American Optometric Association
243 N. Lindbergh Blvd., Floor 1 • St. Louis, MO 63141

What optometrists need to know about ACOs

By Norma Bowyer, O.D., Greg Caldwell, O.D., Clarke Newman, O.D., Jason Ortman, O.D., David Redman, O.D., Harvey Richman, O.D., and Richard Soden, O.D.

By now, you have probably heard something about accountable care organizations (ACOs). Some policymakers think ACOs are the most promising provision of the entire Affordable Care Act and an exciting opportunity to improve health care efficiency by improving quality and lowering costs. Some critics and skeptics think ACOs are gatekeepers that threaten patient choice and access to optometrists. Both views could be correct, to some extent.

In this article, the AOA dispels myths, point outs legitimate concerns, and helps you better understand the role of this new delivery model.

The managed care concept in the 1990s slowed the growth of health care spending temporarily, but the concept collapsed when patients and physicians pushed back. Rather than control utilization to improve care, insurance companies used restrictions on utilization to enhance corporate profits. Instead of putting profits back into the health systems to improve patient outcomes, managed care organizations didn't reinvest. Administrative staff, including accountants, seemed to have the last word on coverage. But in the ACO model, savings from improved care management and coordination will be shared between practitioners and facilities, not just payers. Medicare will determine which patients can be attributed to the ACO based on the primary care services that the patients receive, and compare their actual cost of care to the cost that would have been expected for those patients based on their health status and recent history under the traditional Medicare model.

The idea of an ACO grew out of influential research purporting to show that the cost of health care varies across the country inversely proportional to quality of care. In other words, researchers thought that health care in some areas of the country was both high quality and low cost, while care in other areas was low quality and high cost. Leading health policy experts believe that higher spending in parts of the country does not lead to better health care outcomes, and that overall spending on health care can be reduced while maintaining or improving quality. By putting geographic areas in competition with each other, and rewarding top regions and improvement, all areas would be incentivized to find ways to lower costs and increase quality. There was serious discussion of grouping all Medicare providers and suppliers into regional collaborations centered around large hospitals to compete against other regions on costs and quality. There is also a belief that physicians - a high-achieving group - will embrace such competition and innovate.

In the Affordable Care Act, Congress declined to take a radical approach of ACOs for all. Instead, the law opened the door for voluntary ACOs to be part of the Medicare program. Instead of competing with other geographic regions for cost efficiency, the ACOs in the Medicare Shared Savings Program are measured against the recent history of health care costs for their own

patients. With participation voluntary instead of mandatory, the federal government implemented complicated and demanding requirements to prevent patient shopping and adverse selection. Rather than accountants making coverage decisions in the old managed care world, lawyers became essential for the complex arrangements of previously competing, independent entities.

The principle of the ACO in Medicare is simple: Medicare beneficiaries continue to have the traditional fee-for-service program for their health care, retaining all of their benefits and the right to choose their doctor. The doctors, hospitals, and other practitioners and facilities continue to be paid under the normal fee-for-service fee schedules and prospective payment systems but they commit to work together to better manage all of the patients, improving care coordination and avoiding unnecessary costs. If the ACO participants can save money on their patients for Medicare, then some of the savings will be passed back to the ACO participants. If the ACO doesn't save money, then Medicare doesn't pay any more than the normal fee-for-service rates. In other words, the practitioners and the facilities retain their Medicare income, reduce or avoid unnecessary services, and receive bonus payments as long as they don't stint on necessary care. CMS incorporated quality measurements to try to ensure that Medicare patients were not being denied appropriate care.

The more flexible the rules for ACOs, the more opportunity for innovation in health care markets to find efficient pathways. However, Congress added some additional requirements to prevent participants from getting lucky that the cost of their patient population happened to decrease in a given year. As a result, ACOs must include primary care physicians, but need not include optometrists, ophthalmologists, ambulatory surgical centers, or many other individuals or entities providing patient care. ACOs will be accountable to the all of the patient's cost of care regardless of whether the ACO participants provided the care themselves. Medicare ACOs may include any type of individual or entity enrolled in Medicare to provide care to the patient population. All ACOs must have enough primary care MDs and DOs to be accountable for the care of at least 5,000 Medicare patients. Neither the doctors nor the patients will know whether the beneficiary's costs will be attributed to the ACO until the year is complete. CMS is providing information quarterly to ACOs about the patients that are likely to be included in their cost comparisons at the end of the year, and the ACOs are notifying those patients of their right to opt out of having their data shared with the ACO. The ACO's performance on costs will be compared to the expected costs for its patient population, including considerations of the relative health of the beneficiaries.

