ACCOUNTABLE CARE ORGANIZATION PAYMENT SYSTEMS

*payment***basics**

Revised:
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Payment system changes during the COVID-19 public health emergency

During the public health emergency for the COVID–19 pandemic, CMS has implemented temporary changes for accountable care organizations (ACOs) in the Medicare Shared Savings Program (MSSP). CMS will remove spending for COVID-19 episodes of care from benchmark and performance expenditures. In addition, ACOs will not be liable for shared losses during the public health emergency. Furthermore, ACOs with expiring agreement periods at the end of 2020 had the option to extend their existing agreement period by one year, and ACOs in the BASIC track had the option of maintaining their 2020 level of participation in 2021.

Accountable care organizations (ACOs) are groups of health care providers that have agreed to be held accountable for the cost and quality of care for a group of beneficiaries. ACOs may qualify for shared savings payments if the spending for their assigned patients is lower than expected and may be required to make payments to CMS if the spending is higher than expected. The goals for ACOs are to improve coordination and quality of care, maintain beneficiary choice of provider, and reduce unnecessary service use. Beneficiaries do not enroll in ACOs; instead, Medicare assigns beneficiaries to ACOs based on their Medicare claims history.[1] The beneficiary is still free to use providers outside of the ACO. If assigned beneficiaries choose to go to a provider outside of the ACO, the ACO remains responsible for that spending. This creates an incentive for the ACO providers to satisfy their patients and keep them in the ACO. Medicare provides ACOs with claims data for assigned beneficiaries to help the ACOs coordinate care. This design avoids some of the overhead costs associated with Medicare Advantage (MA) plans, such as marketing, enrollment, creating networks, and paying claims.

There are currently two major Medicare ACO programs. The Medicare Shared Savings Program (MSSP) is a permanent part of the Medicare program. It was created by the Affordable Care Act (ACA) and became operational in 2012. As of January 2021, the program had 477 ACOs serving 10.7 million beneficiaries.

The second ACO program is the Next Generation ACO demonstration (NextGen), which started in 2016 and now has 35 ACOs participating. It incorporates higher levels of risk and reward than the MSSP. Spending targets are set differently so that they are more predictable and incorporate a discount to reflect relative efficiency. The demonstration ends in 2021.

What are ACOs accountable for?

Medicare ACOs are accountable for the total Medicare Part A and Part B spending for a defined population of beneficiaries and for the quality of their care.

Who can form an ACO?

ACOs are groups of providers such as physicians and hospitals. The group must include primary care providers because beneficiaries are assigned to ACOs based on their use of primary care services. Other providers such as specialists and hospitals can be included but are not required. Unlike MA plans, ACOs do not

The policies discussed in this document were current as of October 15, 2021, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

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need to have a network that provides all Medicare services. This is because Medicare beneficiaries who are assigned to ACOs can, like any other fee-for-service (FFS) beneficiary, go to any provider who accepts Medicare. Beneficiaries are not "locked in" to the ACO.

Payment mechanics

Providers in ACOs generally continue to be paid their normal FFS rates by Medicare.[2] In addition to these payments, ACO providers have the opportunity to earn bonus payments if, at the end of the year, actual total spending for the ACO's assigned beneficiaries is less than target spending. An ACO that has chosen to enter a two-sided risk arrangement is also at risk of losses if actual total spending for its assigned beneficiaries is greater than the spending target.

Prior to the start of every performance year, an ACO specifies its participating providers. Medicare then determines which beneficiaries received the plurality of their primary care from those ACO providers in the year prior.[3] Those beneficiaries are then assigned to the ACO if the model uses prospective assignment or provisionally assigned if the model uses retrospective assignment. In the latter case, final assignment is made at the end of the performance year.

To determine the target spending for an ACO's assigned beneficiaries during the performance year (the "benchmark"), CMS computes the total Part A and Part B spending for beneficiaries who would have been assigned to the ACO during a baseline period. In the MSSP program, the baseline period is the three years prior to the start of an ACO's contract.[4] Spending is averaged over the three-year baseline period, with more recent expenditures given more weight. That historical spending for the ACO's beneficiaries is then blended with the average regional spending for FFS beneficiaries in the ACO's market who would have been eligible for assignment to an ACO. To account for inflation, the baseline spending is trended forward using a blend of actual growth rates in regional and national FFS spending.

At the end of the year, actual expenditures for the ACO's assigned beneficiaries

Table 1 MSSP ACO parameters by track and level

	BASIC track				
	A&B level	C level	D level	E level	ENHANCED track
Maximum shared savings:					
Rate	40%	50%	50%	50%	75%
Limit	10% of benchmark	10% of benchmark	10% of benchmark	10% of benchmark	20% of benchmark
Maximum shared loss:					
Rate	No shared losses	30%	30%	30%	40–75%[c]
Limit	No shared losses	2% of revenue[a], 1% of benchmark	4% of revenue[a], 2% of benchmark	8% of revenue[a], 4% of benchmark[b]	15% of benchmark

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).
[a] The maximum shared loss is the lower of the designated percent of the ACO's Medicare fee-for-service revenue or the designated percent of the benchmark.
[b] Shared loss level in Level E will coincide with requirements for advanced alternative payment models.
[c] The rate is set to 1 minus final shared savings rate. The value can vary in the range shown.

Source: CMS. Shared Savings Program participation options. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf

Table 2 Most MSSP ACOs are in one-sided models

One-sided risk models	Number of ACOs	Two-sided risk models	Number of ACOs
BASIC levels A&B	163	BASIC levels C&D	31
Track 1*	119	BASIC level E	69
		Track 1+*	17
		Track 2*	2
		ENHANCED**	76
Total	**282**		**195**

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).
*ACOs that started a three-year contract (prior to July 2019) under Track 1, Track 1+,Track 2, or Track 3 may complete the remainder of those agreement periods.
**ENHANCED includes the former Track 3 ACOs.

