The ACO Proposed Rule and What it Might Mean for Cardiologists

People have had lots to say about the concept of an Accountable Care Organization (ACO) since the passage of the Affordable Care Act (ACA) last year. The legislation that created this program was so broad that people had many different ideas about what it would mean. However, on March 31, Centers for Medicare and Medicaid Services (CMS) released a proposed rule that would govern the program that has given us a great deal of information about the program and how it might work. It is important to remember that proposed rules can change a great deal before they are finalized. We expect to know for sure what this program means in the fall.

What is an ACO?

An ACO is a group of providers of health care who are able to share in savings with the government if the patients for which they are responsible have spending lower than expected. The idea is that the current health care system only provides an incentive to increase the number of services and this program intends to reduce that incentive. An ACO is still paid for each service on a fee-for-service basis.

What makes up an ACO?

In theory, an ACO could be composed of anyone who agrees to take responsibility for a group of patients. However, as proposed, an ACO must include primary care physicians and it must include enough primary care physicians who provide the majority of care for 5,000 beneficiaries. Other providers, including specialist physicians, and hospitals, may be included as well.

Can a cardiologist be part of an ACO?

As proposed, the patients who are attributed to an ACO are attributed based on their visits to primary care physicians. However, any provider of Medicare services can be part of an ACO. Primary care physicians looking to reduce costs for cardiovascular care may very well look to cardiologists to partner with on these efforts.

Can I participate in the ACO even if I am not in the same practice as the primary care physicians?

There are opportunities for physicians who are not part of the same group to partner for the purposes of an ACO. However, there are legal barriers that would require significant review and legal assistance.

Can any size practice decide to be an ACO?

The legislation indicates that the minimum number of patients that can be attributed to an ACO is 5,000. This means that the primary care group must be the primary caregiver for 5,000 Medicare beneficiaries.

Do I get to select who is part of an ACO?

The proposal indicates that patients will be attributed to an ACO based on whether they had the majority of their office visits with that primary care physician. The patients are not selected to participate in the ACO by the ACO.

Can an ACO make money by providing fewer necessary services?

CMS proposes that an ACO will be judged based on 65 different quality measures. The measures are rolled up into five "domains" that are different classifications of quality. If an ACO fails to meet certain levels on one of those domains, it cannot receive any portion of shared savings.

How does CMS determine that an ACO's patients have lower spending than expected?

CMS proposes a relatively complex formula that reviews the expected spending for the population contained in the ACO and compares it the actual spending. The expected spending is adjusted for patient severity and other factors.

Does the ACO get to share any savings, regardless how small or large?

Because there can be annual fluctuation in spending that is not the result of a coordinated effort to control costs, CMS proposes that there be a minimum savings rate that can be attained before the ACO is given any portion of the money. The minimum savings rate is between 2 and 4 percent. If an ACO demonstrates savings that is less than the minimum savings rate, then they get nothing. There is also a cap in shared savings, but that is very high.

If the ACO demonstrates savings beyond the minimum savings rate, how much does it keep?

CMS proposes a relatively complex mechanism in which an ACO will be able to keep only a portion of the savings above a certain threshold. It is far from the entirety of the savings and would only be the majority if the ACO demonstrates extraordinary degree of savings.

What happens if spending is higher than expected?

CMS proposes that ACOs that have higher than expected spending will be subject to penalties that are similar in scope to the bonus payments for shared savings. There are two models proposed for ACOs – one of the models exempts an ACO from penalties for the first two years. The second exposes the ACO to penalties for all three years, but gives larger opportunity for a bonus.

Is this really something that can be done outside of large integrated practices?

The ACO regulations as proposed require significant infrastructure and organization. The ACC interpretation of these draft regulations is that it will be difficult but not impossible for those outside of large integrated practices to participate.

Is there a role for specialists in an ACO?

As proposed, an ACO is structured around primary care physicians. However, more than 20 of the quality measures focus on cardiovascular care. We believe that many ACOs will be interested in working with cardiologists to attempt to manage patients together.

Next Steps

The rule is still proposed. CMS will be collecting comments from the public and then making changes based on their suggestions. The ACC will work with its leadership to identify areas of concern and submit comments. Once a final rule is released, we will inform members of what it contains and how they may be able to be involved.