Medicare's Shared Savings Program for ACOs

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PPACA definition of an ACO

- An organization whose primary care physicians are accountable for coordinating care for at least 5,000 Medicare beneficiaries
  - Having a hospital or specialist 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

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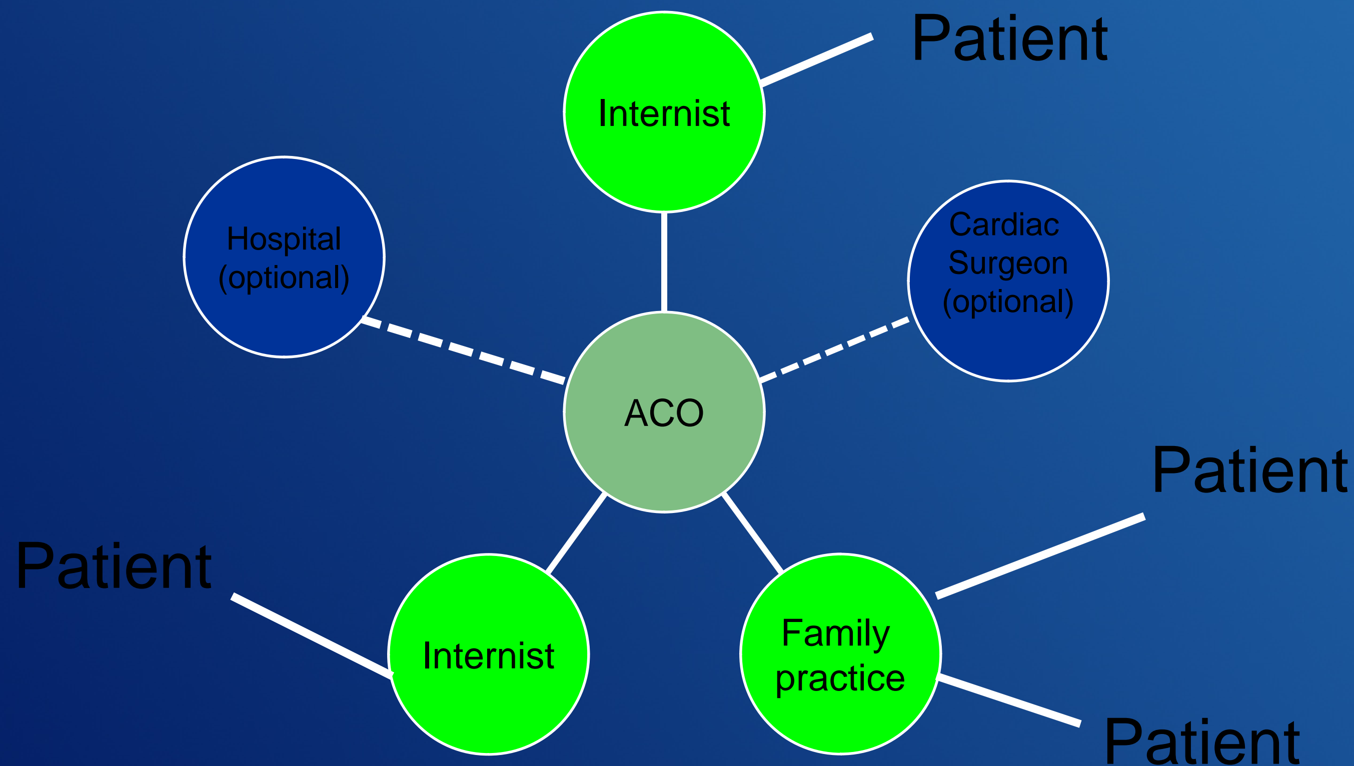
ACO model: Physicians organize ACO, patients assigned



ACO responsibilities under PPACA

- Responsible for high quality and low cost
  - Cost growth allowance is a fixed amount
  - Quality targets must also be met, Secretary has discretion over measures and targets
- The ACO must coordinate care. This implies the ACO:
  - is responsible for direct communication among providers
  - has a system for knowing when its patients are admitted and will be discharged from the local hospital

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How could ACOs generate savings?

- Reduce unnecessary services
  - Admissions
  - Readmissions
  - Other
- Switch to lower priced provider
  - Lower price sector
  - Lower price provider within a sector

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Key regulatory issues for discussion

- Random variation in costs
- Bonus/Penalty model as an alternative to the bonus-only model
- Quality measures, targets, assessment
- How should patients be informed of a physician's decision to join the ACO?

