

Accountable Care Organizations (ACOs) and Financial Risk

ACOs: Bipartisan Roots and Background

Many experts believe that piecemeal, volume-based payment encourages fragmented and inefficient care. To address this, public and private payers have been working for many years to develop alternative payment and delivery approaches, including ACOs. In fact, these ideas were tested in the Physician Group Practice Demonstration Program passed under President George W. Bush's administration in 2000, and they have evolved to today's Medicare ACO program, which encourages providers to coordinate care and be accountable for the quality and cost of patient care. The ACO model is a market-based solution to fragmented and costly care that relies on local groups of physicians, hospitals, and other providers working together to improve quality, enhance patient experience, and reduce waste to keep care affordable.

Medicare ACOs: Investment and Savings

Today, more than 600 ACOs are participating in the Medicare ACO Program, which includes the Medicare Shared Savings Program (MSSP) and the Next Generation ACO Model. These ACOs care for about 12.3 million Medicare beneficiaries - more than one in five beneficiaries. More than 80 percent of these ACOs are in MSSP "Track 1", where they can share savings with the government if they meet certain criteria, including quality targets. ACOs must make significant investments to participate in this model, estimated to be \$1.6 million annually in health information technology, data analytics, and care coordination with considerable uncertainty about whether they will share in any savings. After six years, these ACOs must move to a shared risk ACO model, such as MSSP Track 1+, 2, 3 or the Next Generation Model, where they are both eligible for shared savings and liable for a portion of increased spending, in addition to their direct financial investment. ACOs in Track 1 split the savings with the government 50/50 while ACOs in shared risk models keep a higher portion of savings, up to 100 percent, which limits the portion of savings retained by the Medicare.

Transitioning from Shared Savings to Shared Risk Models

The magnitude of the clinical and operational transformations ACOs are undertaking, coupled with the challenges of dealing with changing program rules, makes for slow but steady progress. Many ACOs currently in Track 1 have not met the financial benchmarks necessary for them to have enough confidence to make the business decision to move to a model with risk. The ACO program is voluntary,

- Shared savings ACO model definition:** ACOs in the Track 1 model can share savings with the government if they meet certain quality standards and other targets. However, similar to providers in traditional fee-for-service outside alternative payment models, they are not at risk for increased Medicare spending for patient care, though increased spending means they are ineligible for shared savings.
- Shared risk ACO model definition:** Under a shared risk model, ACOs are eligible to share savings if they meet certain quality standards and other targets, but they also are liable for a portion of increased spending above certain thresholds.

so forcing ACOs into risk before they have the organizational buy-in to do so will result in ACOs quitting the program and diverting care coordination to patients outside Medicare. This conclusion is supported by a 2018 NAACOS [survey](#), in which 70 percent of the responding Track 1 ACOs reported they are likely to leave the program as a result of being forced into risk. This would be a significant setback for Medicare payment reform efforts and would undermine implementation of the overwhelmingly bipartisan Medicare Access and CHIP Reauthorization Act (MACRA), which is designed to move providers into alternative payment models such as ACOs. Forcing unprepared ACOs into risk is not in the best interest of beneficiaries, Medicare or ACOs.

What is NAACOS's Position on Requiring ACOs to Move to Shared Risk Models?

We strongly support ACOs that are prepared and ready to take financial risk for patient care and encourage them to do so. ACOs ready to move to shared risk models should be allowed to do so at the start of any performance year, but as detailed in this [letter](#) ACOs should not be forced to risk after six years if they meet certain cost and quality standards. We also support efforts to reduce regulatory burden for ACOs and to streamline Medicare ACO requirements with those of Medicare Advantage.