Accountable Care Organizations

Fact Sheet February 2021

BETTER MEDICARE ALLIANCE

Key Facts

- Medicare accountable care organizations (ACOs) are provider-led medical groups that provide coordinated care to the beneficiaries they serve. Patients are assigned to an ACO based on their health care utilization histories.
- The goal of ACOs is to provide quality care to a population of patients, while reducing costs for Medicare.
- ACOs have contributed to the drive towards value-based care in Medicare and generated modest savings to date.

BMA Recommendation

ACOs contribute to the goals of moving providers who accept patients in Traditional Fee-For-Service Medicare away from fee-for-service payment arrangements to value-based payments, incentivizing primary care, and promoting care coordination for patients. Stakeholders and policymakers should consider ways to encourage ACOs to work with Medicare Advantage plans to increase the number of beneficiaries receiving high value care in Medicare, including lower costs for the beneficiaries.

ACO Background

Medicare accountable care organizations (ACOs) are groups of physicians, hospitals, and other providers, who come together to provide coordinated care to a designated group of Medicare beneficiaries. The goal of ACOs is to encourage physician-led provider groups to meet certain quality measurements for their patients, while reducing spending that results in savings for Medicare.

ACOs are paid a set amount per person per month by Medicare. Beneficiaries in Traditional Fee-For-Service (FFS) Medicare are assigned or "attributed" to ACOs based on their health care utilization histories. Beneficiaries receiving the majority of their primary care from a provider participating in an ACO are automatically attributed to that ACO. ACOs receive financial incentives for meeting or exceeding savings targets and quality goals. Beneficiaries may or may not know they are in an ACO or that they were assigned to an ACO.

The most prominent ACO model – the Medicare Shared Savings Program (MSSP) - offers different participation options that allow ACOs to assume various levels of financial risk and shared savings. The Pioneer ACO model gave provider groups the ability to transition from a shared savings model to a population-based payment model similar to the MSSP model. The Next Generation ACO Model builds upon the MSSP and Pioneer ACO models and is intended to enable better care coordination and attain the highest quality standards of care. Another model, the Comprehensive ESRD Care Initiative is designed to identify, test, and evaluate new ways to improve care for beneficiaries with End-Stage Renal Disease (ESRD).

In recent years, MSSP ACOs have grown in the number of participating providers, number of assigned beneficiaries, and total amount of earned shared savings. Over 11.2 million beneficiaries were served by ACOs in 2019. To date, all ACOs, including MSSP models, have generated modest savings, with most evaluations estimating 1 percent to 2 percent reductions in Medicare spending.[1]

ACO's are Different than Medicare Advantage

ACOs principally focus on primary care. They are not insurance companies. They do not take full financial risk for all benefits and all providers, are not required to have financial reserves, are not state licensed, do not market or enroll beneficiaries, and they do not typically process claims. ACOs are not required to create provider networks or design benefit packages. Unlike ACOs, Medicare Advantage plans have full financial responsibility for all covered services for beneficiaries who enroll in their health plan, are required to establish provider networks to offer all Medicare benefits, have flexibility in design of benefits packages, use savings to add supplemental benefits and lower consumer costs, and have the ability to use care management tools not available to ACOs.

Both Medicare Advantage plans and ACOs use data analytics to improve care and use their capitated payments to invest in care delivery and community partnerships, but health plans often have greater resources to engage in these activities because they accept greater financial risk for all beneficiary care and are required to invest savings in innovations in care delivery and enrollee benefits.

Both Medicare Advantage and ACOs have to meet quality measurement standards, provide certain covered benefits and are expected to coordinate care for patients. Medicare Advantage plans often contract with ACO's as provider groups in their networks. ACOs that contract with Medicare Advantage health plans typically do so as at-risk providers, which provides the incentives to improve quality outcomes and achieve savings. Medicare Advantage plans that contract with ACOs have demonstrated improved health outcomes for beneficiaries, financial stability for providers, and greater benefits and lower costs for beneficiaries.

[1]MedPAC, June 2020 Report to the Congress: Medicare and the Health Care Delivery System