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Coming changes with ACOs intended to enhance savings, increase quality care

By

Health care providers that participate in a proposed federal cost-saving initiative would be eligible to receive a hefty share of those savings, provided that they meet or exceed performance standards and reduce growth in health care spending.

One caveat: Participating providers would be required to shoulder a certain amount of risk to receive larger shares of cost savings. Under the proposed plan, clinicians would be able to assume risk immediately or wait 2 years.

Overall, specialties have little to gain or lose from the initiative. Some experts said specialists would need to work closely with primary care providers to obtain patient referrals. And some said they believe that close collaboration would help coordinate care and reduce health care costs.

Jeffrey R. Ruggiero said that potential savings to the federal government could total over $500 billion within the first 3 years of the Medicare Shared savings Program.

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Accountable care organizations (ACOs), collaborative entities comprising primary care physicians, hospitals and other professionals, would be eligible to participate in the Medicare Shared Savings Program starting Jan. 1, 2012. ACOs are a key component of the Patient Protection and Affordable Care Act, which was designed to increase access to care, improve public health and slow the trajectory of skyrocketing costs.

In late March, the CMS issued a preliminary rule defining the role that ACOs would play in the Medicare Shared Savings Program. CMS gathered public comment on the proposed rule until June 6 and is expected to issue a final ruling in October.

A potential upside of the program for specialists is that PCPs would assume a significant share of risk associated with adverse events and poor outcomes. A possible downside is a degree of uncertainty surrounding how much specialists stand to gain in terms of getting patient referrals from PCPs who belong to ACOs.

According to Jeffrey R. Ruggiero, an attorney with Arnold & Porter LLP, CMS estimates that aggregate bonus payments will total $800 million and aggregate penalties will total $40 million in the first 3 years of the Medicare Shared Savings Program. Projected savings to the federal government are expected to total $510 million in that period.

“The real figures could differ substantially, but the

point is that you’re talking about huge numbers here,” Ruggiero said.

CMS anticipates that 5 million beneficiaries would be served by providers participating in ACOs, according to a summary of the preliminary rule from Arnold & Porter.

Structure and scope of ACOs

According to the policy, an ACO that meets or exceeds performance standards of care and reduces growth in heath care spending would be eligible to receive a share of the savings below individual benchmarks set by CMS, according to a CMS fact sheet. An ACO would be required to repay Medicare for a portion of losses or expenditures above its benchmark.

Photo coutesy of: Jeffrey R. Ruggiero

CMS will designate savings benchmarks for each ACO based on the type and number of patients treated by the group. Patient and provider participation in an ACO would be voluntary.

ACOs would be geared largely toward primary care. Under the proposed rule, CMS-approved ACOs would be required to accept responsibility for at least 5,000 Medicare beneficiaries and agree to participate in the Medicare Shared Savings Program for at least 3 years, according to CMS.

At least 50% of an ACO’s primary care physicians would have to qualify as meaningful electronic health record users as defined by the Health Information Technology for Economic and Clinical Health Act and Medicare regulations, according to a summary of the proposed rule from Arnold & Porter.

ACOs would be required to report publicly on shared savings and, in certain cases, losses.

They would also need to report on 65 quality measures in five domains: patient experience of care; care coordination; patient safety; health of the frail, elderly or at-risk population; and preventive health.

The first quality reporting period would end Dec. 31, 2012.

Ruggiero said that most of his clients do not see the quality measures as problematic.

“They think that they can and should be demonstrating benchmarks with respect to quality of care,” he said. “It’s complicated, but there hasn’t been a great deal of concern about that area. So, the clients that we’re working with think that they can likely satisfy [these measures].”

L. Samuel Wann, MD, Section Editor of the Practice Management and Quality Care section of *Cardiology Today*, added that the proposed mechanisms used for quality evaluation should be precise.

L. Samuel Wann

“These new systems presuppose that we actually know how to measure the quality and value of the individual elements of health care, and that we can create efficient systems for coordinating the work of many different kinds of physicians in many different kinds of practice situations caring for many different kinds of patients,” Wann told *Cardiology Today*.

Ruggiero also noted that some groups will miss the Jan. 1 participation deadline.

“One of the things that seems to be troubling to the provider community, the physicians in particular, is the deadline,” he said. “If an ACO misses the Jan. 1 window, it needs to know that it will have a subsequent opportunity before the expiration of the 3 years. That has to be clarified.”

Balancing risks and benefits

ACOs would be able to choose one of two risk models for their initial 3-year participation period.

