

Accountable Care Organization (ACO)

Regulatory Analysis: Impact on Foot and Ankle Surgeons (DPMs)

As part of the Obama Administration's reform of healthcare, Accountable Care Organizations (ACOs) were formed to incent the delivery of high quality care by groups of doctors, hospitals, and other health care providers. These practitioners come together voluntarily to give this coordinated high quality care to the Medicare patients they serve, ensuring that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending healthcare dollars more wisely, it and its participants will share in the savings it achieves for the Medicare program.

Medicare offers several ACO programs, including:

- [Medicare Shared Savings Program](#)—a fee-for-service program
- [Advance Payment Initiative](#)—for certain eligible providers in the Shared Savings Program
- [Pioneer ACO Model](#)— population-based payment initiative for healthcare organizations and providers already experienced in coordinating care for patients across care settings

Organizations across the country have already transformed the way they deliver care, in ways similar to the ACOs that Medicare supports.

ACFAS Action: ACFAS provided comments in June 2011, to the original ACO draft regulations to help ensure foot and ankle surgeons could participate in this important initiative and remain a viable part of the healthcare team. Your ACFAS staff has analyzed the 696-page Accountable Care Organization (ACO) final rules that were published in the November 2, 2011 Federal Register. The Centers for Medicare & Medicaid Services (CMS) received over 1,320 comments on the proposed regulations.

ACO Final Regulations Highlighted: CMS adopted some of the recommendations ACFAS suggested, but as intended, ACOs remain primary care and primary care physician focused and will make up a majority of ACO governance structures. By design, specialists, such as foot and ankle surgeons, will not have much of a role in ACOs.

Academic Healthcare Centers (AHCs) do not have much experience managing populations at risk, so ACOs will likely be formed largely at the community hospital-level. Health policy experts point toward existing provider-based risk-sharing organizations, like Kaiser-Permanente and Healthcare Partners, who will shift their referral patterns in search of value. This will mean hospitals and health systems in search of ACO-type arrangements will purchase advanced specialty care practices as a commodity (offering best services at the best price) or bring in many tertiary procedures in-house (complex surgeries are one example). Foot and ankle surgeons should pay particularly close attention to these trends.

As part of the final rule, CMS adopted many of the recommendations submitted by healthcare related organizations, including ACFAS. Key tenets of the final rule are:

1. Application Process – CMS delayed the first start date to apply to be a recognized ACO under Medicare until April 1, 2012 and provided for a second start date of July 1, 2012.

2. Beneficiary Assignment – CMS will create a list of preliminary beneficiaries likely to receive care from the ACO based on primary care utilization during the most recent periods for which adequate data are available, and provide a copy of this list to the ACO. In addition, CMS modified the methodology for beneficiary assignment. Under the final rule, if a beneficiary cannot be attributed to a primary care physician, he or she will be assigned based on primary care services provided by a specialist or another primary care provider (i.e. RN, PA, CNS). ***We believe DPMs acting in this capacity (providing primary care services to a beneficiary) would be permitted to continue under the ACO regulations. DPMs are still not officially included in the statutory definition of an ACO-provider, however, the regulations speaks to the ability of ACOs to “add or subtract from their care providers” based on the beneficiaries individualized care plan sand whether or not they have an existing primary care physician.***
3. Marketing Guidelines – CMS is allowing marketing materials and activities to be used or conducted five business days following their submission to CMS as long as the ACO certifies compliance with applicable marketing requirements. CMS plans to issue template language.
4. Quality Measures – CMS reduced the number of measures from 65 to 33. Quality measurement will rely heavily on electronic healthcare records and its integration with quality measurement. But ACO participants can use survey-based measures, claims and administrative data based measures, and the group practice reporting options web interface as a means of ACO quality data reporting for certain measures. There are four domains of quality measurement:
 - Patient/Caregiver Satisfaction;
 - Care coordination/patient safety;
 - Preventive health
 - At-risk populations (a place for DPMs who treat the diabetic foot).
5. Payment to Providers
 - Downside risk – CMS revised the one-sided model for smaller populations with more variation in expenditures to be a shared savings only model. The two-sided model targeted for larger populations with set expenditures, allows participants to earn a greater percentage of shared savings than the one-sided model.
 - Eliminate withholding – CMS eliminated both the 25 percent withholding requirement and the provision concerning forfeiture.
 - Increasing cap on shared savings – CMS raised the payment limit from 7.5 to 10 percent of an ACO’s updated benchmark for ACOs under the one-sided model and from 10 to 15 percent under than two-sided model.
6. Start-Up Costs – The Center for Medicare and Medicaid Innovation (CMMI) released the Advanced Payment Model initiative for two types or rural and physician-owned organizations participating in the Shared Savings Program. This should assist the organizations with start-up costs.
7. Definition of a supplier – DPMs are included and the final rule makes some clarification on the list of eligible providers and suppliers allowing DPMs to dispense durable medical equipment with coordination requirements with the primary care provider (PCP).