Medicare Payment for High-Quality, Efficient Care

Shared savings through accountability reforms

Princeton Conference

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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

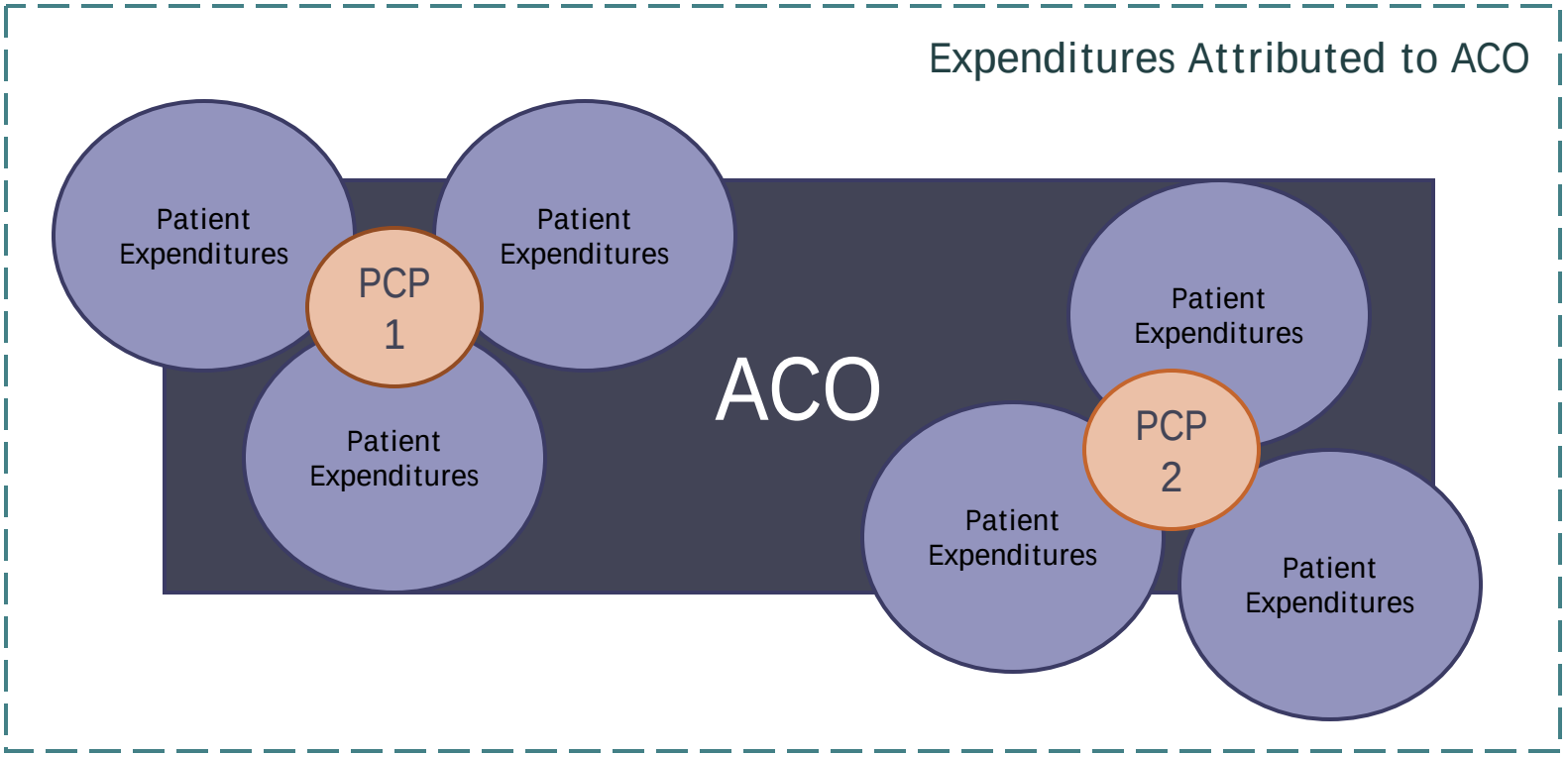
Quality Measurement

- 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

Accountable Care Organizations

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.

