Medicare Accountable Care Organizations
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Introduction
With the passage of the Patient Protection and Affordable Care Act (ACA), policy makers have accelerated their efforts to re-engineer the healthcare system. National healthcare expenditures have continued to grow at a more rapid rate than inflation, consuming nearly 20 percent of the Gross Domestic Product (GDP). While Americans spend twice as much as the next highest industrial nation on healthcare, our population health outcomes do not compare favorably to the rest of the world. More troubling, those areas in the United States that have the highest per capita expenditure for health care, have among the lowest scores on quality.

Realigning payment incentives, as a method to improve quality and reduce overall costs, has received a great deal of attention. A common theme among these initiatives is to move from a system that pays for quantity to one that pays for outcome. Some examples include bundled payments for well-defined and time limited care (e.g., total joint replacement, coronary artery interventions) and care coordination payments for ambulatory management of patients with chronic diseases (“medical home”). An Accountable Care Organization (ACO) is in some ways an amalgam of bundled payments, ambulatory chronic disease management, care coordination/integration, and financial risk sharing - a fairly radical departure from traditional fee-for-service medicine as practiced by independent physicians or small single specialty groups.

What Is An ACO?
The term Accountable Care Organization was first used at a MedPAC meeting in 2006 during a discussion between Glenn Hackbarth (Chair) and Elliott Fisher. The concept of “Accountable Care Organizations” has been touted as a way to improve quality while reducing costs in health care delivery.¹

Principles
Fisher and colleagues, who helped create and develop the concept of Accountable Care Organizations, have defined the following principles:

1. Providers need to become accountable for the overall quality and cost of care for the populations they serve.
2. Provider incomes must be decoupled from volume and intensity of services performed; pay should reflect better value: improved outcomes, better quality and reduced costs
3. The ACO should adopt fully transparent and meaningful performance measures on both quality and cost. This is necessary to overcome patient resistance. Also, reliable risk-adjusted measures of overall costs are a required element so as to measure impact of care changes at the local level.²
ACO’s propose moving from a goal of improved care *coordination* to widespread care *integration* across settings (office, hospital, ASC, SNF, ), providers (primary care, specialist, advanced practice nurses, physician assistants), especially during transitions of care.

**Shared Savings**
Eligible organizations would require a formal legal structure capable of receiving *shared savings*. In either an ACO or a bundled payment program, program savings arising from improved efficiencies, savvy negotiation with vendors, and improved health status of patients within the programs are to be shared with the providers, in part to incentivize these behaviors and in part to compensate for lost income from reduced fee-for-service volume.

Some experts propose that primary care physicians should only be affiliated with a single ACO and would have to be the predominant ambulatory care providers for a sufficient number of patients.² Fisher and colleagues proposed 5,000 as a minimum. If the population is too small, accurately measuring outcomes and cost savings becomes impossible due to a “signal to noise” problem.

The beneficiaries cared for by the ACO for purposes of shared savings and quality measurement could be determined empirically. Fisher proposed determining the predominant provider by looking at historical ambulatory E/M services.

Fisher suggests basing spending benchmarks on the prior three years of per beneficiary Part A & B spending to determine current year level of spending, and then apply growth rate adjustments. These benchmarks would be compared to actual risk-adjusted spending to determine whether benchmarks had been met and whether shared savings were available for distribution.

Accountability would occur through transparent public reporting of results for patients in the ACO. Fisher proposes moving from technical (process) type measures to patient-level health outcome and experience measures to help assure that ACO’s deliver well-coordinated, patient centered care.

Many of the elements of Fisher’s model have appeared in Federal regulations for Medicare ACOs, including panel size, use of ambulatory E/M services for attribution to an ACO, and the three year benchmark. MedPAC discussions on ACOs have also discussed shared savings designs mostly consistent with the elements described above.

**Medicare Demonstration**
While Medicare had introduced a number of value based purchasing initiatives in recent years, the health care reform law specifically required that Medicare create a demonstration program for Accountable Care Organizations.

