



Final ACO Rules and How Captives Could Play A Role

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When it comes to reviving patients from near-death experiences, the Medicare Shared Savings Program (MSSP), or Accountable Care Organization (ACO) initiative, may rival even the most heroic examples of medicine.

Almost overnight on the eve of April Fool's Day, ACOs morphed from being the subject of perhaps the most eagerly anticipated proposed federal rules in recent times to a target of all that is wrong with the Patient Protection and Affordable Care Act. Receiving the most scorn were proposed requirements that every ACO would incur some level of risk during the initial three-year performance period. Critics admonished that the combination of risk, hefty quality reporting and upfront costs coupled with little to no early-stage savings would deter even the most advanced of integrated providers from applying. Public remarks ranged from mildly critical to outright scathing, and many health care policy and political watchers wondered if any takers for a signature Obama Administration healthcare delivery system reform initiative would step forward.

Fast forward nearly seven months and more than 1,300 public comments later and the final ACO rule has received, by and large, a relatively more receptive response from the provider community than its predecessor proposed rule ever did. But concerns still remain and a big question is whether or not the multiple sweeteners in the final rule will be adequate to entice a large enough block of providers to submit the 21-page application between December 1, 2011 and January 20, 2012 to be among the inaugural class of ACOs that begin operating on April 1st.

As this process unfolds, opportunities may exist for captive insurance companies to play a key role, especially with those ACOs willing to assume a greater financial risk for the prospect of a greater reward. By establishing itself as a captive insurance company ("Captive") or forming a Captive subsidiary, an ACO may not only manage the downside risk but also enjoy other advantages under this new regime.

Key Provisions of the Final Rules

In crafting the final ACO rules, CMS officials had to walk a careful line between addressing the most problematic portions of the proposed rule to attract an adequate number of participants while retaining enough of the fundamental reform components. At its core, the ACO concept seeks to reduce health care costs by fostering greater provider collaboration and achieving better patient outcomes by using a combined carrot and stick of cost and quality measures. While some may deride ACOs as "HMO-light," proponents like to note that ACOs are established by providers and also point out that Medicare beneficiaries will retain unencumbered access to providers, including those outside of an ACO.

Reduced Risk

While the proposed rule envisioned two models with the first placing ACOs at risk only in the final year of the three-year period and the second placing ACOs at risk all three years, the final rule eliminates downside risk from the first model completely. Removing risk from the "one-sided" model is a significant modification that should entice some organizations that were deterred by the risk requirement to at least give the question of forming an ACO some more thought. An ACO can only forego risk for one three-year period. After that time, it must agree to accept downside risk for any subsequent three-year period or leave the program all together.

Those ACOs opting to accept downside risk right out of the starting block – as well as those opting for the one-sided risk model but seeking interim payments – will need to demonstrate within their application an adequate ability to repay losses. A higher shared savings rate for those ACOs that accept downside risk – 60 percent vs. 50 percent – is a carrot CMS hopes will prove useful in attracting participants to the two-sided model. The final rule also scraps the 25% withhold CMS had proposed for ACOs accepting downside risk as an insurance policy for the government to receive any repaid losses. Instead, each applicant will need to demonstrate within its application that it can adequately repay any losses.

Fewer Quality Measures

Another point of criticism in the proposed rule was that all ACOs would need to report on an initial set of 65 quality measures. The final rule chops that number nearly in half, to 33. It also phases in the pay-for-performance provisions over time, with ACOs in the first year only needing to report on all measures to comply with the provision. In year two, 25 measures convert to pay-for-performance, and in year 3 performance criteria will be used to evaluate ACOs against all but one measure.