While ACOs are not required to include optometrists, AOA made sure the law and regulations allow ACOs to include optometrists. Since ACOs are accountable for all of the eye care needs of patients, there is an inherent incentive for ACOs to include optometrists to better coordinate care, manage care and control costs. Eye care is generally not one of the more expensive or inefficient specialties. As a result, optometrists may need to proactively approach ACOs to participate. In other words, because eye care is not seen as wasteful or high cost, it's not an area that ACOs will focus on to save money, but AOA members are wise to inform ACOs about

the ways you can help reduce costs and improve quality of care.

Many ACOs will use another concept at its core - the patient-centered medical home (PCMH). The medical home was intended to coordinate care and serve as an information/data warehouse. Its advocates want to provide extra reimbursement for certain primary care doctors who provide these additional services. EHRs and health information exchange eliminate the need for a medical data home, but care coordination remains a desirable service. Since many patients with chronic diseases benefit from care management across a multidisciplinary team of practitioners, the ACO's inclusion of a broader range of practitioners and entities is more ideal. To help manage patients and costs, many ACOs will include a medical home as a core part of its structure.

Keep in mind that, unlike MCOs, ACOs are not payers. Whether public or private, payers have an obligation to cover the necessary care of the insured population. Unlike MCOs, some of the risk and potential reward is directly on the practitioners and facilities in the ACO. In private markets, ACOs might include integrated delivery systems like IPAs. If you're looking at a closed panel, then the ACO in your market is contracting with payers in a perpetuation of managed care delivery, like HMOs or PPOs. If you're looking at an open panel, then the ACO is more closely following the ACO concept, and the trail blazed by Medicare.

At the federal level, the only approved ACOs are the entities participating in the Medicare Shared Savings Program, including the "Pioneer" model and the "Advance Payment" model. The Pioneer ACOs are part of a specific demonstration program for established integrated systems, but the Medicare Shared Savings Program is not a demonstration. The MSSP is now a permanent part of the fee-for-service program. There is no limit to the number of ACOs that can participate in the program, and no limit on the number of beneficiaries that might be served by an ACO. Regardless of the type of ACO, none are required to include optometrists but none can prevent a Medicare beneficiary from seeking care from any doctor, including any optometrist. The AOA has worked very hard to make sure that Congress and CMS did not create a gatekeeper system that shuts out optometry.

In the last decade, CMS ran a demonstration project with very large physician group practices. This initiative was a precursor to ACOs. Nearly all of the large groups that participated included optometrists. Thus, optometrists need not accept that ACOs are not for them. To the contrary, ACOs need optometrists as part of the team, even if that need is not appreciated initially.

Some states, such as Minnesota and New Jersey, are implementing ACOs for their Medicaid programs. States will generally follow the same approach in Medicaid as the federal government chose in Medicare: Measure the cost of care of the patient population served by the ACO, and measure quality of care provided by the ACO to make sure that medically necessary services are not eliminated. States know that they depend on ODs to provide medical eye care for their Medicaid patients. Optometrists should work with their state affiliate optometric associations, if necessary, to ensure that their state Medicaid program includes vital

eye care providers.

AOA is going to great lengths to help provide members with all of the tools needed to succeed in these new paradigms of patient care. The new products from AOA Excel will be a gateway to many of the programs and services that ACOs will need and demand. AOA will screen the vendors available and obtain significant group discounts for members.

AOA also continues to advocate on your behalf with the federal government. The only mention of ACOs in the health care reform law is for the Medicare Shared Savings Program. The AOA ensured that federal law and regulations would allow optometrists to participate in Medicare ACOs. The creation of ACOs is a complicated task because CMS and Congress established many requirements to prevent organizations from creating only the appearance of savings. The MSSP does not alter the universe of fee-for-service Medicare but adds a layer of bureaucracy. Outside of Medicare, private payers implementing ACO programs must still abide by state and federal consumer protections. There may be more opportunities for optometrists with ACOs participating in state or commercial payer value-based contracting programs. The AOA is developing tools to help members take advantage of this new delivery model to grow your practice.