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Accountable Care Organizations Payment Options for ACOs Pursuant to the Proposed Rule

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The Affordable Care Act (the "ACA") establishes the general requirements for payments to participating Accountable Care Organizations ("ACOs") pursuant to the Shared Savings Program, described in Section 3022 of the ACA. The ACA provides that ACO participants will continue to receive payment under the original Medicare fee-for-service ("FFS") program under Parts A and B. In addition, ACOs can receive payment for shared Medicare savings provided that they meet both quality performance standards and demonstrate achievement of savings against a benchmark of expected average per capita Medicare FFS expenditures. On March 31, 2011, the Centers for Medicare and Medicaid Services ("CMS") released its proposed rule regarding ACOs (the "Proposed Rule"). This blog entry is an overview of the payment options for ACOs set forth in the Proposed Rule. (For a discussion of the legal structure and governance of ACOs, please see our April 11, 2011 entry.)

One-Sided or Two-Sided Model?

CMS is proposing that ACOs have the option between two tracks of participation:

Track 1: Under Track 1 or the one-sided model, an ACO would have no downside risk for the first and second years of the required 3-year agreement period. In other words, ACOs would not be responsible for any portion of the losses incurred in excess of their applicable expenditure target. For the third year, an ACO would be required to share any losses with Medicare that may be generated, as well as savings. After the initial 3-year period, ACOs that wish to continue participating in the Shared Savings Program would only have the option of participating in Track 2. CMS believes the one-sided model provides an entry point for organizations with less experience with risk-models.

Track 2: ACOs that are "ready to share in losses with greater opportunity for reward" may elect to enter the two-sided model. An ACO participating in Track 2 would be under the two-sided model for the entire 3-year agreement period. Under this model, the ACO would be eligible for higher sharing rates than would be available under the one-sided model, but would also have to share losses for the entire 3-year period.

Establishment of an Expenditure Benchmark

CMS will establish an expenditure benchmark for each ACO to determine shared savings or responsibility for losses. The expenditure benchmark can be seen as a measure of what Medicare expenditures would have been in the absence of the ACO. The difference between actual expenditures of the ACO's beneficiaries during each year of the agreement period and its benchmark should, according to CMS, reflect how well the ACO is coordinating care and improving overall efficiency. The ACA specifies several requirements with regard to the benchmark: (1) the benchmark must be based upon the most recent available three (3) years of per-beneficiary expenditures for parts A and B services for Medicare FFS beneficiaries assigned to the ACO; (2) the benchmark must be adjusted for beneficiary characteristics and such other factors that CMS determines are appropriate; (3) the benchmark must be updated by the projected absolute growth in national per capita expenditures for parts A and B; and (4) the benchmark must be reset at the start of each ACO 3-year agreement period.

Regarding the first requirement (that the benchmark must be based on the most recent available three (3) years of per-beneficiary expenditures), CMS proposed two possible approaches. The key difference between the approaches is the beneficiary population used to determine expenditures for purposes of the benchmark. Under the first approach, the benchmark would be based upon expenditures of beneficiaries who would have been assigned to the ACO in each of the three (3) years prior to the start of an ACO's agreement period using the ACO participants' tax identification numbers. In contrast, under the second approach, the benchmark would be based upon expenditures of beneficiaries who are actually assigned to the ACO during each performance year, with expenditures being those incurred in the three (3) years immediately preceding the ACO's agreement period. In the Proposed Rule, CMS has opted for the first approach, but is soliciting comments on both options.

