Medicare Payment for High-Quality, Efficient Care

Shared savings through accountability reforms

Princeton Conference
May 28, 2008
Current Payment System

- Rewards and encourages volume/intensity growth
- Reinforces fragmentation of care
- Fails to support physicians who provide high-quality, efficient care
- Penalizes physicians and many other providers who invest in unreimbursed activities that increase efficiency of care in Medicare (electronic healthcare, coordination services, etc.)
Components of a Successful Solution

- Achieves long-term payment goals
  - Transparency and accountability for cost and quality
  - Aligned incentives for providers
  - Rewards for high quality care, efficiency, and appropriate/up to date capacity
  - Budgetary savings and higher value of Medicare spending
- Support for broad range of innovative organizations, including actual/virtual integration, to provide high-value care under diverse circumstances
- Feasible steps for incremental progress now toward long-term goals
Overview of ACO Proposal

- Quality reporting mechanism
- Allows for shared savings
- Promotes actual or virtual integration of care - key is payment for supporting coordination and accountability to deliver better results
- Provides for incremental approach, starting with pilot strategy, to provide foundation for broader reform
What is an ACO?

- Legally constituted entity that can receive Medicare payments and has arrangements in place for sharing bonus payments
- Ability to specify physicians voluntarily participating within the ACO and meet performance reporting requirements.
- Minimum of 5000 Medicare beneficiaries must be assigned to ACO
Assigning Beneficiaries to ACO

- No registration by beneficiaries
- Beneficiaries with at least one E&M service in the previous year will be assigned to an ACO based on the largest share of E&M services from exclusive ACO providers, measured by number of ambulatory visits
- Results in a unique assignment for the patient
- Assignments revisited on an annual basis
Quality Measurement

- ACOs would participate in public reporting of ACO-level performance measures,
  - Eligibility for shared savings dependent on meeting targets for quality

- Quality accountability should emphasize patient-level results and care coordination, including:
  - Technical quality -- key processes of care
  - Outcomes of care
  - Patient experience

- Requires steps by ACOs and Medicare to improve quality measurement and the use of Medicare data for care coordination
  - Clear timeline for use of clinically enriched electronic data, e-prescribing, registries
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Calculating ACO Spending

For beneficiaries assigned to an ACO (based on receiving the largest share of their evaluation and management visits from a particular ACO’s unique provider), all Part A & B allowed charges will be used to calculate ACO spending.
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Shared Savings
Based on Spending Benchmarks

- Medicare actuaries make A & B spending projection

- Benchmark requires % savings below projected growth
  - Baseline -- ACO specific per-beneficiary A-B spending
  - Benchmark = Baseline + Projected growth - Y% (e.g. 2%)
  - Projection / Benchmark could be national, regional, or ACO-specific

- Shared savings payments based on performance relative to benchmark over 2 yrs (based on rolling average of 8 quarters of data, with partial payments in first year of program)
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Overview of shared savings approach

Performance period

Benchmark (e.g. 2% below prediction)
Savings to be shared if benchmark achieved

ACO specific Baseline - Year 1

Predicted spending
Actual spending

2008 2009 2010
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Overview of Shared Savings Approach

- Predicted spending
- Actual spending

Additional payout based on cumulative savings

Performance period

2008 2009 2010
Incentives for Participation

- Opportunity for shared savings from improving the quality and efficiency of patient care (after initial savings off projections go to Medicare)
- Potential interaction with SGR requirements
- Better practice environment

AND...

- Opportunity for “windfall” payments: additional payments for what the ACO providers would have done anyway
## Accountable Care Organizations

**ACO Participation:**
Medical Practice Currently Involves Distinctive Patterns of Physician Interactions

<table>
<thead>
<tr>
<th>Number of Medicare Beneficiaries</th>
<th>Percent of Beneficiaries</th>
<th>Number of Hospitals</th>
<th>Major Teaching Hospitals</th>
<th>Average Patient “Loyalty”</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,000 - 10,000</td>
<td>26.5%</td>
<td>864</td>
<td>56</td>
<td>73.3%</td>
</tr>
<tr>
<td>10,000 - 15,000</td>
<td>20.6%</td>
<td>395</td>
<td>22</td>
<td>75.6%</td>
</tr>
<tr>
<td>15,000 +</td>
<td>29.8%</td>
<td>324</td>
<td>41</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

Illustrative purposes only using 2004 physician data on hospital use; ACO proposal involves no requirements for hospital-based affiliations. From Elliott S. Fisher, Douglas O. Staiger, Julie P.W. Bynum and Daniel J. Gottlieb, Creating Accountable Care Organizations: The Extended Hospital Medical Staff, Health Affairs 26(1) 2007:w44-w57.
Tradeoffs in Determining Shared Savings

