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HEALTH LAW CHECKUP

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ACOs: Big Deal or Big Mistake?

When Congress passed the Affordable Health Care Act, Accountable Care Organizations ("ACOs") were touted as a cutting-edge solution to rising U.S. health care costs. Now, ACOs are being criticized, with even some of those touted as models for the program refusing to participate under the proposed rules. This Health Law Checkup will discuss several potential disincentives to ACO participation contained in the proposed regulations for ACOs, which were promulgated by the Department of Health and Human Services earlier this year.

What Are ACOs?

ACOs are designed to be integrated groups of health care providers (hospitals, physicians and others involved in patient care) that work together to coordinate care for Medicare patients. According to the Centers for Medicare & Medicaid Services (CMS), ACOs are expected to "help improve the care Medicare beneficiaries receive, while also helping lower costs." ACOs are supposed to address the fragmented care that many patients, especially seniors with multiple illnesses, experience. Fragmented care can often lead to medical mistakes and increased costs.

ACOs will be required to meet certain outcome-based performance measures and, in turn, will share in the savings they generate for Medicare.

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Patient Assignment to ACOs

One of the troubling aspects of the proposed regulations is the retrospective assignment of patients by Medicare to the ACOs. Under the proposed regulations, ACOs would not even know which patients would be assigned to them until the end of their first year as an ACO. Instead, CMS will assign patients "based on their utilization of primary care services." It will also be difficult for the physician or patient to determine whether a patient might retrospectively be assigned to a particular ACO. If, as discussed above, ACOs are supposed to be a solution to the fragmented care that Medicare patients are receiving, it is unclear how an ACO is going to be able to control costs and manage patient care without knowing which patients are assigned to them. Retroactive assignment may also exclude patients from assisting their physicians in implementing a successful ACO.

Profit Sharing

"Shared savings" is a key feature of the ACO model as a way to incentivize health care providers to help reduce health care costs. The proposed regulations require ACOs to meet certain cost-savings goals before they are allowed to share in the cost savings. Specifically, an ACO must have cost savings of between 2 percent and 3.6 percent (depending on the size of the ACO) in order for the ACO to share in the cost savings. Otherwise, Medicare pockets the savings. CMS claims that this threshold is needed to ensure that the savings are non-random. However, critics have noted that this required threshold serves as a disincentive to participation. Moreover, the rationale for such a requirement is unclear. Even if the savings were random, why should CMS, and not the fledgling ACO, be rewarded?

Performance Metrics

In addition to exceeding the minimum savings rate, an ACO must meet 65 different performance measures in order to qualify for shared savings. Under the proposed regulations, there is no flexibility for ACOs to meet these required metrics. An ACO cannot choose among a list of "primary" metrics or initially satisfy some number of metrics less than 65, and has no say in the performance standard set by CMS. This one size fits all approach is puzzling. The key performance measures for, say, a rural hospital ACO are likely to be fundamentally different from those appropriate to an ACO based in an urban setting—whether due to different geographic issues or types of patients.

Moreover, many of the proposed metrics are new and untested. Basing shared savings on unproven and untested metrics may not do enough to encourage active participation in the ACO program.

Loss Sharing

One of the cornerstones of ACOs is that their members will be financially rewarded for improved patient care. Under the proposed regulations, there are two approaches to profit (and loss) sharing, called “track one” and “track two.” Under track one, ACOs will be eligible for shared savings during the first two years of their three-year ACO commitment without any downside risk in shared losses. During year three, however, if an ACO fails to meet a benchmark—which would be set by CMS—the ACO would have to repay a share of any Medicare losses. Under track two, ACOs will face a risk of financial loss if they do not meet CMS’s benchmarks during all three years. However, ACOs under track two may qualify for higher upside benefits by receiving a greater proportion of the shared savings.

Organizations such as the American Medical Association and American Hospital Association have criticized this proposed allocation of losses to ACOs at these early junctures and instead favor a “go slow” approach. With CMS and health care providers just figuring out how ACOs are going to work, such penalties may be premature and unduly restrict the innovation needed to make ACOs work.

Start-Up Costs

There are likely to be significant financial investments required to form and operate an ACO before any shared savings payments start. These large start-up costs seem to have had the effect of encouraging hospitals to take the lead in forming ACOs, although the AMA has stated that ACOs should be physician-led. CMS may have recognized this issue, and recently solicited public comment on alternative funding arrangements and grants to help small practices get into the ACO game. In addition to the required financial investments, providers will likely need to invest substantial time and effort to the ACO’s formation and operation such as the time to study, analyze and develop systems, protocols and guidelines to better coordinate health care within the ACO. In an environment where a physician’s time is money, it may be difficult to convince physicians to sacrifice their patient time to help out with an ACO.

These are just some of the issues that would face providers who want to form an ACO. Due to these perceived difficulties, the final ACO regulations could be substantially different from the proposed regulations. CMS wants to foster the growth of ACOs and may conclude that some changes are needed. If not, potential ACOs will need to thoroughly examine the requirements and carefully evaluate whether to proceed.

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