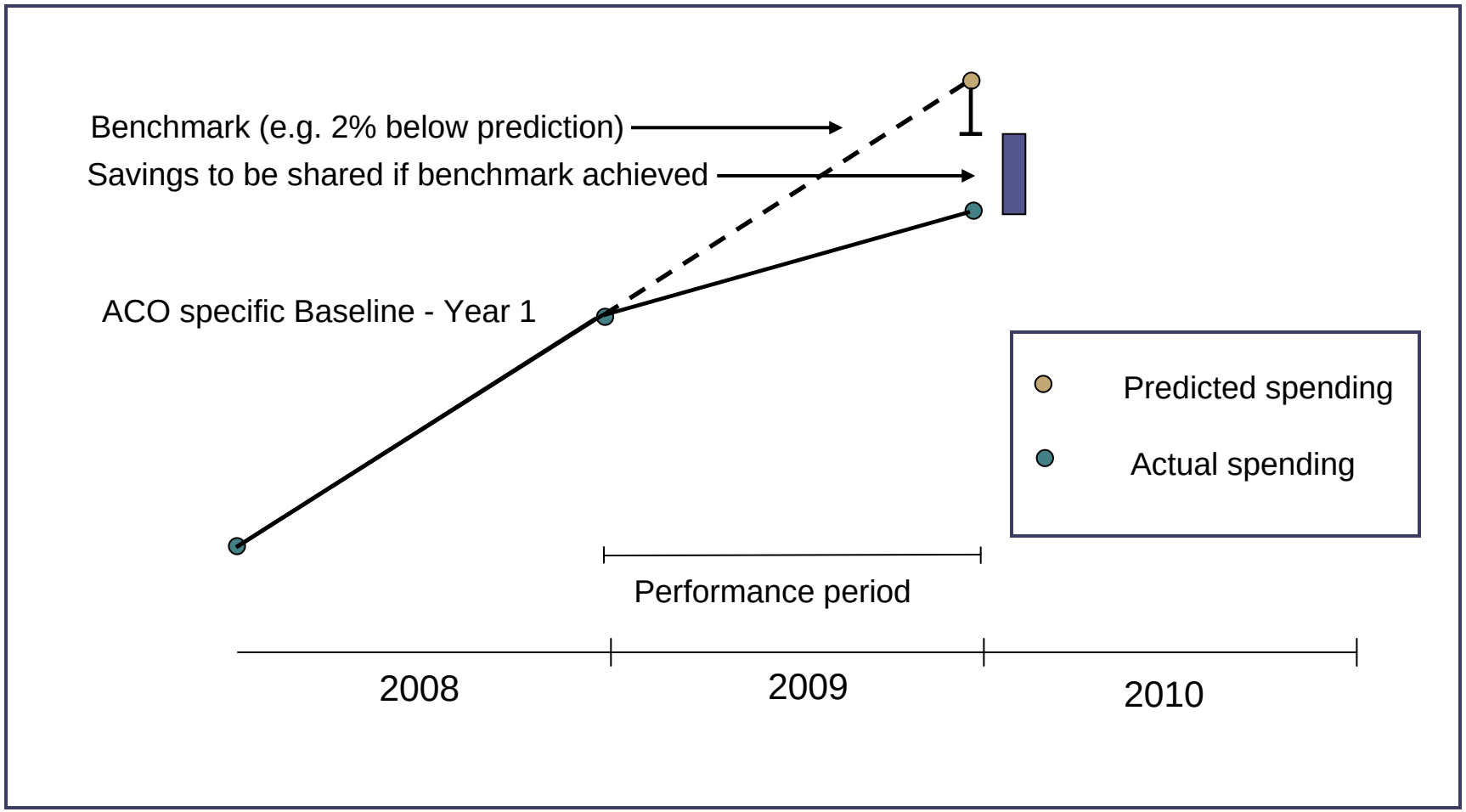


Shared Savings

Based on Spending Benchmarks

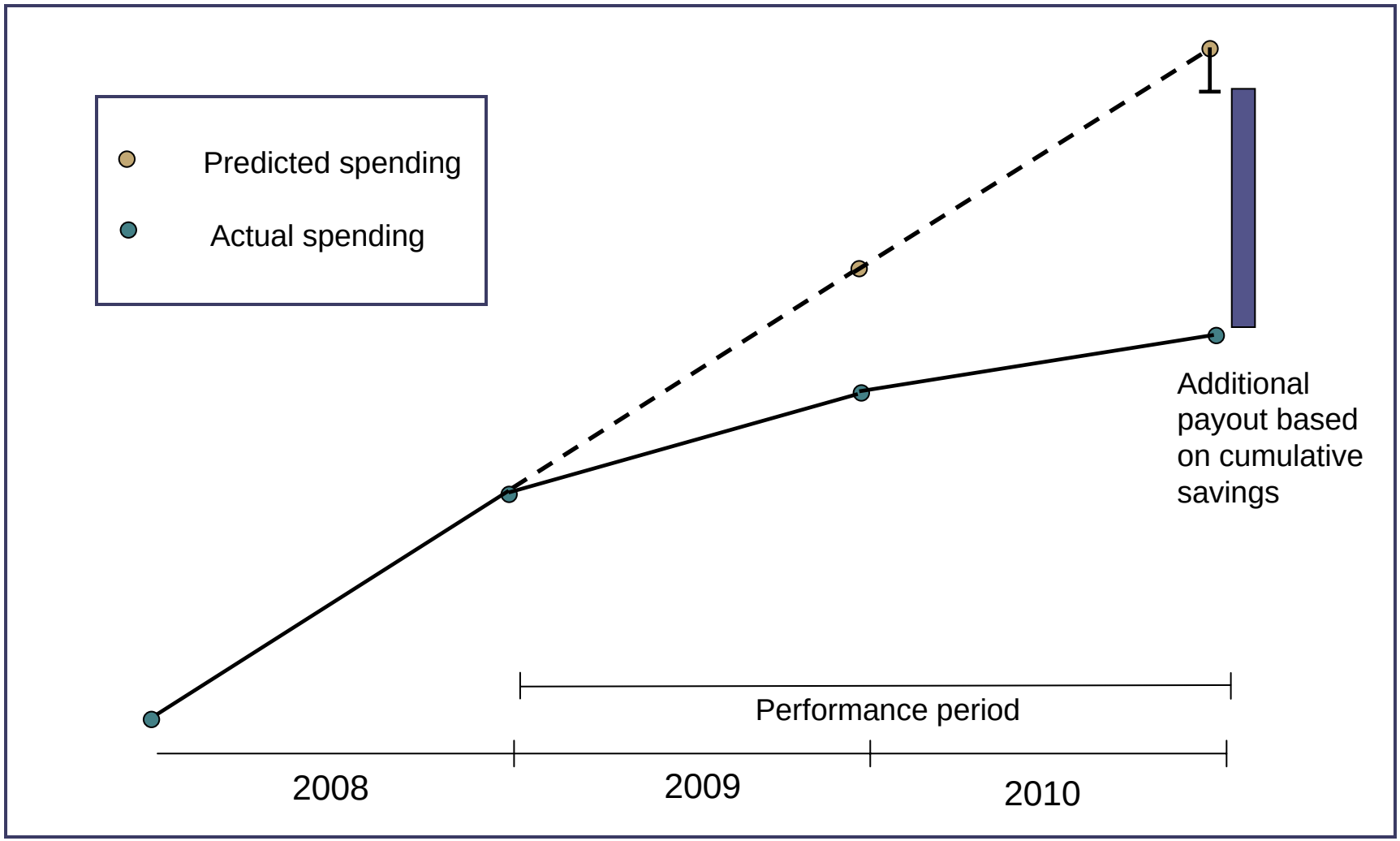
- Medicare actuaries make A & B spending projection
- Benchmark requires % savings below *projected* growth
  - Baseline -- ACO specific per-beneficiary A-B spending
  - Benchmark = Baseline + Projected growth – Y% (e.g. 2%)
  - Projection / Benchmark could be national, regional, or ACO-specific
- Shared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