**ACA mandate**
The ACA legislation includes SEC. 3022, entitled “Medicare Shared Savings Program.” This provision amended Section 1899 of Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to create a Shared Savings Program:

“Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infra-structure and redesigned care processes for high quality and efficient service delivery...”

The legislation delegated many aspects to the Secretary of HHS, but did define the types of providers and suppliers who may participate, several organizational structures that would be acceptable, requirements that must be met to participate in shared savings (accountability, duration of agreement, primary care participation, reporting requirements, leadership and management organization, specific care processes, and patient-centeredness requirements), other shared savings programs that would preclude involvement, and methodology for calculating shared savings.

Rule-Making Status
Legislation begets regulation. The approximately 5 pages of legislative language has resulted in Medicare listening sessions and a formal request for information, a proposed rule for the program and one for guidance on anti-trust and other legal issues, and final rules covering the same areas. Interested parties, including the American Society of Anesthesiologists (ASA), filed comment letters on the listening session and the proposed rules. The proposed and final rules were each more than ten-fold larger than the original legislative language.

Request for Information
In the November 17, 2010 Federal Register, the Centers for Medicare and Medicaid Services (CMS), under Administrator Donald Berwick’s name, issued a request for information about ACO’s. The series of questions identified areas where CMS sought additional information to help it prepare rule-making for the shared savings program. (See Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program; 75 Fed. Reg. 70,165 (November 17, 2010); CMS-1345- NC. http://edocket.access.gpo.gov/2010/pdf/2010-28996.pdf ).

The ASA ACO Ad Hoc Committee and ASA health policy staff prepared responses to these questions, which can be downloaded from the ASA website: http://www.asahq.org/For-Members/Advocacy/Washington-Alerts/ASA-Responds-to-CMS-on-ACOs.aspx. The ASA stressed that the ACO program needed to be flexible, inclusive, administratively simple to manage, sensitive to risk adjustment in quality measurement, allow for attribution to anesthesiologists for the care they provide, and could be well-served by the creation of a “perioperative home” led by anesthesiologists. The ASA also was a co-signer of a joint letter from ASA and many surgical specialties, addressing more general surgical concerns with ACO’s (see http://is.gd/NpLNUY ).

Proposed Rule
Given that the PPACA legislation mandated creation of the shared savings program by 1/1/2012 and that organizations implementing ACO’s would need some time and resources to create legal structures, sign-up providers and suppliers and do the myriad things necessary for success, ASA and other medical specialties anticipated publication of proposed rule-making around the beginning of 2011. Unfortunately, CMS issued a notice of proposed rule-making (NPRM) at the end of March 2011. In addition to the over 400 page document from CMS, the Federal Trade Commission (FTC) and Department of Justice (DOJ) issued a “Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program.” The Internal Revenue Service (IRS) also issued a notice about tax-exempt organizations, ACO’s, and implications for maintaining such status.

- CMS Proposed Rule: [http://is.gd/Emyg80](http://is.gd/Emyg80)
- FTC/DOJ Proposed Statement: [http://is.gd/K4MFqG](http://is.gd/K4MFqG)
- IRS Notice: [http://is.gd/nkdc2q](http://is.gd/nkdc2q)

CMS also issued a number of “fact sheets” which have been archived on the ASA ACO web page – [http://is.gd/UwUQw5](http://is.gd/UwUQw5) – under Proposed Rule.

**Comment Letters**

The ASA Ad Hoc Committee on ACO’s and ASA staff carefully reviewed the proposed rules and developed two comment letters for ASA leadership to consider. In general, the ASA ACO experts found the proposed rule to be severely flawed as the shared savings program as defined was administratively complex, overly restrictive, expensive to implement and virtually impossible to generate sufficient shared savings and cost efficiencies to offset loss of fee-for-service revenue; furthermore, the focus was almost entirely focused on primary care with little opportunity for anesthesiologists or other specialists to contribute in a meaningful way to improvement in value-based care.