Under a two-sided risk model, an ACO would be accountable for losses but would also be eligible for a larger share of achieved savings than under a one-sided model. An ACO would be able to choose a one-sided risk model for the first 2 years of its agreement period but would be required to shift to the two-sided model for the third year and subsequent agreement periods, according to the Arnold & Porter summary.

CMS proposed a maximum sharing rate of 60% for ACOs that select the two-sided risk model and 50% for those that take the one-sided model. The total amount payable would be capped at a percentage of the ACO’s benchmark for the year, or 7.5% in the one-sided model and 10% in the two-sided model, the summary said.

Ruggiero noted that CMS' inclusion of the risk models surprised and troubled some of his clients.

"We haven't had one of our clients decide to abandon its effort as a result of this, but it has created consternation," he said. "There's a feeling here of the fact that CMS has somewhat veered off course, that the original premise of the legislation was to create an upside and that now they've inserted a potential downside, particularly so early on. Congressional intent, as we understand it, was to foster innovation and collaboration, to really empower the provider community, specifically the physician community, to take on this venture. That seems a little bit inconsistent with this kind of risk component."

Physicians, whether in primary care or specialty medicine, should not be forced to assume additional risk, **John A. Hovanesian, MD,** clinical assistant professor at the UCLA Jules Stein Eye Institute in Los Angeles, said in an interview.

John A. Hovanesian

"Patients who are challenging and complicated cost us in a number of ways that typical patients don't," he said. "The implication of taking on risk is that we can control that risk, but we really can't. What happens is that they end up squeezing physicians to do more for less. … It's not a winning proposition for physicians, and most physicians are aware of that."

For cardiologists, the balance between risks and benefits will also be important, particularly for those in community-based practice.

"In recent comments to the Centers for Medicare and Medicaid Services (CMS), the American College of Cardiology noted that the complexity and the incentives associated with the ACO program will prohibit participation by most community-based cardiologists," **Richard J. Kovacs, MD,** professor of clinical medicine at Indiana University School of Medicine and director of Krannert Institute of Cardiology, told *Cardiology Today*. "There are just too many barriers to putting together a legal structure that includes multiple separate parties. If the rewards were more significant or if there was no downside risk, that might change."

In an HMO or managed care system, unhealthy patients can see their PCPs as often as they wish, with their only costs being co-pays for office visits, Hovanesian said. he also said he was concerned that ACOs would follow a similar trend and that patient care would suffer as a result.

Richard J. Kovacs

"What doctors end up doing in response to that is trying to do less for those patients who need more," he said. "Those complicated, unhealthy patients need access to care, want access to care. They want it inexpensively, so the doctors tend to see them as little as possible. I've seen it personally, and it's very disconcerting when patients come to us to pay out of pocket to have surgery outside their managed care plan simply because they didn't have enough access to their assigned doctors. Maybe some problems are solved by managed care, but others are certainly created."

Focus on primary care

Under the new policy, patients would have the option of seeking specialty care inside or outside their assigned ACO. Ruggiero said that there is no built-in mechanism to encourage patients to seek specialty care within an ACO.

"The primary care physicians, obviously, would be encouraged to persuade those beneficiaries to seek care within the umbrella of the ACO. But they have no tools to do more than to encourage that," Ruggiero said. "The ACOs and the primary care physicians in those ACOs don't really have any sort of tools to impose any sort of utilization discipline on these beneficiaries. Yet, the ACOs are going to be charged with the cost of that specialty care."

In addition, Medicare beneficiaries who wish to seek primary care outside their assigned ACOs would have to establish a relationship with a new PCP, Ruggiero said. That may prove to be disconcerting for some patients.

"These are elderly patients," he said. "Presumably, they have a good and productive relationship with their primary care physician. I would assume that they would take disruption of that relationship seriously. But they may stay with the primary care doctor, but again, they can seek specialty care elsewhere."

Collaboration between PCPs and specialists is a two-way street, Ruggiero said.

"I think it's critical for specialty physicians to get involved in the formation of these ACOs," he said. "Primary care physicians who are enlightened understand they need to collaborate with the specialists. They need to understand particular clinical protocols and what's really necessary in terms of the provision of care and, perhaps more importantly, what's unnecessary and how care can be improved. The primary care doctors can't do that alone."

Many cardiologists, however, may get the opportunity to participate in an ACO by virtue of being part of a large multispecialty practice or hospital employees, according to Kovacs.

“In that case, the challenge will be making sure that there is a proper focus on specialty care,” he said. “Although patients are assigned to an ACO on the basis of their primary care visits, they may still receive the bulk of their care under the directions of a specialist like a cardiologist. In addition, many of the quality measures focus on CVD — cardiologists are in the best position to manage these diseases.”

