ACCOUNTABLE CARE ORGANIZATION PAYMENT SYSTEMS

paymentbasics

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The policies discussed in this document were current as of September 30, 2023. This document does not reflect proposed legislation or regulatory actions.

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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 first, 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 2023, the program had 456 ACOs serving 10.9 million beneficiaries.

In addition, the CMS Innovation Center has tested several ACO models, including the Pioneer, Next Generation, Global and Professional Direct Contracting, and ACO Realizing Equity, Access, and Community Health (REACH) models. The ACO REACH model began in January 2023. These models incorporate higher levels of risk and reward than the MSSP.

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 need to have a network that provides all Medicare services. 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 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.

The MSSP has two tracks, BASIC and ENHANCED (Table 1). Within the BASIC track there are five levels (A through E)

Table 1 MSSP ACO parameters by track and level, 2023

	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 percentage of the ACO's Medicare fee-for-service revenue or the designated percentage 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. Medicare Shared Savings Program shared savings and losses, assignment and quality performance standard methodology. https://www.cms.gov/files/document/medicare-shared-savings-program-shared-savings-and-losses-and-assignment-methodology-specifications.pdf-2.

Table 2 Most MSSP ACOs are in two-sided models, 2023

One-sided risk models		Two-sided risk models	
Track	**Number of ACOs**	**Track**	**Number of ACOs**
BASIC Levels A&B	151	BASIC Levels C&D	19
		BASIC Level E	125
		ENHANCED	161
Total	**151**		**305**

Note: MSSP (Medicare Shared Savings Program), ACO (accountable care organization).

Source: CMS. Shared Savings Program fast facts—As of January 1, 2023. https://www.cms.gov/files/document/2023-shared-savings-program-fast-facts.pdf

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 2023, 151 MSSP ACOs are in a one-sided risk arrangement and 305 are in a two-sided risk arrangement (Table 2).

Risk adjustment—To determine the performance of an ACO in MSSP or ACO REACH, CMS takes into account the reported change in health status of an ACO's population. For example, the MSSP uses the hierarchical condition category 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 and accounting for the relative changes to an ACO's demographics (e.g., age, sex, original Medicare entitlement due to disability), 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. ■

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 REACH 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.