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How does bonus only model work?

- FFS payments continue to all providers
- Bonus paid if meet quality goals and have costs below the target
- Target equals prior year spending, plus fixed growth amount, minus threshold
- Threshold set by CMS given the size of the ACO's panel of patients
- No penalty if spending exceeds target

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How will CMS address random variation in bonus only model?

- There is random variation in Medicare spending for groups of beneficiaries
- PGP Demo: to avoid bonuses for 1 or 2 percent random changes in spending, CMS set a threshold of 2 percent savings prior to distributing bonuses
- Because new ACOs may be smaller than the size of PGP sites, random variation may be larger
  - Thresholds may be larger for smaller ACOs
  - May need to pool small ACO performance over several years to reduce random variation

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How much random variation is there?

	Pools of 5,000 beneficiaries		Pools of 10,000 beneficiaries		Pools of 20,000 beneficiaries	
	10th %	90th %	10th %	90th %	10th %	90th %
Difference between 2006 to 2007 growth in spending per capita and national average growth rate	-3.6.%	4.0%	-3.1.%	3.0%	-2.1	2.1%

Source: MedPAC analysis of 2006 and 2007 from the CMS Beneficiary annual summary file. Variation in spending for 1,000 random pools of beneficiaries (for each size category) who were enrolled and alive on January 1, 2006 and January 2, 2007.

Result: CMS needs to require a savings "threshold" to prevent excessive bonuses for random variation

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Weak incentives in bonus only model

- Two types of incentives
  - Strong group incentives to reduce FFS revenue of providers outside of the ACO
  - Weak group incentive to reduce ACO’s own revenue
- Will only cut their own FFS revenue if there is a strong possibility of a large enough bonus
- Why is the bonus uncertain?
  - Must meet threshold—threshold may be large for small ACOs
  - Random variation can offset savings, resulting in no bonus

Bonus/penalty model has stronger incentives

- CMS may have authority to create alternative models
- Bonus / Penalty model option would increases incentives to constrain spending because:
  - No threshold—bonus for 1st dollar savings
  - Penalty creates additional incentive to reduce spending
- Could set risk corridors to protect ACOs from large swings (e.g. a limit of 4 or 5%)
- Providers may accept risk of a penalty to eliminate the threshold and share in the first dollar of potential savings

What distinguishes bonus-only, bonus-penalty ACOs, and MA plans?

	ACO: Bonus-only	ACO: Bonus-penalty	Medicare Advantage
Responsibility	▪ Bonus for low spending ▪ Bonus contingent on quality scores ▪ No insurance risk	▪ Bonus for low spending ▪ Penalty for high spending ▪ Bonus contingent on quality scores ▪ Partial insurance risk	▪ Responsible for overall costs ▪ Responsible for quality ▪ Full insurance risk
Operations	▪ Distribute bonus payments ▪ Coordinate care	▪ Distribute bonus, pay penalty ▪ Coordinate care	▪ Negotiate prices ▪ Must pay claims ▪ Some plans coordinate care
Incentives	▪ Hard to overcome incentive for increased volume	▪ Stronger incentive than bonus-only to constrain volume	▪ Benefits from lower volume growth

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How quality is measured and evaluated is crucial

- Quality metrics should reflect desired outcomes. ACOs should improve:
  - Population health
  - Care coordination
  - Patient experience of care
- How should CMS set quality targets, assess achievement?
- Quality metrics, targets, assessment could influence membership and size of ACOs

When should beneficiaries be informed?

- Beneficiaries do not enroll, they are assigned
  - First, a physician chooses to join an ACO
  - Second, CMS assigns patients to the physician (retrospective or prospective)
- If the patient is informed in advance, then assignment must be prospective
- Once informed, a patient could choose to:
  - stay with physician
  - switch physician
  - stay with physician, but opt-out of the ACO?

ACO issues for discussion

- Is 5,000 enough beneficiaries?
  - Will there be too much random variation
  - Should CMS set high "thresholds"?
- What should an alternative to the bonus-only model look like?
  - Potential for gains and losses
  - Eliminates need for the threshold
  - May require risk corridors
- Quality: what measures and targets, how to assess achievement?
- When should patients be informed that their physician is in an ACO?

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