CMS has been granted the authority to adjust both the benchmark and the average per capita expenditures for beneficiary characteristics and the benchmark for "such other factors" as CMS determines are appropriate. CMS has proposed to adjust the benchmark and annual per capita expenditures to account for changes in beneficiaries' health status. CMS stated that this requirement "helps to ensure that quality and efficiency in the delivery of health care services are the basis for realizing and sharing savings under the Shared Savings Program." CMS discussed two options in the Proposed Rule. One option would only consider patient demographic factors, such as age, sex, Medicaid status and the basis for Medicare entitlement (for example, age or disability). The second option would also consider diagnostic information, that is the CMS-HCC prospective risk adjustment model that has been used under the Medicare Advantage Program. CMS is proposing to adopt the second methodology. It believes this methodology will encourage ACOs to maintain complete and accurate medical documentation which could result in "better information for population management, care coordination, and quality improvement." CMS has proposed to calculate a single benchmark risk score for each ACO, which will then be applied throughout the agreement period.

The Proposed Rule also addresses a number of other technical adjustments to the benchmark. CMS discussed whether it would be appropriate to remove from the benchmark and the calculation of actual expenditures for an ACO: (1) the indirect medical education adjustment (the additional payment to teaching hospitals to support medical education) and/or (2) the Medicare disproportionate share hospital adjustment. However, CMS noted that the ACA only provides authority to adjust expenditures in the performance period for beneficiary characteristics, not for other factors. As a result, CMS concluded that an adjustment to the benchmark based upon such payments would be inappropriate since the benchmark would be set artificially lower relative to the performance period and would make it more difficult for an ACO to achieve savings. CMS also discussed adjusting the benchmark calculation to remove the effects of geographic payment adjustments from the calculation of the benchmark. After consideration of comments, CMS may adopt such a policy in the final rule.

Pursuant to specific statutory authority, CMS is proposing to exclude Medicare expenditures or savings for incentive payments and penalties for value-based purchasing initiatives, including the Physician Quality Reporting System and the EHR incentives for eligible professionals under the HITECH Act from the computation of both the benchmark and actual expenditures during the agreement period. CMS has stated that this approach will reduce the chance that such payment incentives would discourage full participation in the Shared Savings Program.

Minimum Savings Rate

The ACA establishes than an ACO will only be eligible for payment of shared savings if the estimated average per capita Medicare expenditures under the ACO for Medicare FFS beneficiaries for Parts A and B, adjusted for beneficiary characteristics, is at least the percent specified by CMS below the applicable expenditure benchmark, termed the minimum savings rate ("MSR"). The MSR is the margin to account for normal variation in expenditures. For Track 1 participants, the MSR will be determined based on the number of its assigned beneficiaries. The proposed MSR varies from 2% for ACOs with at least 60,000 beneficiaries to 3.9% for ACOs with between 5,000 and 5,999 beneficiaries. CMS is soliciting comments on the MSR scale. For Track 2 participants, the MSR will be 2% and not subject to any variance based upon the number of beneficiaries.

It is important to note that ACOs will be eligible to earn varying payments for achieving savings in excess of the MSR. For Track 1, the Proposed Rule provides that, unless exempted, an ACO must exceed its applicable MSR by at least 2% of the expenditure benchmark to be eligible to share in savings. Although the drafters considered sharing savings from the first dollar once an MSR was reached, "given the normal variation in expenditures" and due to "concerns that sharing on first dollar could result in sharing on unearned savings rather than on savings achieved by the ACO for redesigned care processes" that option has been rejected. However, Track 2 participants are eligible to share in savings from the first dollar of savings in excess of their applicable

MSR. Again, CMS has provided an incentive to participants to select Track 2.

CMS has proposed that certain ACOs be exempt from the MSR threshold, including, for example, ACOs with less than 10,000 assigned beneficiaries in the most recent year for which complete claims data exists and which are comprised only of ACO professionals in group practice arrangements (i.e., medical groups) or networks of individual practices of ACO professionals (i.e., IPAs).

ACOs will be subject to similar minimum loss rates prior to being responsible for sharing in losses in excess of expenditure targets. CMS has stated this is necessary in order to provide sufficient confidence that the losses are not the result of random variation. To share losses, an ACO's average per capita Medicare expenditures for the performance year must be at least 2% above its benchmark costs for the year.