Source: CMS. Shared Savings Program fast facts—As of January 1, 2021. https://www.cms.gov/files/document/2021-shared-savings-program-fast-facts.pdf.

are compared with the spending benchmark, and savings or losses are computed. If there are savings (that is, actual expenditures are less than the benchmark), those savings are shared between the Medicare program and the ACO at a defined shared savings rate. For example, in the MSSP, ACOs can receive bonus payments of up to 75 percent of savings. If there are losses (that is, actual expenditures are greater than the benchmark), those losses may be shared between the program and the ACO, if the ACO has agreed to a two-sided risk arrangement. (Losses are not shared under a one-sided risk arrangement.) Quality also enters into the calculation of shared savings and losses. ACOs must meet a minimum quality performance threshold to be eligible for shared savings. In addition, the higher the quality, the smaller the share of the losses in a two-sided risk arrangement. In the MSSP, this process is repeated each year of the contract, and then the ACO baseline is rebased to start another contract period.

Prior to July 2019, the MSSP had four separate tracks—Track 1, Track 1+, Track 2, and Track 3—with varying risk arrangements and other parameters. Track 1 contained bonuses only (one-sided risk). Track 1+ incorporated limited downside risk (two-sided risk) with additional flexibilities to coordinate care. Tracks 2 and 3 incorporated greater bonuses and greater downside risk. ACOs that began a contract under one of these tracks prior to July 2019 have the option of completing the remainder of the contract (up to three years).

Starting in July 2019, the MSSP has two tracks, BASIC and ENHANCED (Table 1). Within the BASIC track there are 5 levels (A through E) with increasing levels of risk. Generally, ACOs in the BASIC track must move up one level each year until they reach the highest level of risk (Level E). All models in both the BASIC and ENHANCED tracks allow ACOs to choose between prospective and retrospective assignment each year and all require a minimum of 5,000 assigned beneficiaries. As of January 2021, 282 MSSP ACOs are in a one-sided risk arrangement and 195 are in a two-sided risk arrangement (Table 2).

Risk adjustment—To determine the performance of an ACO in MSSP or NextGen, CMS takes into account the reported change in health status of an ACO's population. For example, the MSSP uses the hierarchical condition category (HCC) risk scores of the assigned beneficiaries to assess their risk. However, because some reported change in beneficiaries' health status could be due to changes in coding, risk scores for an ACO's population are adjusted to be comparable

with the change in risk scores for all FFS beneficiaries eligible for assignment. After adjustment, the MSSP limits the increase of an ACO's average risk score to 3 percentage points between the final baseline year and the performance year.

Quality—CMS scores ACOs on a small set of quality measures which includes clinical care for at-risk populations, patient experience, and readmissions. CMS designates a performance benchmark and minimum attainment level for each measure.

ACOs must meet the designated minimum attainment level in order to share in savings. In two-sided risk models, the higher the quality score (ACO performance compared to the benchmark), the lower the shared loss rate.

Results to date

CMS reports that the MSSP has shown modest success in improving quality, with MSSP ACOs showing improvement in performance on quality measures over time and achieving better results than FFS on many of the quality measures for which comparable results were available. CMS also reports that some ACOs have achieved modest reductions in spending relative to their benchmarks. The reductions to date have been disproportionately from ACOs in areas with high service use.

It is important to note that assessments of the success of Medicare's ACO programs depend on the metric used for comparison. ACO benchmarks are designed to reflect policy goals and create incentives for individual ACOs. Benchmarks are not necessarily the best measure of the ACO program's overall success at reducing service use and spending. When assessing the success of a Medicare ACO program as a whole, a counterfactual (i.e., what spending would have been in the absence of an ACO program) measure should be used. MedPAC has estimated that the change in spending from 2012 to 2016 for beneficiaries assigned to MSSP ACOs in 2013 was 1 to 2 percentage points lower than a comparison group of beneficiaries.[5] This estimate does not account for shared savings payments made to the MSSP ACOs over that period.

As for the NextGen demonstration, a recent study found a 1.2 percent reduction in Medicare spending in 2016, 2017, 2018, and 2019 combined for assigned beneficiaries relative to a counterfactual, not taking into account shared savings payments to the ACOs. After accounting for shared savings, the study found no reduction in spending for aligned beneficiaries.[6] ■

1 CMS allows beneficiaries to identify a "main doctor;" if they do so, the agency assigns those beneficiaries to ACOs on that basis. However, to date, few beneficiaries have identified a main doctor.

2 NextGen ACOs have the option of participating in a capitation-like payment arrangement instead of being paid normal FFS rates. Under this option, Medicare makes monthly lump-sum payments directly to the ACO based on estimated total expenditures to participating providers for the ACO's assigned beneficences. Medicare makes a corresponding reduction in FFS payments and the ACO is responsible for paying claims to participating providers.

3 *Plurality of primary care* is defined as an ACO's practitioners providing the plurality of certain qualified evaluation and management services measured by charges for those services.

4 Until July 1, 2019, contracts in the MSSP were three years long; they are now five years long.

5 Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

6 NORC at the University of Chicago. 2021. *Fourth evaluation: Next Generation Accountable Care Organization (NGACO) Model evaluation*. Report prepared by staff from NORC at the University of Chicago for the Center for Medicare & Medicaid Innovation. Bethesda, MD: NORC.