Center for Health Care Strategies

Medicare Accountable Care Organizations in California: An Overview

Accountable Care Organizations (ACOs) are provider-led organizations that work to improve health care quality, outcomes, and experience of care for their patients while lowering the total cost of care. These organizations can be made up of a single provider organization (such as a primary care practice or hospital system) or a group of provider organizations. ACOs pursue the goals stated above through improved care management and coordination, data sharing and analysis, and the implementation of value-based payment (VBP) incentives that encourage provider organizations to move away from the fee-for-service (FFS) billing structure, which is typically used under Original Medicare, and toward quality improvement and value.

This fact sheet presents an overview of Medicare ACO models relevant to California, including key characteristics of select models and definitions of key terms. It was developed to inform California Department of Health Care Services' (DHCS) stakeholders about Medicare ACO models that have served California Medicare beneficiaries over time.

Through the Office of Medicare Innovation and Integration (OMII), DHCS is releasing resources to highlight characteristics of the Medicare population across the state as well as the health care models and systems that support them.

Key Definitions

- **Accountable Care Organization (ACO)** – An entity comprised of physicians, hospitals, and/or other providers that improves health care quality, outcomes, and care experiences and can offer shared savings.
- **Value-Based Payment (VBP)** – Paying for health care services in a manner that directly links performance on cost, quality, and the patient's care experience.
- **Fee-for-Service (FFS)** – A payment system in which a payer (such as Original Medicare) pays providers for each service rendered.
- **Medicare Shared Savings Program** – An ACO model that encourages providers to improve health for the Medicare FFS beneficiary population and reduces spending with a focus on value and outcomes.
- **Shared Savings** – A VBP incentive designed to reward provider organizations that keep costs below a total cost-of-care benchmark and meet quality standards with a percentage of the savings.
- **Downside Risk** – VBP arrangements under which provider organizations agree to accept financial risk (and potential losses) if their costs exceed a total cost-of-care benchmark.
- **Quality Metrics** – Standards to assess provider performance that are often tied to shared savings or losses.
- **Attribution** – The method used to assign a patient to an ACO through their prior health care utilization or choice of primary care provider.
- **CMS Innovation Center** – Within the Centers for Medicare & Medicaid Services (CMS), the CMS Innovation Center supports strategies to improve patient care and alignment between payment systems while also reducing costs.
- **Health Equity** – When everyone has a fair and just opportunity to be as healthy as possible and obstacles to health — such as poverty, discrimination, and their consequences — are removed.
- **Health Disparities** – Measurable and preventable differences in health outcomes, safety, or opportunities that result from inequities.

Developed for the California Department of Health Care Services by the Center for Health Care Strategies.

Medicare Beneficiaries Served Through ACOs

While ACO activity is prevalent across health care payer types, most ACO activity occurs under the Medicare program through models instituted by the Centers for Medicare & Medicaid Services (CMS) and CMS Innovation Center. These models serve Original Medicare beneficiaries, including individuals that are dually eligible for both Medicare and Medicaid. As of 2020, nationally there were more than 10.3 million individuals served by Medicare ACOs, representing 16 percent of the Medicare population.* In 2020, approximately 403,000 Californians were served by ACOs. Californians dually eligible for Medicare and Medicaid made up 16% of California Medicare ACO beneficiaries ages 65+ in 2020.

Medicare ACO Models

Select Medicare ACO models and their status in California are described below.

MODEL AND DESCRIPTION	STATUS IN CALIFORNIA
Medicare Shared Savings Program (2012-Present) – The Medicare Shared Savings Program (MSSP) is the first and largest ACO program in the nation with 483 ACOs. This program, which was statutorily established under the ACA, employs a shared savings and losses model and has several different "tracks" with varying levels of upside and downside financial incentives.	Twenty-nine (6%) of the 483 MSSP ACOs primarily serve California; 21 (4%) of 483 solely operate in California.
Pioneer ACO Program (2012-2016) – Advanced ACO Model with higher levels of financial incentives, including downside risk.	Three (16%) of 19 Pioneer ACOs served California in calendar year 2015.
Next Generation ACO Program (2016-2021) – This model, the "next generation" successor to the Pioneer ACO Program, had stronger financial incentives and additional tools to support patient engagement and care management.	Two (6%) of 35 Next Generation ACOs served California in calendar year 2021.
Advance Payment ACO Model (2013-2015) – This model, related to the MSSP, focused on helping smaller ACOs with less access to capital participate in the MSSP through upfront monthly payments.	Two (6%) of 35 Advance Payment ACOs served California during the model's period of operation.
ACO Investment Model (AIM) (2015-2018) – The AIM Program, which succeeded the Advanced Payment ACO model, focused specifically on MSSP participants from rural and underserved areas.	Three (7%) of 45 AIM ACOs were based in California during the model's period of operation.
ACO REACH Program (under development) – This new model focused on "Realizing Equity, Access, and Community Health" will advance health equity by bringing the benefits of accountable care to Medicare beneficiaries in underserved communities. The model creates strong financial incentives for participation, including a full-risk global payment model.	Model proposed to launch in 2023.

