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The Financial Effects of ACO Risk Sharing

The 10th advisory in our series on the newly proposed ACO regulations implementing Section 3022 of the PPACA

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As summarized in our previous advisories, the Patient Protection and Affordable Care Act anticipates the creation of accountable care organizations comprised of physicians, hospitals, and other health care suppliers.

ACOs must be willing to enter into a three-year Shared Savings Program agreement with the Centers for Medicare and Medicaid Services and be accountable for the care of at least 5,000 Medicare beneficiaries. If quality performance standards are met, the ACO is eligible to receive shared savings bonus payments in addition to fee-for-service payments. The details are contained in the proposed ACO rule published by CMS on April 7, 2011.

This 10th advisory in our series on ACOs focuses on how CMS proposes to either financially reward or penalize ACO participants. During the first two years of the program, participating ACOs will have the choice to share savings with no downside risk (the “one-sided model”). By year three, however, all ACOs must both share savings and be at risk should the costs of care exceed the established thresholds (the “two-sided model”). ACOs in the two-sided model have the opportunity to achieve larger financial bonuses, but also run the risk of having to refund money to CMS.

CMS proposes to calculate performance by comparing the ACO’s future Medicare payments against a “benchmark” of what CMS would have paid for services to the same patient population absent the ACO’s efforts to achieve cost savings.

As explained in more detail below, the cost and risk sharing components of the proposed ACO model are complex and the amount of the potential reward seems relatively modest when one considers the level of investment required to establish the ACO infrastructure. Based on the industry’s reaction to the proposed rule, it appears that the ACO model is more likely to evolve through innovation by providers and commercial payors.

Minimum savings rate

CMS has proposed that the one-sided model require a minimum savings rate (MSR) that varies between 2 percent and 3.6 percent of all Medicare Parts A and B expenditures, depending on the size of the population served. By contrast, the two-sided model will require a flat MSR of 2 percent, the same as the minimum loss rate, as explained below.

Special bonuses for ACOs that include FQHCs and/or RHCs

Under the two-sided model, CMS proposes to double the financial bonus to ACOs that choose to incorporate the services of Federally Qualified Health Centers (FQHCs) and rural health centers (RHCs). Two-sided ACOs that incorporate such services will be rewarded with a bonus of up to 5 percent of the shared savings, instead of 2.5 percent for one-sided ACOs.

As with the one-sided model, the size of this bonus varies with the number of participating beneficiaries. An ACO would need at least 41 percent of its beneficiaries to have at least one encounter with an FQHC or RHC in order to receive the maximum 5 percent bonus.

More shared savings and no threshold

CMS proposes that ACOs in the two-sided model will benefit from both a higher potential shared savings and a higher cap on bonuses than one-sided ACOs. Two-sided ACOs will be eligible to share up to 65 percent of the savings (including the maximum 5 percent bonus for FQHC/RHC participation) as opposed to 52.5 percent for one-sided ACOs (including the 2.5 percent bonus). The cap on their shared savings will be increased to 10 percent of the benchmark from 7.5 percent.

In addition, unlike ACOs in the one-sided model, which don't share any savings until a savings threshold of 2 percent of the benchmark has been achieved, two-sided ACO's will be entitled to shared savings on a "first dollar" basis. In other words, any two-sided ACO that exceeds its MSR will participate in the savings, without application of any minimum threshold.

Shared losses

The obvious downside of ACO risk sharing is the requirement that ACOs also share in CMS' losses. Two-sided ACOs that fail to achieve their benchmarks will have to repay CMS a portion of the difference between their benchmark and CMS' actual Medicare Parts A and B expenditures for their assigned beneficiaries. As with shared savings, the shared losses will be ameliorated by a minimum loss rate threshold, shared loss caps, and adjustments for FQHC/RHC participation.

CMS wants ACOs that meet the quality standards and FQHC/RHC participation goals to benefit from that success despite suffering a loss. Consequently, the maximum loss rate is essentially the obverse of the maximum savings rate. For example, if an ACO acheives the maximum potential savings rate of 65 percent, then the maximum loss rate will be 35 percent (100 percent minus 65 percent).

In any year for which an ACO is responsible for shared losses, there will be a minimum shared loss threshold of 2 percent: the ACO won't have to pay CMS anything unless the losses exceed 2 percent of the benchmark. In addition, there will be a phased-in shared loss cap: ACOs will not have to pay back CMS for more than 5 percent of the benchmark in its first year in the two-sided model, 7.5 percent in the second year, and 10 percent thereafter.

Ensuring loss repayment

CMS takes repayment of ACO shared losses seriously. CMS will hold back 25 percent of every ACO's shared savings as a down payment against any future losses. But, recognizing that the holdback may not be sufficient to cover potential shared losses, CMS requires ACOs to take additional steps.

CMS decided to allow ACO's to propose for CMS' prior approval a "self-executing method" for repayment of potential shared losses equal to at least 1 percent of beneficiary expenditures for the most recent year available. Self-executing methods may include: agreeing to impose a capital call on ACO provider participants, obtaining reinusurance, placing sufficient funds in escrow, obtaining a surety bond, establishing a line of credit for the Medicare program to draw from directly, or any other approved, infallible method for repayment.

In addition, two-sided ACOs must publicly report their losses as well as their savings, and any ACO that experiences losses for three straight years will be barred from further participation.

Finally, ACOs will also be responsible for verifying CMS' calculations of both savings and losses. In both cases, ACOs must certify to the accuracy, completeness and truthfulness of all data submitted and considered by CMS. Shared losses must be repaid in full to CMS within 30 days of CMS' written notification, but shared savings will only be paid after a written request from the ACO.

Conclusion

CMS may be trying its best to make the two-sided ACO model appear to be an attractive business proposition. Vast sums of money are involved, and it is possible that an ACO could do quite well financially.

Considered in a vacuum, CMS' approach of requiring an ACO applicant essentially to guarantee the repayment of shared losses may be a prudent business decision. However, in the context of promoting such a radical change in our national health care delivery system, CMS has not done itself any favors by adding to the task list of a would-be ACO the need to obtain a letter of credit or an agreement from the participating providers to answer a capital call in the event of losses which CMS appears to expect. The proposed rule has already come under heavy criticism, and it remains to be seen what the final rule will look like.

In our ongoing series on the newly proposed ACO regulations, we will be issuing additional separate advisories focusing on specific topics raised by the regulations and the affiliated guidance and requests for comments including:

- State law restrictions
- When things go wrong or circumstances change

Please also see our past installments in this series:

"The New ACO Regs: They're Here (Well, Sort of ...)" (04. 05.11)

"Antitrust Enforcement Agencies Issue Proposed Guidance on ACOs" (04.06.11)

"What the Proposed ACO Regulations Say About Legal Structures and Governance" (04.11.11)

"ACOs: The Fraud & Abuse Waivers – Finding a Path Through the Maze" (04.15.11)

"Proposed Quality Measures for ACOs " (04.18.11)

"If You Build It, Who Will Come?" (05.02.11)

"How IRS Guidance Addresses ACO Participation for Exempt Hospitals and Other Health Care Organizations" (05.09.11)

"Are There Enough ACO $hared $avings to $hare?" (05.23.11)

"CMS Innovation Center Advertises Opportunities for 'ACO Pioneers'" (05.23.11)