Medicare accountable care organization (ACO) policy options

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Status of Medicare ACO programs

- 23 Pioneer ACOs starting third year in demonstration
- Medicare shared savings program (MSSP)
  - 220 ACOs that started in 2012 or 2013
  - 123 new ACOs as of 1 January 2014
  - Next phase of MSSP begins in 2015
  - Forthcoming from CMS: Information on first year performance, quality reporting

Opportunities for ACO policy refinements

- Pioneer ACO
  - *Request for information: Evolution of ACO initiatives at CMS*
  - Comments by March 1
- Medicare shared savings program (MSSP)
  - Expected proposed rule
  - Comments in Summer 2014

Areas for refinement

- Beneficiary attribution to ACOs
- Benchmark calculations
- One-sided vs. two-sided risk models
- ACOs sharing savings with beneficiaries

Current attribution rules

- Beneficiaries are attributed to ACOs based on plurality of primary care claims
- Direct attribution to mid-level practitioners not allowed in MSSP
- Second stage attribution based on specialists is allowed
- Final attribution in MSSP retrospective

Attribution issues

- ACOs concerned that:
  - beneficiaries they expected to be attributed were not
  - others were attributed they did not expect
  - not sure of which beneficiaries they would be accountable for (MSSP)
- Specialists practices concerned that:
  - can only be member of one ACO because they can be used for attribution
  - they may lose referrals from primary care practices in other ACOs

Simplifying attribution

- Allow direct attribution to mid-level practitioners—requires legislation
- Identify providers individually
- Have ACOs designate their 'primary care providers'
- Second stage attribution based on specialists no longer necessary
- Make attribution fully prospective

Prospective attribution

- Allows ACO to know who they are accountable for at the start of the year
- Under prospective attribution the ACO remains accountable for the beneficiary:
  - Has incentive to educate and manage their care—engagement
  - Removes incentive to send potentially expensive beneficiaries elsewhere—selection
- Compatible with prospective benchmarks

Benchmark issues

- Benchmark not known in advance
  - Makes planning difficult
  - Difficult to make mid-course corrections
- Is improvement over own baseline sustainable over time?
  - Second cycle benchmark based on ACO beneficiaries historical expenditures
  - If ACO is relatively efficient, benchmark lower

Improving benchmark calculation

- Make fully prospective
  - Gives target in advance, allows better planning and midcourse correction
  - CMS would need to forecast FFS growth rate
- Take into account ACO-specific mortality rates and input prices
- Do not rebase benchmarks for relatively efficient ACOs in second cycle

Comparing one-sided and two-sided risk sharing

- One-sided (no shared losses) could bring in more ACOs
- Two-sided (shared savings and losses) gives stronger incentive for efficiency
  - Any improvement in efficiency is rewarded
    - Greater incentive to invest in care management
    - Less incentive to invest in growing volume
  - Lower (or no) savings threshold

Illustrative example of power of two-sided vs. one-sided risk model

	One-sided risk model	Two-sided risk model
Payment per MRI (all payers)	$500	
Practice profit	$100,000 = $500,000 revenue − $400,000 cost	
Change in Medicare spending for ACO's patients	$200,000 (40% of MRI revenue)	
Probability of a decreased bonus (or an increased penalty)	**60%**	**100%**
ACO share of savings	70%	70%
Expected effect on ACO bonus or loss	− $84,000 = $200,000 x .6 x .7	− $140,000 = $200,000 x 1.0 x .7
Net incentive for practice to lease MRI machine	$16,000	− $40,000

One-sided vs. two-sided risk sharing

- Commission commented that two-sided risk eventually should be only option
- Pioneer ACOs now all have two-sided risk
- Continue to allow one-sided risk in first agreement period and require MSSP ACOs to have two-sided risk in second and subsequent agreement periods
- Note: Two-sided risk is not necessarily full risk, there can be caps, reinsurance, other limitations

What's in it for the beneficiary?

- The beneficiary does not now share in any savings if the ACO succeeds
  - Better care coordination, higher quality not obvious to beneficiary
  - Risk of backlash if beneficiaries think ACO and Medicare get savings and they get nothing
- Restrictions on beneficiary engagement unclear
  - Communication—notification letter confusing
  - Can ACOs offer additional benefits? Incentives differ from FFS; inducement less of an issue

Allowing ACOs to share success with beneficiaries

- Clarify marketing/communication guidelines
- Improve notification letter
- Explicitly allow waiving cost sharing for primary care
- Clarify that ACOs can recommend high-quality PAC providers

Discussion

- Changes to attribution
  - ACOs ID providers with NPI and TIN
  - Fully prospective, no 2nd stage attribution
- Improving benchmark calculations
  - Fully prospective, ACO mortality and input prices
  - Do not rebase relatively efficient ACOs
- Move to two-sided risk in 2nd cycle
- Allow ACOs to share savings with beneficiaries
  - Improve notification letter, relax marketing guidelines
  - Allow waiving cost sharing for primary care, recommending high quality PAC providers