Advising the Congress on Medicare issues

Medicare accountable care organization (ACO) update

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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	ACO	MA
Pay by service	Mixed payment: FFS payment +/- shared savings	Pay for population Full capitation
Silo-based	All Part A&B	All Part A&B
Some VBP	Quality incentive	Quality bonus
No risk	Limited risk	Full risk

Payment and delivery system integration

VBP = value based purchasing

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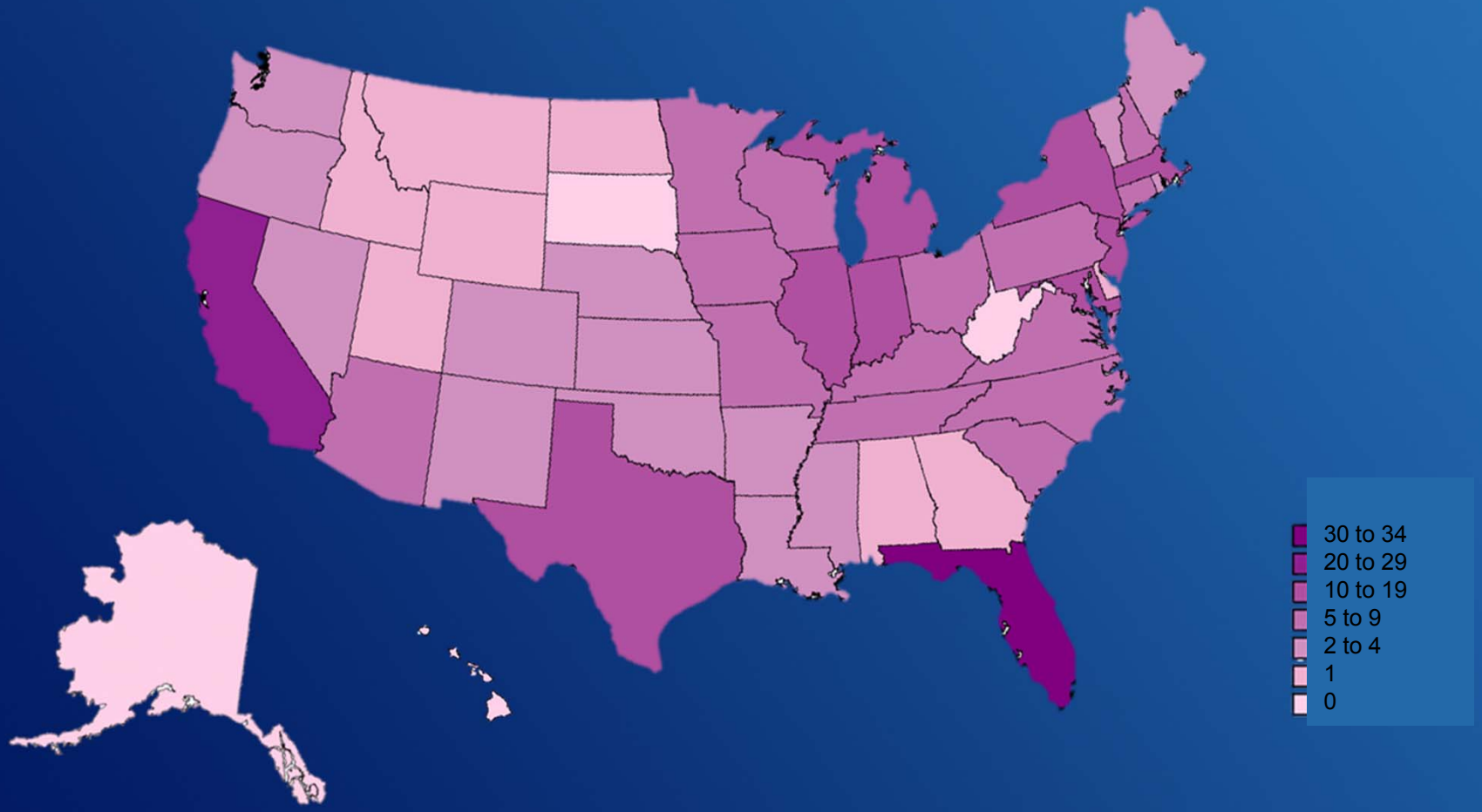
Current status: Pioneer ACO model

