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Despite Decreased Regulatory Burdens and Increased Financial Incentives, ACOs Still Face Large Start-Up Costs and Uncertain Savings In Final CMS Rules

Under final rules issued by the Centers for Medicare and Medicaid Services (CMS), Accountable Care Organizations (ACOs) will continue to face large start-up costs and uncertain savings, despite a decreased regulatory scheme and increased financial incentives. ACOs are organizations of health care providers that agree to be accountable for cost, quality and the overall care of Medicare beneficiaries. Responding to over 1300 public comments filed in response to earlier draft regulations, CMS made a number of modifications that result in greater flexibility of ACO operations, increased financial incentives for ACO participants and simpler, more streamlined quality performance standards. Nonetheless, the modifications are unlikely to change the cost-benefit analysis that healthcare providers will face when deciding whether to participate in the ACO program.

In an implicit acknowledgement that healthcare providers will be slow to warm to the idea of ACOs, CMS lowered its range of anticipated ACOs to between 50 and 270, a drastic decrease from the 300 to 800 potential ACOs it estimated in its draft regulations. However, CMS maintains that start-up and ongoing annual operating costs will remain at approximately $1.7 million per ACO, despite a widely-publicized American Hospital Association study that estimated such costs to be in the range of $11.6 million to $26.1 million, depending on the size of the ACO.[1] CMS also maintains that the median estimated savings shared with ACO participants to be $1.3 billion over a four-year period. Due to the lower number of anticipated ACO participants, CMS estimates that ACOs will enjoy a benefit-cost ratio of 2.9. However, if the AHA estimates of start-up and operating costs are correct, ACOs will not achieve any savings and will face enormous losses.

1 AHA Press Release, May 13, 2011, *New Study Finds the Start Up Costs of Establishing an ACO to be Significant; CMS underestimates the investment needed to create an ACO*, available at: http://www.aha.org/presscenter/pressrel/2011/110513-pr-aco.shtml

History of ACO Regulations

ACOs were created under the Patient Protection and Affordable Care Act of 2010 in an attempt to increase health care quality while reducing costs. On April 7, 2011, CMS issued proposed rules that were heavily criticized for containing burdensome data collection requirements, large start-up costs, uncertain savings, possible financial loses and troublesome governance mandates. In an attempt to blunt heavy criticism of the draft regulations, CMS announced the creation of so-called "Pioneer ACOs" in May 2011. However, the Pioneer ACOs provided only slight modifications to the draft ACO regulations. At the same time, CMS announced it was seeking comments on "Advance Payment ACOs" that would allow ACOs to receive up-front financial assistance to lessen the burden of high start-up costs.

Even after the "Pioneer ACO" and "Advance Payment ACO" regulations were released, CMS received approximately 1320 public comments on the April 7, 2011 regulations that addressed issues on multiple topics. In response to those comments, CMS changes in three general areas: greater flexibility of ACO operations; increased financial incentives; and simpler and more streamlined quality performance standards.

Greater Flexibility of ACO Operations

In order to provide a base of operations for providing accountable care, ACOs must have a sufficient base of primary care providers to oversee the health of the patient population. The proposed regulations required that primary care physicians be exclusive to one ACO. However, the final regulations allow a primary care physician to be part of multiple ACOs if he or has not been billing under an individual taxpayer identification number. Additionally, ACOs will be allowed to choose between two start dates if they begin operations in 2012, rather than the January 1, 2012 start date in the proposed regulations. For those ACOs that start in 2012, a longer performance period than three years will be allowed, though the period will only be extended by approximately six months – through December 31, 2015.

ACOs will be given greater flexibility in their governance structure. The proposed requirement that each participant be on the governing board has been eliminated in favor of a requirement that ACOs simply provide for meaningful participation in the composition and control of the ACO's governing body by ACO participants or their designees. However, CMS has maintained the draft regulation that ACO governing boards contain a Medicare beneficiary from the patient population served by the ACO.