Payment and Loss Limits

The Proposed Rule includes limits on how much ACOs may receive for achieving shared savings. CMS describes competing considerations at play. While there is a clear need to incentivize ACOs to maximize savings there is also a concern that providing ACOs with opportunities to earn large amounts for creating savings could cause excessive reductions in utilization which could potentially cause more harm than good for beneficiaries.

Under the Proposed Rule, ACOs participating in Track 1 would be limited to earning up to 50% of the shared savings with a payment cap of 7.5% of their expenditure benchmark. In order to incentivize ACOs to adopt Track 2 and assume risk for shared losses immediately, the payment limits in Track 2 are increased to 60% of the shared savings with a payment cap of 10% of expenditure benchmarks. ACOs that include Federally Qualified Health Centers and/or Rural Health Centers as ACO participants are eligible for increases in their proportionate share of savings (and therefore a converse decrease in their proportionate share of losses) of up to 2.5% for Track 1 participants and 5% for Track 2 participants (no increase in the payment caps are available however). Again, comments are being solicited on these limits.

Conversely, CMS is also proposing limits on ACO losses. ACOs participating in Track 2 and ACOs in the third year of Track 1 will have a phased-in cap on losses of up to 35% of shared losses (determined by subtracting the percentage of shared savings achieved from 100%) with a payment cap of 5% of their expenditure benchmark for year one (1) of their contract, 7.5% of their expenditure benchmark for year two (2) and 10% of their expenditure benchmark for year three (3). ACOs participating in Track 1 will have a cap of 5% of their expenditure benchmark for the third year of their agreement (the only year in which they are required to share risk of losses).

Clearly, CMS has provided numerous incentives to participants who choose Track 2. Will the bigger "carrot" offered under Track 2 be attractive enough to outweigh the risk of shared losses in year one and two?

Payment Holdback and Other Protections

CMS has proposed that 25% of any payments otherwise due to an ACO based on the previous year's shared savings be held back by CMS to guard against future losses. Positive balances from this withhold are repaid at the end of a 3-year ACO agreement and ACOs that do not complete a 3-year agreement would forfeit withheld savings.

Additionally, CMS has proposed to require ACOs to establish self-executing methodologies for repaying losses by agreeing that funds may be recouped from Medicare payments to ACO participants, obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing lines of credit or establishing other acceptable protections.

Payment Mechanics

Unlike the typical shared risk pool arrangement wherein medical groups are often eligible to carry losses and positive balances forward year to year, the Shared Savings Program will reconcile any payments due to or from an ACO on an annual basis (although the 25% withhold each year will carry forward until the end of a contract period). CMS has proposed to inform ACOs of their eligibility to receive shared savings payments or their obligations to make payments to CMS for shared losses. CMS proposes that ACOs must make payments in full of any shared losses within 30 days of receipt of notification along with certifications as to ACOs' compliance with program requirements and accuracy, completeness and truthfulness of data submitted to CMS. Presumably ACOs with obligations for shared losses may direct CMS to offset such amounts from previously withheld savings to the extent they exist, although such mechanics are not discussed in the Proposed Rule.

Furthermore, ACOs will not automatically receive shared savings payments. ACOs must actually request such amounts and submit similar compliance certifications in order to receive payments from CMS. Interestingly, no time periods for payments from CMS have been proposed nor have penalties for delays been discussed. No dispute resolution procedures are contemplated. The Proposed Rule states "[t]here is no reconsideration, appeals, or other administrative or judicial review" of the determination of whether an ACO is eligible for shared savings, the amount of such shared savings, the average benchmark for the ACO or the percent of shared savings to which the ACO is entitled.

The benchmark determinations, MSR thresholds and final payment limits and mechanics will be pivotal to the success of the Shared Savings Program. There is a fine line between incentivizing efficiencies and savings in the program and rewarding excessive limitations in care. A balanced approach will be necessary to maximize interest in ACOs. We urge all healthcare professionals to provide their comments on these factors to CMS.

If you have questions about ACO formation, please contact Eric Klein at (310) 228-3728 or Kenneth Yood at (310) 228-3708.