- 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

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

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 ≥ 2% in years 1 and 2

Payment in shared savings ACOs

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

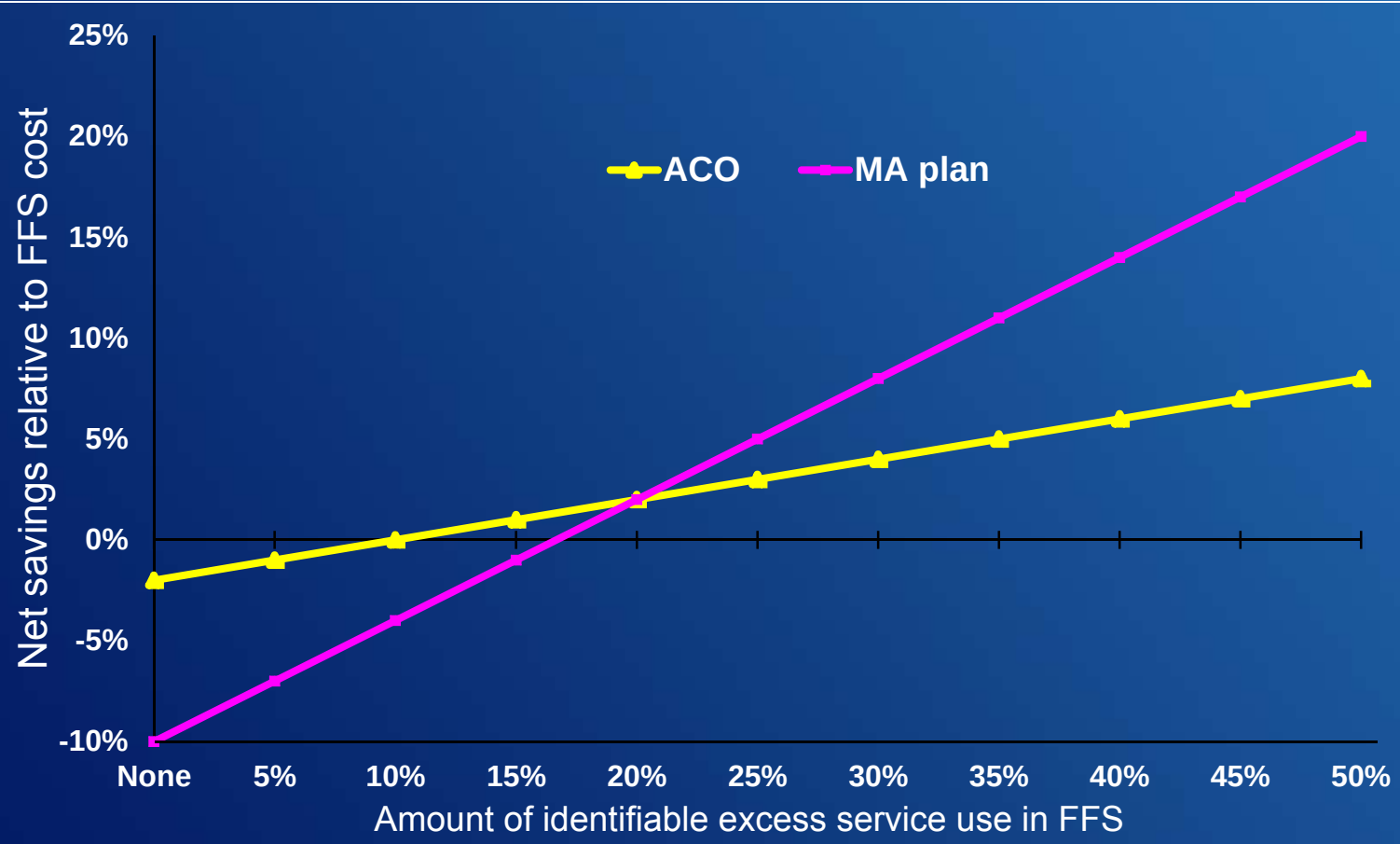
Issues of Commission concern

- 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



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.

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ACOs are concentrated in markets with higher potential for managed care gains

	Average MA plan bid relative to FFS costs in 2013		
Market characteristic	MA bids 5% or more **lower** than FFS	MA bid within 5% of FFS	MA bid over 5% **higher** than FFS
% of beneficiaries	44%	34%	22%
% of potential ACO beneficiaries	61	28	10
Share of ACOs	54	35	11

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