Overview of shared savings approach



Accountable Care Organizations

Overview of Shared Savings Approach



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

Number of Medicare Beneficiaries	Percent of Beneficiaries	Number of Hospitals	Major Teaching Hospitals	Average Patient "Loyalty"
5,000 - 10,000	26.5%	864	56	73.3%
10,000 – 15,000	20.6%	395	22	75.6%
15,000 +	29.8%	324	41	76.9%

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

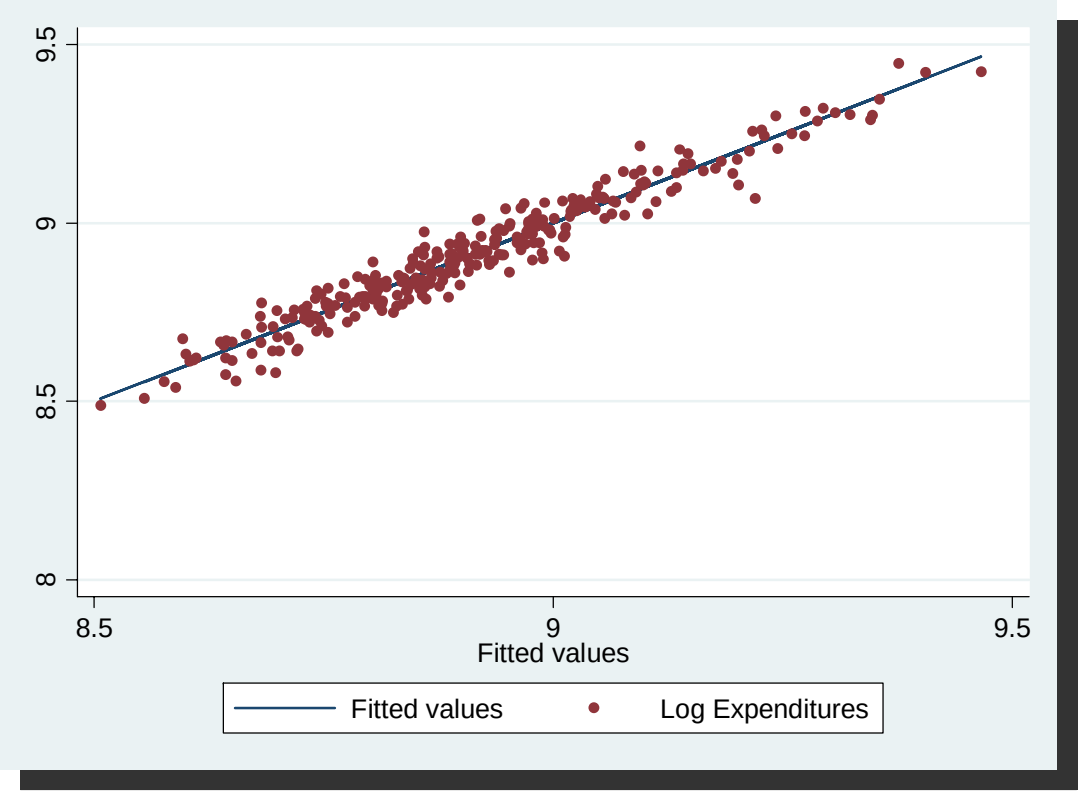
Tradeoffs in Determining Shared Savings

- 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?

Accuracy of ACO Baseline



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

	National Benchmark		ACO-Specific Benchmark	
Year	1-Year Performance Period	2-Year Performance Period	1-Year Performance Period	2-Year Performance Period
2004	1.8%	-	2.1%	-
2005	1.7%	3.1%	1.9%	3.0%
Avg. Annual	1.8%	1.6%	2.0%	1.5%

Source: Medicare claims data, 1999-2005.
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

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

Accountable Care Organizations

HYPOTHETICAL

Illustrative Example of Quality Measurement Timeline

	Year 1-2	Year 2-3	Year 3-4
Structural			
Patient Registries	AMI	Diabetes	Colon Cancer
Enhanced Communication	Compacts	Partial EHR	Full EHR
Process & Outcome			
Technical Quality	AQA, HQA	Diabetes Testing	Diabetes Control
Patient Experience	H-CAHPS	MD-CAHPS	Care Transitions
Health Outcomes		AMI	Diabetes

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