• Goals
  ▫ Paying for true “shared savings,” not good luck or existing efficient behavior - payouts for either tend to raise Medicare spending
  ▫ Encouraging participation and behavior change
Tradeoffs in Determining Shared Savings

- Steps to encourage participation may increase payouts for random variations and existing behavior, raising spending:
  - Benchmark set in advance
  - Earlier payouts
  - Ability to predict own spending relative to benchmark, and get “windfall” payment if low

- Steps to mitigate payouts unrelated to changes in behavior may reduce participation and raise issues of fairness:
  - Longer performance period
  - Larger savings threshold before payouts begin
  - More accurate prediction of “baseline” ACO spending growth

- We considered a range of alternatives for answering key question: What is best way to promote changes in behavior while achieving budget savings?
Predicted and actual log age-sex-race Medicare expenditures, 2003-05, for EHMSs with at least 5000 people.

N = 287
R^2 = .94
Error = .04
### Potential for “Windfall” Payments

**Total Bonus Payments as Percent of Participating ACOs’ Total Medicare Spending**

<table>
<thead>
<tr>
<th>Year</th>
<th>National Benchmark</th>
<th>ACO-Specific Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1-Year Performance Period</td>
<td>2-Year Performance Period</td>
</tr>
<tr>
<td>2004</td>
<td>1.8%</td>
<td>-</td>
</tr>
<tr>
<td>2005</td>
<td>1.7%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Avg. Annual</td>
<td>1.8%</td>
<td>1.6%</td>
</tr>
</tbody>
</table>


Notes: To qualify for bonus during a 2-year performance period, the ACO’s spending must be lower than the benchmark spending in a given year and its 2-year cumulative spending must be lower than the 2-year cumulative benchmark spending. All ACOs are defined as EHMSs with 5000+ Medicare beneficiaries. National benchmark is based on the projected 1-year growth rate per beneficiary spending in the CBO baseline. ACO-specific benchmark is based on the ACO’s 3-year average growth rate in per beneficiary spending. The threshold for bonus is 2% below projected spending. Shared savings is 80%.
Larger Long-Term Savings Potential

- Over time, baseline spending trends will be gradually revised based on actual spending experience.

- Equivalent to updating DRG benchmarks and Part D benchmarks based on actual spending - baseline adjusts as savings achieved in program.

- Thus, any shared savings in early years eventually translate into 100% program savings in subsequent years, leading to potential for dynamic improvements in budget outlook from behavior changes.

- Promotes continuing improvements in care that add up to growing savings over time.
Enhanced Update for Quality Measures

- Current PQRI reporting would evolve
- Physicians may report a “virtual network” of providers with whom they collaborate, as basis for reporting patient-level cost and quality measures as in ACOs
- Specialists might report data for patient registries to construct episode- and patient-level measures.
- Quality measures would include coordination of care measures, e.g. CAHPS, and enhanced patient-level quality and cost measures for common health problems
Enhanced Update for E-Health

- Compliance with CMS standards for e-prescribing and possibly mandatory e-prescribing over time

- Implementation of e-prescribing could support both quality reporting and new information to providers (e.g., prescription fills) to promote effective coordination of care
Small Group Reforms

Transition to Accountability for Overall Quality and Costs

• Opportunities for payment increases for quality reporting and e-health would diminish over time

• Over time, updates would be increasingly tied to improving overall quality and costs of care

• ACO pilot would help determine whether smaller size requirements or other modifications were feasible to facilitate small or virtual group participation in shared savings
Moving Forward: Feasible Next Steps

- Short-term physician payment reforms that promote patient-focused quality and cost improvements, with better measures and better support for physicians working together to improve care

- Pilot version of ACO now, to provide foundation for building support in Medicare fee-for-service program for higher quality and slower cost growth
# Illustrative Example of Quality Measurement Timeline

<table>
<thead>
<tr>
<th></th>
<th>Year 1-2</th>
<th>Year 2-3</th>
<th>Year 3-4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Registries</td>
<td>AMI</td>
<td>Diabetes</td>
<td>Colon Cancer</td>
</tr>
<tr>
<td>Enhanced Communication</td>
<td>Compacts</td>
<td>Partial EHR</td>
<td>Full EHR</td>
</tr>
<tr>
<td><strong>Process &amp; Outcome</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Technical Quality</td>
<td>AQA, HQA</td>
<td>Diabetes Testing</td>
<td>Diabetes Control</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>H-CAHPS</td>
<td>MD-CAHPS</td>
<td>Care Transitions</td>
</tr>
<tr>
<td>Health Outcomes</td>
<td>AMI</td>
<td>Diabetes</td>
<td></td>
</tr>
</tbody>
</table>

*Accountable Care Organizations*

*HYPOTHETICAL*