



**Budget Options**  
**Volume 1**

**Health Care**

December 2008



## Preface

**T**his volume—which expands on one of the Congressional Budget Office’s (CBO’s) regular reports to the House and Senate Committees on the Budget—presents 115 options for reducing (or, in some cases, increasing) federal spending on health care, altering federal health care programs, and making substantive changes to the nation’s health insurance system.

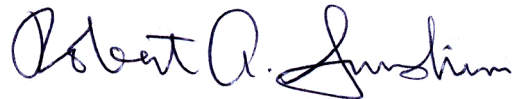
The options compiled for this volume stem from a variety of sources, including extensive discussions with Congressional staff; reviews of legislative proposals, the President’s budget, and academic literature; and analyses conducted by CBO staff, other government agencies, and private groups. Although the number of health-related policy options shown here is significantly greater than in previous *Budget Options* volumes, it is not an exhaustive list: Some options could not be included because of time constraints or analytical complexity. The inclusion or exclusion of a particular policy change does not represent an endorsement or rejection by CBO; to ensure impartiality, the discussion of each option summarizes arguments for and against it. In keeping with CBO’s mandate to provide objective analysis, the report makes no recommendations.

An introductory chapter provides an overview of the volume and offers some important context for understanding the options. Chapters 2 through 12 present those options, organized by broad themes (for example, payment for Medicare services, cost sharing in federal programs, and long-term care). Each chapter is introduced with a page of background information about the theme. The volume is available in multiple formats on CBO’s Web site ([www.cbo.gov](http://www.cbo.gov)).

This report is the product of an enormous effort involving more than three dozen members of the CBO staff over a period of many months. That effort was skillfully coordinated by Lara Robillard (of the Budget Analysis Division) and Lyle Nelson (of the Health and Human Resources Division). The volume was edited by Loretta Lettner and Leah Mazade. Appendix A lists the many CBO staff members who contributed to the report.

The Congressional Budget Office would like to thank the staff of the Medicare Payment Advisory Commission, the Centers for Medicare and Medicaid Services, the Engelberg Center for Health Care Reform at the Brookings Institution, and many others who provided invaluable assistance with data and analysis. In addition, CBO is grateful to the staff of the Joint Committee on Taxation—specifically, the health policy group—which prepared the revenue estimates for several options. CBO, however, is solely responsible for the content of this volume.

Finally, special thanks are due to CBO's former Director, Dr. Peter R. Orszag, who conceived the idea for this report and was instrumental in its development.

A handwritten signature in black ink that reads "Robert A. Sunshine". The signature is written in a cursive, flowing style.

Robert A. Sunshine  
Acting Director

December 2008

**Option 37****Allow Physicians to Form Bonus-Eligible Organizations and Receive Performance-Based Payments**

(MILLIONS OF DOLLARS)	2010	2011	2012	2013	2014	Total	
						2010-2014	2010-2019
Change in Mandatory Spending	0	0	0	-50	-270	-320	-5,300

5 In Medicare's fee-for-service (FFS) program, providers have little or no financial incentive to coordinate the care that their patients receive across different treatment settings; to assume accountability for the costs and quality of that care; or to deliver care in an efficient, cost-effective manner. Instead, providers have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists. Not only can the lack of coordination be confusing to patients, but inadequate coordination can also lead to inefficient, lower-quality care. For example, poor coordination could result in duplicated or unnecessary services leading to higher-cost care that contained no additional benefit for patients.

Under this option, groups of providers meeting certain qualifications would have the opportunity to participate, on a voluntary basis, in Medicare as bonus-eligible organizations (BEOs). The concept of BEOs is similar to the accountable care organization models proposed by some researchers. In general, a group of providers, in order to qualify as a BEO, would have to be able to work together to manage and coordinate care for patients. BEOs could consist of physicians practicing in groups, networks of discrete physician practices, partnerships or joint ventures between hospitals and physicians, hospitals employing physicians, integrated delivery systems, or community-based coalitions of providers. Each FFS beneficiary would be automatically assigned to a primary care provider (PCP). That assignment would be based on the physician from whom the beneficiary received the most primary care in the preceding year and would affect payments only if the beneficiary's PCP elected to participate in a BEO.

Medicare would continue to pay providers under the current FFS system, but providers in participating BEOs would be eligible for bonuses if they met certain quality measures and if spending was below a benchmark. Beneficiaries would continue to be able to see providers both

in and outside of their BEO, but PCPs, in order to have more control over the costs and quality of care delivered, would have an incentive to keep as much of the beneficiary's care within the BEO as possible. The benchmark for each BEO would be set using the most recent three years of total per-beneficiary spending for beneficiaries assigned to the BEO; that amount would then be updated by the projected rate of growth in national per capita spending for the original Medicare FFS program, as projected (using the most recent three years of data) by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS).

