American Academy of Physician Associates

PAs and Accountable Care Organizations

Introduction to ACOs

An Accountable Care Organization (ACO) is a group of healthcare providers (including PAs, physicians, hospitals, and other healthcare entities) who voluntarily agree to jointly provide coordinated, high-quality care to Medicare patients. ACOs are financially incentivized to reduce spending while achieving good patient health outcomes. This is achieved through the shared savings between Medicare and the ACO participants if quality care can be delivered for less than a predetermined benchmark cost level.

Background

ACOs were established by the Affordable Care Act in 2010. Medicare has recently implemented several types of ACOs, including the Medicare Shared Savings Program (MSSP), Pioneer ACO Model, and the Next Generation ACO model, each with varying levels of risk and reward. Medicare aims to have 100% of Medicare beneficiaries enrolled in an accountable care model by 2030.[1] The recent focus for ACOs has been in primary care settings, where it has been shown to generate the most savings.[2]

Key Components

ACOs assume responsibility for the cost and quality for an assigned group of patients. Their success is determined by shared savings and losses:

- ACOs that spend less than the benchmark set by Medicare while meeting quality benchmarks can share in the savings, between 40% and 75% for the 2024 performance year.[3]
- ACOs with downside risk, in which ACOs take on financial risk for their outcomes, whose spending exceeds cost benchmarks may have to pay a portion of that additional spending back to CMS, between 30% and 75% for the 2024 performance year.[3]

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[1] Centers for Medicare and Medicaid Services. *CMS Announces Increase in 2023 in Organizations and Beneficiaries Benefiting from Coordinated Care in Accountable Care Relationship*. January 17, 2023 https://www.cms.gov/newsroom/press-releases/cms-announces-increase-2023-organizations-and-beneficiaries-benefiting-coordinated-care-accountable

[2] Congressional Budget Office. *Medicare Accountable Care Organizations: Past Performance and Future Directions.* April 2024. https://www.cbo.gov/system/files/2024-04/59879-Medicare-ACOs.pdf

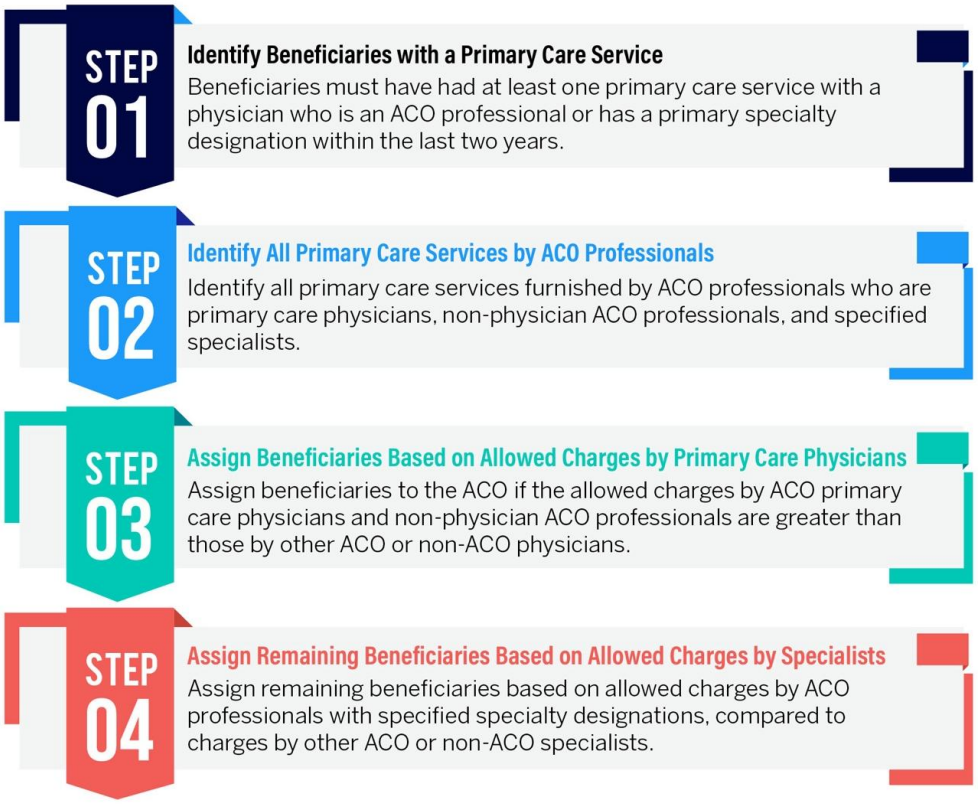
[3] Centers for Medicare and Medicaid Services. *Medicare Shared Savings Program: Shared Savings and Losses, Assignment and Quality Performance Standard Methodology.* Version 12. January 1, 2024.
Shared Savings and Losses, Assignment, and Quality Performance Standard Methodology Specifications Version 12

- Quality Measures: ACOs are evaluated based on a set of quality measures, including patient and caregiver experience, care coordination, patient safety, and preventive health. Specific quality measures vary across ACOs as different ACOs manage various patient populations, geographical areas, and provider types.

ACO Attribution Process

Medicare primarily identifies beneficiaries for ACO assignment based on claims data using the process outlined in the table below.

Table: ACO Attribution Process



PA Participation in ACOs

PAs are eligible to participate in ACOs, though some barriers exist. Beneficiaries can either designate a PA as their primary care provider for ACO attribution purposes through a voluntary process, or patients can be assigned to ACOs through Medicare's attribution process. Current barriers for PAs include:

- Traditional Attribution Models
  - The existing framework only identifies beneficiaries who have had at least one physician visit with a primary care service within the last two years.
  - Beneficiaries who have only received services from a PA within that period would not be identified for ACO attribution, even if the PA is an ACO provider.
- Claims Data Transparency Issues
  - When PAs bill "incident to" under a physician's NPI, their work is captured or attributed incorrectly by claims data, leading to inaccurate attributions and under-recognition of the PA's role in the ACO.
- Lack of Standardized Recognition Across ACO Models
  - For PAs participating in multiple ACO models, such as a Medicare ACO and one or more state Medicaid ACOs, different programs have varying rules and structures regarding quality metrics, reporting, and attribution, creating confusion and inconsistent recognition of a PA's role across different ACOs.

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