling?

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- ACOs responsible for all patients
  - Not just those with multiple chronic conditions
  - Not just those admitted to a hospital
- ACOs create two key incentives
  - ACOs have a financial incentive to keep patients healthy and reduce initial hospital admissions
  - ACOs have an incentive to restrain recruitment and health care capacity

# Two possible ACO paths

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- Voluntary ACO
  - Existing group practices volunteer to be held accountable for resource use and quality
  - Practices that do not volunteer are unaffected
- Mandatory, virtual ACO
  - Physicians are assigned to ACOs based on claims
  - Almost all physicians will be in an ACO

# Voluntary ACO characteristics

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- Design could be similar to physician group practice demo (PGP)
  - Multispecialty group practice volunteers to be responsible for resource and quality for a panel of patients
  - Rewards for constraining resource use and improving quality
  - Measure resource use relative to the ACO's own baseline
  - Would be large enough to judge resource use and quality
- Some areas do not have multispecialty groups

# Issues with voluntary ACOs

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- Difficult to structure rewards/penalties that attract all ACOs
  - High-use ACOs want ACO specific targets
  - Low-use ACOs want national targets
- Only those that expect bonuses would enroll
- Could create problem maintaining budget neutrality

# Mandatory ACO characteristics

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- Patients assigned to physicians based on claims
- Physicians assigned to “virtual” ACO based on claims (e.g., extended hospital medical staff)
- Physicians jointly responsible for all patients in the ACO
- No formal contract between members of ACO
- Physicians have an incentive to work together to control costs and improve quality scores

# Reducing variation among mandatory ACOs

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- Substantial variation between markets
  - High use (e.g. Miami and Los Angeles)
  - Low use (e.g. Portland and Minneapolis)
- Substantial variation within markets
  - Miami
  - Los Angeles
- There is room for reduced variation, even within markets

# Issues with mandatory (virtual) ACOs

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- Will physicians accept attribution and assignment to ACOs?
- Is peer pressure in a virtual organization enough to change practice patterns?

# Common challenges for voluntary and mandatory ACO design

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- ACOs will have an incentive to drop patients who they predict will have costs above their risk adjusted expected costs
- Determining how quality scores and resource scores will interact to determine bonuses and penalties
- Determining how to set individual ACO's resource use targets
  - Could start with ACO-specific baseline spending
  - Allow for a common level of spending increases per year

# Possible bonus and penalty methodology

## Quality target

Resource use target

Meets target

Doesn't meet target

Meets target

Return withhold + share of savings (i.e. bonus)

Return withhold

Doesn't meet target

Return withhold

Withhold not returned (i.e. penalty)

# Potential method of setting ACO resource use targets

## Targets in a market with average spending of \$10,000

	National average	Low-use ACO	Average ACO	High use ACO
Year 1	\$10,000	\$8,000	\$10,000	\$11,000
Expected growth	\$ 500			
Year 2 target	\$10,500	\$8,500	\$10,500	\$10,500
% change		6.3%	5.0%	-4.5%

Assumption: Wage index = 1, risk score = 1

# ACO issues for discussion

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- Should ACOs be viewed as a complement to the medical home in a multifaceted effort to control volume?
- Should they be voluntary or mandatory?
- Should they include a hospital?