BEOs would be eligible to receive a bonus only if they met a set of quality performance measures and if their patients' average Medicare expenditures over a two-year period were at least 2 percent below the average benchmark for the corresponding two-year period; the BEO bonus share would be half of the percentage point difference between the two-year average of their patients' Medicare expenditures and 98 percent of the two-year average benchmark. The bonus, in dollars, would equal the bonus share multiplied by the benchmark for the most recent year. For example, if a BEO's benchmark was \$9 million in the first year and \$11 million in the second year, and the BEO's actual expenditures were \$8 million in the first year and \$10 million in the second year, then the average benchmark would equal \$10 million, and the average actual expenditure would equal \$9 million. The BEO bonus share in the second year would equal half of the difference between 90 percent (\$9 million divided by \$10 million) and 98 percent (the bonus threshold), which is equal to 4 percent. The bonus amount in the second year, in dollars, would equal 4 percent of \$11 million, or \$440,000.

To qualify as a BEO, the organization would have to meet the following criteria. First, the BEO must have a formal legal structure that would allow the organization to receive and distribute bonuses to participating

providers. Second, the BEO must include the PCPs of at least 5,000 Medicare beneficiaries and must be willing to become accountable for the overall care of all the Medicare beneficiaries assigned to those PCPs. Third, the organization must provide CMS with a list of primary care and specialist physicians participating in the BEO in order to support beneficiary assignment, the implementation of performance measures, and the determination of bonus payments. Additionally, to qualify as a BEO, organizations must have the following: contracts in place with a core group of key specialist physicians; a leadership and management structure; and processes in place to promote evidence-based medicine, to report on quality measures, and to coordinate care.

In estimating the budgetary effects of this option, the Congressional Budget Office assumed that approximately 20 percent of FFS Medicare beneficiaries would be assigned to PCPs participating in a BEO by 2014, and 40 percent would be assigned by 2019. This option would reduce Medicare spending by an estimated \$0.3 billion from 2010 to period and by \$5.3 billion over the 2010–2019 period.

The savings to Medicare from this option would decline over the 2010–2019 period, CBO expects. The decline in savings reflects two factors. First, over time, the share of BEOs that met the quality requirements—and, therefore, would be eligible to receive bonuses—would grow, which would increase bonus payments. Second, this option would reduce somewhat the volume of Medicare-covered physicians' services and services "incident to" physicians' services. Because of the sustainable growth rate (SGR) mechanism that Medicare uses to determine physician fees, such volume reductions would lead to increased Medicare physician fees at the end of the period—which would reduce the savings to Medicare from this option. (The option would specify that the anticipated reductions in the volume of physicians' services as a result of the bonus payments would not be treated as "law and regulation" changes for the purposes of calculating spending targets under the SGR.)

The nationwide implementation of BEOs would be new to the Medicare program, and estimates of the effects of such an arrangement are therefore particularly uncertain. One area of uncertainty lies in the details of how CMS would implement such an arrangement. Designating BEOs would require that CMS perform a number of new and complex functions, including the assignment of ben-

eficiaries to PCPs, the projection of spending benchmarks for BEOs, the measurement of quality for BEOs (to determine eligibility for receiving bonuses), and the disbursement of bonus payments. CBO assumed that CMS would be able to implement this option beginning on January 1, 2013, but the date of implementation could be changed depending on the administrative difficulties encountered. The second area of uncertainty relates to providers' behavioral responses to BEOs. CBO assumed that providers, in response to the financial incentives under a shared-savings program, would reduce somewhat the volume and intensity of services provided to their patients. Additional modifications to this option, such as penalties for nonparticipation or for spending above the benchmark, could make savings more likely. A pilot or demonstration project that evaluated BEOs could provide valuable insights into the effects of alternative designs and the magnitude and nature of providers' responses.

An argument in favor of this option is that it would provide a stronger incentive than currently exists for providers to treat Medicare patients in a coordinated and cost-effective manner. If this option was implemented, providers would have incentives to develop coordinated systems for delivering care and would be rewarded to the extent that those activities reduced beneficiaries' overall spending. By encouraging providers to begin developing more coordinated, more efficient systems for delivering care, this option could be an initial step toward changing providers' current systems of delivering care and could pave the way for greater changes in the future. Another argument in favor of this option is that its performance and reporting requirements would encourage the development of higher quality, evidence-based care. Not only would providers need to meet a quality standard to be eligible for bonuses, but the information they reported could be used to further refine performance measures. Finally, because of the voluntary nature of this option, it would be minimally disruptive to existing provider–patient and provider–provider relationships. Providers finding it difficult to join a BEO would not be required to do so.

An argument against this option is that there is a substantial and somewhat unpredictable degree of variation in the growth of Medicare's spending from year to year, even among large groups of Medicare beneficiaries. Thus, Medicare would be paying bonuses, in some cases, for slowdowns in spending growth that would occur even in

the absence of the policy change. Additionally, because of the voluntary nature of the option, providers able to anticipate performing at a more efficient level would be more likely to choose to participate. Another argument against this option is that providers participating in a BEO might object to their remuneration being tied to decisions made by patients (for instance, their deciding to

see a specialist outside of a BEO), which they might feel are beyond their control. Finally, if the performance and quality measures were inadequate, providers might not offer adequate care, leading to a decline in the overall quality of care.

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