John B. Pinto, president of J. Pinto and Associates Inc., a health care consulting firm in San Diego, said in an interview that it is in specialists’ self-interest to observe how PCPs and institutions cut costs.

John B. Pinto

“Get involved to find out what’s going on,” he said. “Don’t disengage from your local primary care and health system community. Stay nimble and be prepared to adjust your practice cost structure to match any adjustment in cash flow. The future for every single reader is going to be to realize that these efforts to contain costs, whether they’re called HMOs or PPOs or PHOs or ACOs or medical homes or other things in the future, are going to continue for the rest of your career. Stay light on your feet. Expect and prepare for change.”

Wann suggested that the verdict is still out on whether ACOs will succeed in reducing costs.

“As currently proposed, ACOs are but one early iteration of much-needed methods to evolve from our historic fee-for-service payment system, which emphasizes procedures and can result in overutilization of individual services, to a system which rewards delivery of overall health care value,” he said. “The final impact of ACOs on routine clinical practice is unknowable at present, but the mandate to control health care spending is real, and we should all hope that improved models of health care delivery can be developed which don’t destroy the good in the current system, but eliminate waste and inequity.”

Regulatory and economic barriers

The CMS and the Office of Inspector General proposed waivers of the Physician Self-Referral Law (Stark Law), Civil Monetary Provision Gainsharing Prohibition on payments from hospitals to physicians and the federal Anti-Kickback Statute, according to the CMS fact sheet.

The waivers would apply to ACOs and their participants, providers, suppliers, and individuals or entities outside of an ACO for activities related to the ACO’s participation in the Medicare Shared Savings Program.

In a letter to CMS Administrator **Donald Berwick, MD,** executive vice president and CEO of the American Medical Association, **Michael D. Maves, MD,** said that antitrust and anti-kickback laws favor hospital-based systems that employ physicians.

Allowing physicians to form ACOs independently of hospitals and large health systems would maintain robust competition and patient choice, Maves said. In addition, he said, safe harbors from antitrust laws, anti-kickback laws and the Stark Law would enable small, independent practices to collaborate with hospitals and other providers to deliver coordinated health care.

CMS should offer loan guarantees and technical assistance to help small practices make the investments they need to join ACOs, Maves said.

In a letter to Donald S. Clark, Federal Trade Commission secretary, **Cecil B. Wilson, MD,** AMA president, expressed serious concerns about proposed FTC and US Department of Justice rules regarding the enforcement of antitrust policy relating to ACOs.

Wilson said the ACO policy may undermine the ability of physicians in small practices to participate in ACOs. Under the proposed policy, an ACO that controls less than 30% of a designated public service area would be eligible for protection from antitrust law. The threshold should be increased to 40% for ACOs that face stiff competition from other providers, Wilson said in the letter.

In a later statement to CMS, Wilson said he supported the development and testing of ACOs “as one of an array of payment and delivery innovations.” However, the AMA “has urged CMS to make significant changes to the proposed rule to allow all interested physicians to lead and participate.”

For example, the AMA recommended assignment of patients to ACOs based on voluntary agreements and allowing physicians to know which patients are in their ACOs. The AMA also suggested a payment option that does not require shared loss and allows groups to receive a percentage of all savings.

“Our clients believe that these ACOs, in order to be successful, have to be physician-owned, physician-managed and physician-governed, and that physicians have to be empowered to help develop utilization protocols, quality protocols and credentialing protocols,” Ruggiero said. “One of the risks here, and we’re seeing it happening more and more, is that you’re going to end up with the institutional providers buying up

seeing it happening more and more, is that you're going to end up with the institutional providers buying up the physician practices." – *by Matt Hasson with additional reporting by Eric Raible*

For more information:

Improving Quality of Care for Medicare Patients: Accountable Care Organizations. Centers for Medicare and Medicaid Services website. www.cms.gov/MLNProducts/downloads/ACO_Quality_Factsheet_ICN906104.pdf.

Summary of Proposed Rule Provisions for Accountable Care Organizations Under the Medicare Shared Savings Program. Centers for Medicare and Medicaid Services website. www.cms.gov/MLNProducts/downloads/ACO_NPRM_Summary_Factsheet_ICN906224.pdf.

What Providers Need to Know: Accountable Care Organizations. Centers for Medicare and Medicaid Services website. www.cms.gov/MLNProducts/downloads/ACO_Providers_Factsheet_ICN903693.pdf.

Disclosures: Dr. Hovanesian, Dr. Kovacs, Mr. Pinto, Mr. Ruggiero and Dr. Wann report no relevant financial disclosures.