While California providers have actively participated in many of these Medicare ACO models, provider participation appears to be lower than the national average relative to other states. This is of particular interest given the size of California's population and the presence of health care systems that are accustomed

* Data on ACO enrollment is from the 2020 ACO Public Use File and indicated in person-years, percentage obtained using Medicare enrollment data from CMS.gov.

to accepting financial risk (i.e., large hospital systems, integrated hospital systems, independent physician associations [IPAs]).

ACO Leadership Types

While all ACOs that participate in the Medicare ACO models are led by provider organizations, they vary in composition. Many are "physician-led," which typically includes large primary care practices, IPAs, or virtual networks of primary care providers that have come together to participate in the ACO arrangement. Other ACOs are led by hospital systems, and some have hybrid memberships, led by a mix of physician-led practice and hospital system partners. Many of these ACOs (especially virtual ACOs) operate across many states. In general, physician-led ACOs have been more successful than hospital-led ACOs on achieving shared savings and improving quality, but many hospital-led ACOs and virtual ACOs have also found success in lowering costs and improving quality.

ACO Model Characteristics

To be able to take on risk and manage care for a defined patient population, Medicare ACOs operate within a landscape of complex rules and regulations that vary from model to model. A number of these model characteristics fit into three core categories: **Payment Approach**, **Quality Metrics**, and **Attribution Approach**. Understanding these categories can help provide a foundational understanding of ACO model types.

Payment Approach

ACO models are generally structured through a shared savings or risk-based VBP framework, and the level of risk an ACO assumes can vary by ACO or model. An ACO may have "upside only" risk or "shared savings" — in which, if savings are achieved based on an expected total cost of care target, those shared savings are shared with CMS. In an arrangement that also includes "shared losses" or "downside risk" — if the ACO's total cost of care exceeds its target — it must pay back a portion of the overage to Medicare. Generally, models with downside risk provide a larger shared savings potential to the ACO.

Quality Metrics

All Medicare ACOs report on and have their performance measured based on a set of federally defined quality metrics that are tied to any shared savings or losses. Providers will not receive any shared savings payment if they do not meet or exceed an acceptable amount of these quality targets. The MSSP had its own set of quality metrics for many years, but recently aligned its quality metrics reporting and scoring process with that of the Alternative Payment Model Performance Pathway (APP), which is part of the CMS Quality Payment Program required for all Medicare providers. These metrics vary from year to year, but MSSP ACOs are currently required to report 10 CMS Web Interface measures or three electronic Clinical Quality Measures.

Patient Attribution Approach

Attribution approaches tell ACOs which of their patients they are accountable for in terms of cost and quality. Medicare ACO models have one of two types of attribution models, retrospective or prospective, which are typically specified in the model. Retrospective approaches assign patients to ACOs after the performance period, based on actual utilization during the performance period. This model is most common and used by the MSSP. Prospective models assign patients before the performance period, either by utilization patterns in prior years or patient choice of a primary care provider (PCP). This approach is used by more advanced ACO models, such as the Next Generation ACO model, which ended in 2021.

Patient Experience with ACOs

Patients generally do not realize that their care is being managed by a Medicare ACO. ACO attribution is passive and does not impact the Medicare benefits a patient is entitled to or their choice of care providers. Retrospective models are done after the fact based on patient utilization; as a result, the patient would not receive notification of the provider to which they were attributed. Prospective models based on past PCP utilization are similar. While patients can be attributed prospectively based on their choice of PCP, they may not necessarily know that the PCP is part of an ACO. While there are some Medicaid and commercial ACO approaches that have patients select an ACO, no CMS-led Medicare models have this option. Generally, ACOs (including the MSSP) are required to post a sign in providers' offices explaining that the provider is part of an ACO and be able to provide more information if requested. Some practices do choose to voluntarily disclose this information through intake paperwork or marketing efforts, but it is not required.

ACOs may refer patients to preferred providers within the ACO or provide different levels of care coordination based on their participation in an ACO, but this is generally not explained to the patient as an ACO activity or benefit. However, even though patients are generally not aware of ACO activities, patient experience of care has been shown to improve for MSSP ACO's first year, and for hospitals that participated in the Pioneer ACO program, though other studies did not find a significant link to improvements in patient experience.

ACOs in the Future

ACOs are poised to continue their evolution into the future, both inside and outside of the Medicare program due to CMS' continued investment in refinement of ACO models as well as ongoing bipartisan support at the federal level. While some of the models used today have replaced prior models, the MSSP remains the "flagship" Medicare ACO model. Other models for more advanced ACOs (Pioneer, Next Generation) and underserved populations (Advance Payment, AIM) have come and gone, but each served a valuable function as an experimental platform. Lessons from these models have been incorporated into the continued development of the MSSP and anticipated ACO REACH model. Future models from the CMS Innovation Center are likely to continue this trend.

In terms of potential refinement of ACO model characteristics, the CMS Innovation Center is likely to continue to push Medicare ACO models to take on higher levels of downside risk and accountability. A larger focus on health equity and reducing health disparities beyond what has been included in the ACO REACH model is also probable. The types of quality metrics used may target health equity goals more directly, and over time they may also include greater focus on mental health, substance use, and patient experience of care.

Prepared by the **Center for Health Care Strategies (CHCS)**, a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS supports partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit **www.chcs.org**.

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