In an important concession to the realities of operating a healthcare organization, CMS will allow ACO participants to be added or subtracted during the course of the agreement period, with appropriate notification to CMS. CMS has also eliminated the requirement that at least 50% of an ACO's primary care physicians be "meaningful EHR users" by the start of the second performance year.

The final rule further eliminates the earlier requirement that certain ACOs be subject to mandatory review by antitrust agencies prior to their enrollment in the ACO program. This review is now voluntary, however, CMS has stated it will still coordinate closely with antitrust agencies throughout the ACO application process and the duration of the program to ensure that ACOs do not have a detrimental impact upon competition.

Increased Financial Incentives

CMS was persuaded by the comments to the draft regulations to improve the financial attractiveness of the program to encourage broad participation by providers and suppliers, especially those likely to comprise smaller ACOs such as small and medium sized physician practices and rural and safety net providers. Most importantly, CMS has removed the proposed 25% withhold of shared savings that it sought to keep to ensure repayment of any future losses. Also, ACOs that choose to enroll in the so-called "one-sided" ACO program containing no risk of repayment losses can stay in that program for the duration of the agreement, instead of being transitioned to a risk-based model in the third year of the agreement. However, in subsequent enrollment periods, those ACOs will have to participate in the two-sided risk model. CMS hopes this change will increase participation by those ACOs not yet ready to assume risk.

Also important, CMS has eliminated its proposal that one-sided model ACOs could only share in savings after savings had surpassed a minimum savings rate that would be established by CMS. Instead, one-sided ACOs will be able to share in first-dollar savings.

To attract academic medical centers and safety net hospitals, CMS will exclude IME and DSH payments from ACO benchmark and performance year expenditures, which should make it more financially more attractive for these institutions to participate in ACOs.

CMS will also allow two-sided ACOs, who will carry the risk of repaying losses, additional time in which to repay any losses. This time period has been extended from 30 to 90 days.

CMS further announced that it will pay for the cost of mandatory patient experience of care survey in 2012 and 2013, though in 2014, ACOs will have to select and pay a vendor for this function.

The claims run-out at the end of the agreement period will also be shortened from 6 to 3 months, in an attempt to provide a final accounting in a quicker manner, and so that ACOs will be able to receive shared savings faster.

Finally, CMS has increased the shared savings cap, which will enable ACOs to potentially receive a greater percentage of shared savings.

Simpler, More Streamlined Quality Performance Standards

In perhaps the biggest structural change to the ACOs that will impact quality, CMS announced it will assign Medicare beneficiaries to ACOs on a prospective rather than a retrospective basis. This will allow ACOs to identify in advance those patients for whose care they will be given responsibility and to measure performance standards. However, CMS stressed that it will continue to monitor the operations of ACOs to detect if they are engaged in avoidance of high risk or high cost beneficiaries. Such behavior by an ACO can result in its termination from the program.

Equally important, CMS announced it was reducing the number of quality indicators from 65 to 33. CMS removed those measure perceived as redundant, operationally complex or burdensome and retained those that would still demand a high standard of quality while focusing on priority areas. The new measures are designed to include both process and outcome measures that will be able to measure short-term outcomes while lessening the burden of data reporting by the ACOs.

Are These Modifications Enough to Overcome Significant Regulatory and Financial Burdens?

Despite having made modifications to the proposed regulations in three major areas described above, there remain significant regulatory burdens and high implementation costs associated with ACOs. They will continue to face a significant outlay of resources to create new legal entities, build a management and leadership structure, provide for IT platforms and comply with the still numerous CMS regulations, including an unchanged compliance requirement from the draft regulations. Especially concerning is the wide divergence of estimates for start-up and operating costs between studies produced by CMS and the AHA. If even a fraction of the higher AHA costs are realized, ACOs will certainly lose money in this endeavor. Healthcare providers should continue to exercise caution before joining an ACO due to this potential.