What You Need to Know About Accountable Care Organizations

WITH WILLIAM L. RICH III, MD

The Patient Protection and Affordable Care Act (PPAC Act; H.R. 3590) includes a provision for the formation of Accountable Care Organizations (ACOs). ACOs, which will comprise physicians, hospitals, and other health care providers such as long-term care facilities, will be required to meet quality standards in the following areas: patient/caregiver care experiences; care coordination; patient safety; preventive health; and at-risk populations.

The goal of ACOs will be to deliver appropriate care to patients in a timely manner to reduce costs of health care. Ultimately, cost savings will be shared between ACOs and Medicare under the Medicare Shared Savings Program on an incentive basis.

What does this mean to retina specialists? To gain a better understanding of how ACOs will be organized, what they will do, and what impact they will have on ophthalmology in general and retina in particular, Retina Today *turned to William L. Rich III, MD, the Medical Director of Health Policy for the American Academy of Ophthalmology. Dr. Rich also answered some questions related to payment for imaging technology and procedures performed in ambulatory surgery centers (ASCs).*

Retina Today: What are some key criteria and goals of ACOs?

Dr. Rich: The health-care–provider entities that form an ACO are required to collectively provide care to 5,000 primary care patients. The system must be integrated by information technology (IT) and must involve Medicare services (eg, inpatient, outpatient, and rehabilitation services). The basic idea is that through improving the coordination of care, ACOs will cut unnecessary health care costs, and these savings will be split with Medicare.

I have some doubts that this will work. One doubt relates to what occurred with the Massachusetts health care reform law. Instituted in 2006, the law was designed to increase patient access to insurance and reduce the high costs of providing care to the uninsured (an idea with which we are all familiar). Instead of reducing costs, however, integrated hospitals bought up outlying practices and gained more market share, commanded higher fees, and ultimately drove costs up.

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_RT:_ Will ACOs have a major impact on ophthalmologists? If so, when will this take effect?

Dr. Rich: Hospital and large independent practice associations (IPAs) will be involved in forming ACOs. Hospitals and IPAs are preparing by buying up profitable providers such as primary care, cardiovascular, cardiology, and spinal surgery practices. They are not interested in acquiring ophthalmology practices because we provide very little hospital revenue when compared with other specialties.

ACOs, however, must provide all services covered by Medicare, so they will be contracting with ophthalmologists and ASCs beginning, most likely, in 2014.

_RT:_ What should ophthalmologists consider when signing a contract with an ACO?

Dr. Rich: Most important, never sign an exclusive contract with an ACO. You will be locked out of busi-

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ness from other competing ACOs in the community. Further, remember that ACOs need you because they must provide your services. If they present you with only one option, walk away.

***RT:* What do you think are the chances that a balanced billing option will be allowed in Medicare?**

Dr. Rich: The chances of a balanced billing option are close to zero. In the private health insurance sector, the average family is spending $12,000 per year in out-of-pocket cost for heath care. This is expected to increase to $16,000 by 2013, so these families will be paying for 30% of their health care. For patients on Medicare, however, the situation is worse. Deductables and coinsurance in Part B premiums have risen 54% in just 3 years, and the average income of a Medicare beneficiary is $15,000. Congress is not going to unload more cost sharing on Medicare beneficiaries, particularly when 22% of these patients do not even have Medigap coverage to cover the approximate 20% of uncovered costs. There are an estimated 680,000 physicians in the United States and an estimated 43 million Medicare beneficiaries who vote: Who do you think will win that political battle?

***RT:* Recently, payments for optical coherence tomography (OCT) exams were cut by 50%. Why did this happen, and will other retinal imaging services be destined for this fate?**

Dr. Rich: OCT is the fastest growing service billed to Medicare. The initial valuation for OCT services was based on old data that were collected before software advances. Thus, it was assumed in the old valuation that it takes 20 minutes of technician time and more than 12 minutes of physician time per each eye that is scanned, which is no longer true. A red flag for the Centers for Medicare and Medicaid Services (CMS) was the fast growth of billing for OCT, and, although justified, there was no chance to defend the previous value.

All office-based testing across medicine will undergo valuation scrutiny because software improvements have dramatically decreased the time and work of the technician and the doctor. I do not think we will see anything near the cuts we saw with OCT, however, because of the significant improvement in this technology since we first began using it.

***RT:* What ever happened to the yearly updates for ASC payments that were supposed to increase with hospital payments?**

Dr. Rich: When CMS unfroze ASC payments, we waved the flag and declared victory. For 8 years I, along with others, fought on behalf of the American Academy of Ophthalmology to allow more procedures to be performed outside of the hospital setting and to make these procedures more profitable in ASCs. At the time, we thought this was great—hospitals are politically powerful and receive market basket updates every year; if ASCs only received a small percentage of these increases, we could make a profit. What actually happened was that as our payments went up so did our volume, making the outcome budget-neutral. I think that we will realize some small increases in the years ahead but certainly not the increases that were anticipated. ■

William L. Rich III, MD is currently the Medical Director of Health Policy for the American Academy Ophthalmology. He is the Senior Partner at Northern Virginia Ophthalmology Associates in Falls Church, VA. He can be reached via e-mail at hyasxa@gmail.com.

George A. Williams, MD, is Professor and Chair of the Department of Ophthalmology at Oakland University William Beaumont School of Medicine and Director of the Beaumont Eye Institute in Royal Oak, MI, and a member of the Retina Today *Editorial Board. He is also the delegate for the American Academy of Ophthalmology to the American Medical Association's Specialty Society Relative Value Scale Update Committee and a member of the American Academy of Ophthalmology's Health Policy Committee and Board of Trustees. He can be reached via e-mail at GWilliams@beaumont.edu.*

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