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ACO Payments: Risk, Reward, and Reviewing Your Healthcare Partners

By Keith L. Martin | April 21, 2011

"The financial opportunity for an ACO to achieve shared savings will vary according to its initial tolerance for risk."
– CMS Administrator Donald M. Berwick

With one of its main tenets of shared savings, the recently-released proposed rules for accountable care organizations outline how physicians can balance risk versus reward in these new healthcare partnerships. In addition to choosing whether to participate in ACOs, who physicians select as their partners in these new ventures is equally as important.

As Berwick notes in his statement in the New England Journal of Medicine, ACOs who register with CMS have options as to how they would like to receive shared savings payments, depending on how confident they are in their structure and partners. ACOs that register with CMS must indicate to the federal agency which one of two savings models they plan to participate in.

The shared savings models are defined as "tracks":

Track 1: ACOs participating in this track are eligible for annual shared savings of up to 50 percent without having to accept the risk of being penalized for any losses for a period of two years. This is primarily designed for newer ACOs just starting out under the new initiative. In the third year of ACO participation, however, these groups automatically begin accepting risk for the first time.

Track 2: ACOs participating in this track immediately accept risk and pay a penalty if Medicare expenditures exceed their pre-determined benchmark of savings. In return for immediately accepting risk, the ACO receives a savings sharing rate of up to 60 percent.

John C. Erickson III, an attorney focusing on healthcare for Columbus, Ohio-based Squire, Sanders & Dempsey, said CMS "has made it very clear" that having both tracks "is necessary for permanent and meaningful changes."

"They believe placing the ACOs at risk is what really will drive permanent changes in healthcare," said Erickson.

He added that Track 1, which permits initial participation in the one-sided model, is particularly

important for physician groups as ACOs driven by physicians, which will tend to be smaller, may not have the same risk tolerance or experience with population management as larger hospitals.

"Therefore, CMS wanted to encourage as broad participation as possible out of the gate, so this is CMS' way of saying 'we appreciate if you are smaller and don't have this type of experience, we want you to participate and if you participate, we'll shield you from the downside for two years.'" Erickson said.

NO RUSH TO RISK

But don't expect a long line of first-time participants when the ACO rules are finalized later this year and registration opens up on Jan. 1, 2012, according to Erickson. He anticipates between 75 and 125 applications at the onset, with many waiting for best practices to emerge first. ACOs must, however, wait until Jan. 1 of each year to register, although the proposed rule by CMS indicates that there is a "possible" additional July 1 start date to come next year.

So that means, said Erickson, that those jumping in for 2012 — the "sophisticated players" — will likely elect for Track 2, having established their ACOs and partnerships well in advance and willing to take on risk for greater rewards. That means very few ACOs selecting Track 1 as early adopters of the collaborative approach will likely watch and wait for results from others nationwide.

"I think there is no shame in letting best practices develop and emerge and clearly, there will be a whole lot written and spoken about this," said Erickson. "Whatever comes out of this will be trumpeted as public good."

That stance is echoed by Martie Ross, a partner in the Overland Park, Kan., office of law firm Spencer Fane Britt & Browne, who advises physicians practices on a number of issues, including healthcare reform initiatives.

"I'd encourage everyone to slow down," she said. "I think it would be nearly impossible, unless you are talking about a Geisinger Health System or a Mayo or Cleveland Clinic, to be ready to go and apply for the Jan. 1 [2012] date. Everyone is excited about ACOs, but it is fine if you don't get in until Jan. 1, 2013."

PARTNERSHIPS KEY TO PICKING 'TRACK'

If you are going to share savings, you are also going to share the impact of losses under the ACO proposed rule. That means before signing up to be part of a collaborative team, you need to know your partners and have your own role clearly defined, said our experts.

Like any other business partnership, Erickson says physicians' practices need to realize that they can control their own costs, but ask if the same can be said for their potential ACO partners and what happens if a partner is not as equally successful. That risk level may not be appealing to some physicians who already have referral patterns and associated with one or two hospitals already.

"So it presents an interesting question," said Erickson. "Am I going to jump in and take the risk early with participants that I don't know well and don't know how they bill for services?"

Ross said the devils are in the details of ACOs, with physicians needing to be keenly aware of their agreements with partners on sharing savings as well as responsibility for losses.

For an ACO to succeed, she notes, it has to be driven by collaboration, led by physicians, to better allocate resources in patient's care plan. A physician group may be able to do this on their own, without a hospital partner, and therefore realize a greater savings distribution, but having the resources to get started on their own is a big obstacle.

"Most physicians won't be in a position to do that since they don't have the infrastructure for their organization, don't have the developed management skills, and it really doesn't foster this concept of collaboration," Ross said.