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Valuation of Accountable Care Organizations: Reimbursement

The U.S. healthcare payment and delivery system is increasingly moving to a value- and quality-based system. Accountable care organizations (ACOs) are at the forefront of delivering high-quality and cost-effective care to millions of Medicare beneficiaries and privately insured patients, incentivized by substantial shared savings for those who increase quality while containing costs. This third installment of a five-part series on the valuation of ACOs will discuss the reimbursement environment in which ACOs participate.

The U.S. government is the largest payor of medical costs through Medicare and Medicaid and has a strong influence on reimbursement to hospitals. In 2021, Medicare and Medicaid accounted for an estimated $900.8 billion and $734.0 billion in healthcare spending, respectively.[1] The prevalence of these public payors in the healthcare marketplace often results in their acting as a price setter, and being used as a benchmark for private reimbursement rates.[2]

ACOs generally have the dual goal of achieving certain quality thresholds and containing costs, sufficient to attain reimbursement in the form of shared savings. Medicare Shared Savings Program (MSSP) ACO providers continue to receive fee-for-service (FFS) rates from Medicare under their respective fee schedules.[3] Unlike other FFS providers, MSSP participating providers also have the opportunity to earn shared savings and/or share the losses with Medicare.[4] If, at the end of a performance year (PY), the ACO's assigned beneficiary spending is *less* than the target, the ACO shares those savings (the difference between the target spending and the actual spending) with Medicare, up to a predetermined percentage.[5] In two-sided risk agreements, if the ACO's assigned beneficiary spending is *more* than the target, the ACO shares the losses with Medicare, up to a predetermined percentage.[6] Determining the target spending for an ACO during the PY (the "*benchmark*") is computed using the total Medicare Part A and Medicare Part B spending for the assigned beneficiaries for that period.[7] The baseline is calculated using the three years of data prior to the ACO's contract.[8] Spending is averaged over the three years prior to the contract's commencement, then blended with average regional expenditures for the beneficiaries who would have been eligible for assignment to the ACO.[9] The baseline also accounts for inflation by trending spending forward.[10] An ACO's actual spending for the year is compared to that baseline to calculate savings or losses for the year.[11] Savings and losses (if applicable) are shared with the ACO at the defined rate according to the track in which the ACO participates,[12] up to 75% in the MSSP.[13]

Quality is also factored into the calculation of shared savings and losses.[14] Higher quality gains by an ACO allows for larger shares of the savings and smaller shares of any losses.[15] The process of determining an ACO's performance in MSSP, for example, begins with a consideration of the health status of the ACO's population.[16] The MSSP utilizes risk scores of assigned beneficiaries to assess the risk,[17] which scores are limited to 3% increases between the baseline year and the PY.[18] Next, quality is measured based on four domains: (1) patient experience; (2) readmissions; and, (3) clinical care for at-risk population.[19] In order to share in savings, ACOs must meet the minimum level of attainment.[20] With the two-sided models of risk, the shared loss rate will be lower where quality scores (benchmark compared to performance of the ACO) are higher.[21]

In 2021, MSSP ACOs realized net savings of $1.66 billion, marking a fifth consecutive year where the program generated high-quality performance results and overall savings.[22] 58% of the ACOs earned payments for their performance; the ACOs that realized higher net savings tended to be low-revenue, serving rural areas, and principally comprised of physicians.[23] ACOs comprised of fewer primary care physicians saw $149 per capita in savings, whereas ACOs comprised of 75% or more primary care physicians saw $281 per capita.[24] Overall, close to 99% of ACOs met the quality standards needed to share savings.[25]

Going forward, ACOs will have to overcome a number of challenges in order to remain viable in the U.S. healthcare delivery system's ongoing paradigm shift, including the design and implementation of new care delivery, which is the most-reported challenge for ACOs.[26] Other common challenges facing ACOs include aligning physician compensation with value-based contracts, mixed quality of payor data, and lack of data analytic capabilities.[27] Notably, ACOs in downside risk arrangements (two-sided contracts) are more likely to have concerns regarding the quality of health plan data.[28] The quality of data provided from a health plan can determine the success of an ACO, especially if the ACO does not have advanced data analytics capabilities.

The current state of regulatory enforcement for ACOs will be addressed in the next installment of this five-part series.

(Continued on next page)

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