Advancing High Performance Health

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2019 Issue Brief
Accountable Care Organizations

Issue

Participants in the federal Accountable Care Organization (ACO) program have made significant improvements in care processes and the delivery of high-quality care, while reducing health care utilization. Although many ACOs have increased overall quality and saved Medicare dollars, program results have been uneven at best. ACOs have encountered significant obstacles in program design that threaten not only their own success, but also the future viability of this program. AMGA members have invested significant financial, clinical, operational, and leadership resources to establish sophisticated care management infrastructures and organizational cultures necessary to support the goals of the ACO program. They have done so because it is the right thing to do for their patients and they want to assist Congress, the Centers for Medicare & Medicaid Services (CMS), and other payers to create the new payment models that reward coordinated, patient-centered care with measurable outcome improvements. To achieve that goal, ACOs need a workable financing and operational structure that adequately incentivizes this important work.

In order to maintain the viability and structure of the ACO program, AMGA recommends:

Synchronize rules across all federal ACO levels: This will allow each risk model to operate under the same regulatory framework and ensure continuity when ACOs move up the risk continuum.

Reduce regulatory burdens on ACOs: Reduce regulatory and administrative burdens on ACOs by simplifying payment waivers, such as the 3-day qualifying inpatient stay for skilled nursing facility care and other post-discharge home-visit supervision requirements. Policymakers should further implement policies that allow for increased flexibility for ACOs to encourage providers to work with their patients to provide services in the most clinically appropriate location.

***Risk Adjustment Factor*:** Policymakers should use a symmetric percent risk ratio cap between the performance year renormalized risk score and the most recent benchmark year for all assigned beneficiaries.

Shared Savings Rate*:* CMS' current proposal of a 40% shared savings rate for Basic Levels A and B only weakens financial incentives. Instead, policymakers should increase the shared savings rate proportional to the amount of risk that an ACO takes on. Thus, CMS should implement a shared savings rate starting at 50% in Basic Levels A and B, increasing to 60% in Level C, 70% in Level D, and 75% in Level E and the Enhanced Track.

Adjust ACO regional benchmarking so that they are not competing against themselves: Currently, CMS incorporates historical spending when resetting subsequent agreement period benchmarks. Historical spending should factor into a reset benchmark for those ACOs that are spending more than their region. These ACOs will then have the incentive to address their spending and align their costs to that of their region. However, those ACOs that have demonstrated an ability to deliver care below the regional cost should be evaluated against their region, as it would be increasingly difficult for an ACO to consistently perform better than its historical costs.

Provide for new repayment mechanisms for ACOs: As of 2015, CMS no longer allows ACOs to purchase reinsurance policies as a repayment mechanism. Allowing for ACOs in two-sided risk-based contracts to purchase a reinsurance policy would allow them to mitigate significant financial losses.