RESTRUCTURING
Health Care Delivery

Can Accountable Care Organizations Hit the Trifecta: Improve Quality, Reduce Cost, and Increase Physician Compensation?

The New York Times recently reported that it found that the amount paid by a patient's insurance plan for a routine colonoscopy varies significantly: between $740 and $8,500, depending upon the location, the particular doctor and where the procedure is performed. *The Times* found that colonoscopies cost the most when performed in hospitals and the least when performed in a doctor's office. Another significant variable for price is who administers the sedative, if one is required. Similar variations in price exist for other procedures such as M.R.I. scans and common orthopedic and cardiology procedures such as artificial hips and coronary angiograms with stent replacement.

Paul Giancola, JD

The Patient Protection and Affordable Care Act ("ACA") is designed to reduce (or at least control growth) in medical costs and improve quality of care. One method to achieve these goals is with an Accountable Care Organization ("ACO"). An ACO is a group of healthcare providers, usually a combination of a hospital and physicians, who contractually agree to take on the shared responsibility for a defined population of patients. The ACO takes responsibility for both the quality and the cost of care for the patient population. As an integrated delivery system, ACOs require state of the art management and payment structures to support the delivery of care.

An ACO may be paid a global payment for services to its patient population. Additionally, the ACA allows Medicare, through the Medicare Fee-For-Service Shared Savings Program ("MSSP"), to reward ACOs with a share of the savings that result from improved quality of care and reductions in the cost of care. The MSSP currently has two tracks: a savings only model; and a share savings and loss model. ACOs that take on risk for losses are eligible for a higher percentage of shared savings. Additionally, shared savings programs being developed include full and partial capitation and bundled care payment models. Thus, Medicare ACOs are incentivized to share in the savings to the federal government – but only if they are able to improve quality and reduce cost.

Reducing the cost of health care is also predicated upon studies, such as what the Times found, that payment for care, regardless of the retail price, various significantly by payer whether government – Medicare, TRICARE, AHCCCS – or commercial. For ACOs, the difficult goal is, as it was for HMOs, to ensure that the quality of care does not suffer in the quest for lower cost. For this reason, ACOs point to prevention, coordination, improved chronic disease management and reduced utilization, rather than simply reducing prices, as the foundation for reducing cost and improving outcomes. Consequently, the Congressional Budget Office projects that the MSSP will save the federal

government $5.0 billion dollars between fiscal year 2013 through fiscal year 2019.

It is expected that shared savings programs similar to the MSSP will be designed (and be required) by employer-based payers. How savings will be achieved is generally considered to be based on group rather than individual physician decisions. This task requires, among other things, information technology to manage patients across a continuum of care settings, clinical practice guidelines and performance measurements.

There may also be cost-savings achieved by providers within an ACO by sharing costly equipment, for example, an imaging machine, rather than each entity purchasing their own machine. To allow sharing of services, the Justice Department and the Federal Trade Commission, while recognizing that consolidation of services has antitrust implications for higher prices, has published rules to allow for a certain amount of consolidation, known as safe harbor protection, without triggering antitrust enforcement activity. Similarly, the OIG and CMS have jointly issued a rule on fraud and abuse waivers for ACOs participating in the MSSP.

To achieve success, ACOs are designed to assume financial accountability for the cost and quality of care provided to patients.

To achieve success, ACOs are designed to assume financial accountability for the cost and quality of care provided to patients. Many providers may find these concepts to be competing rather than complimentary. This will likely require the ACO to take a hard look at clinical practice guidelines and how medical decisions are made in prescribing tests and procedures – as well as where those procedures will take place. Under the current system, physicians are often incentivized to order tests and procedures utilizing equipment they own or to take place in a surgery center where they share a facility fee. For example, when a provider has in-office lab and imaging equipment, studies repeatedly show that those providers order more tests than those providers who do not have such equipment.

An open question is whether the shared savings promised by an ACO will be sufficient to overcome long-held physician behaviors regarding prescribing – when any failure to order "optimum" care may be interpreted by a Plaintiff's attorney as providing a lower standard of care for financial for gain. If participating in an ACO results in organizational or individual cost conscious medical decision-making, the ACO and its providers may be at risk for malpractice exposure whenever cost-savings translates poor outcomes. Consequently, for ACOs to succeed with evidence based medical decision-making, it may be necessary for Congress to provide the protection of tort reform, as there is for antitrust enforcement.

Even with achieving the twin goals of improved quality and reduced cost, many physicians, who already feel overworked and unpaid, wonder whether replacing volume with value will make their compensation any better. After all, reduced cost and improved quality does not necessarily translate into increased compensation. Instead it could mean lower health insurance premiums, lower cost to the federal government, and reduced compensation to physicians. Moreover, what happens to shared savings incentives if the lower cost achieved in one year becomes the baseline for the next year? At some point there may be no "savings" to share. Then what? **AM**

Paul J. Giancola, JD, is a partner in the Healthcare Practice Group, Snell & Wilmer, LLP, Phoenix, Arizona. His practice includes healthcare compliance and regulatory matters for healthcare organizations and physicians, including medical staff matters, HIPAA, Stark, licensing board investigations, fraud and abuse, peer review, risk management, physician employment contracting, joint ventures, practice formation and separation.