Given the complexity of the rule, ASA’s 12-page response to CMS consisted of an executive summary identifying three key issues – patient accountability, the role of anesthesiologists, and beneficiary assignment – as well as a detailed response to other areas of the rule that were problematic for the specialty, including those mentioned above. ASA provided a three page response to the FTC and DOJ, raising concerns about potential consolidation of hospital market power as a result of clinical integration requirements, concerns about the arbitrary selection of the PPACA signing date for which any antitrust analysis would be based, and supporting rule of reason analysis whether or not an ACO continues to participate in the shared savings program. Also, ASA joined with a large number of other organizations encouraging CMS to exclude direct and indirect graduate medical education (GME and IME) payments and disproportionate share payments (DSH) from calculating expenditure benchmarks and targets for ACO’s. Doing so would disadvantage teaching centers from participating effectively in ACO’s.

CMS received over a 1,000 comments on the proposed rule and a great deal of unfavorable press. Organizations which had been among the biggest proponents of ACO’s indicated that they would not participate without significant change. CMS indicated that they would address many of the problem areas in the final rule, which many expected would be published by late summer.

- ASA comment letter to CMS: [http://is.gd/0UJtDi](http://is.gd/0UJtDi)
- ASA comment letter to DOJ/FTC: [http://is.gd/GXKT12](http://is.gd/GXKT12)
Final Rule

Once again, CMS took more time than expected to issue the final rule for the shared savings program. The rule entered the public realm on October 20, 2011, around 70 days from the legislatively mandated start date for the shared savings program. CMS and the FTC/DOJ did much to improve the rule, with stakeholder responses much more positive compared to the proposed rule. CMS, recognizing that the late publication of the final rule was a problem, delayed the initial start date to April 1, 2012.

ASA has undergone a detailed analysis of the changes between the proposed and final rule. In many cases, items, which ASA identified as problem areas, received substantial modification, usually for the better. Unfortunately, anesthesiologists and surgical specialists will have little more than a peripheral role in ACO’s as defined in the shared savings program.

- CMS Final Rule: http://is.gd/3WsKw
- DOJ Final Rule: http://is.gd/HBWMDd
- ASA Analysis: http://is.gd/qJCJ7u

Other Initiatives

CMS has used the authority granted it by the PPACA healthcare legislation to create a number of new initiatives involving ACO’s, bundled payments and other innovative programs. Of interest to smaller groups with limited financial resources, CMS has created and Advance Payment Model Initiative (http://is.gd/iVQ3ya) that will advance shared savings payments to qualifying ACO’s to help offset startup costs. Also, the Center for Medicare and Medicaid Innovation (CMMI) has announced a number of programs. At the time of this writing, CMMI has just announced its Health Care Innovation Challenge, which will award up to $1 billion in grants ($1 million to $30 million in size), to support “compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP, particularly those with the highest health care needs.” Anesthesiologists may have the opportunity to use this program to fund demonstrations of the surgical/perioperative home model. CMMI Innovation Challenge: http://is.gd/T6LGXF

Why Should Anesthesiologists Care?

Accountable Care Organizations have the potential to redefine how healthcare providers both deliver care and receive compensation for their services. In the same way that risk-bearing managed care contracts altered physician-physician and physician-facility relationships in the 1990’s, ACOs, where implemented, will as well.

At this early stage in the ACO movement, anesthesiologists are rarely if ever mentioned. Depending on the venue, either primary care physicians, hospitals or large integrated physician-hospital organizations are seen as the most influential in effective performance of ACOs. Proponents argue that cost savings will arise from keeping patients out of the hospital through better ambulatory care or improving outcomes in hospital through better management of chronic conditions and enhanced care coordination.
Anesthesiologists, have important roles to play in improving population health, coordinating and managing care in the peri-procedural period, optimizing processes of care to improve efficiency and reliability, and impacting procedural outcome. For many, the most important reason for anesthesiologists to care about ACOs is that the methodologies that determine payment will substantially change in this model of care. If anesthesiologists do not actively participate in the process and contribute to its success, they may see substantial and undesired changes in compensation.

**Bibliography**