CMS Rolls Out Draft Rule for ACOs

BY MARY ELLEN SCHNEIDER

After months of deliberation, officials at the Centers for Medicare and Medicaid Services released a proposed rule outlining how physicians, hospitals, and long-term care facilities can work together to form accountable care organizations and share in the savings they achieve for Medicare.

The voluntary program was created under the Affordable Care Act and will begin in Jan. 2012. Under the proposal, accountable care organizations (ACOs) could include physicians in group practice, networks of individual practices, hospitals that employ physicians, and partnerships among these entities, as well as other providers. The idea is for ACOs to be a partnership among a range of physicians, including specialists and primary care providers. However, only primary care providers will be able to form an ACO, according to CMS.

According to the proposed rule, providers in the ACO would continue to receive their regular fee-for-service payments under Medicare, but they could also qualify for additional payment if their care resulted in savings to the program. The proposed framework requires that ACOs meet certain quality standards and demonstrate that they have reduced costs in order to be eligible to share in any savings. The proposal outlines 65 quality measures in five quality domains: patient experience, care coordination, patient safety, preventive health, and care of at-risk and frail elderly populations.

"ACOs aren't just a new way to pay for care; they're a new model for the organization and delivery of the care under Medicare," Dr. Donald Berwick, CMS administrator, said during a press conference to announce the proposed rule.

Dr. Berwick said he doesn't know how many ACOs will form under the program, but that the level of interest is "enormous."

Since the Affordable Care Act was passed last year, the health care community has been buzzing about how ACOs might be structured and if they could succeed in reducing health care costs. Integrated care organizations like Geisinger Health System in Danville, Pa., are considered to have a leg up because their hospital and outpatient care is already coordinated.

But Dr. Berwick said that the proposal allows for ACOs at various levels of development to participate. For example, less developed ACOs can choose to receive only shared savings for 2 years before assuming risk. More mature organizations can assume risk immediately but be eligible for greater levels of shared savings.

CMS officials estimate that the program could result in as much as $960 million in Medicare savings over 3 years.

ACOs will not be set up like HMOs. Medicare beneficiaries will continue to be able to see their choice of providers under fee-for-service Medicare. Providers will be the ones that enroll in ACOs and must notify patients that they are receiving care within an ACO.

In addition to the ACO proposed rule, the Department of Justice and the Federal Trade Commission have issued guidance on how physicians and hospitals that form an ACO can steer clear of antitrust laws. Officials at the CMS and the Office of the Inspector General have also issued a notice on potential waivers that could be granted in connection with the shared savings program, and the Internal Revenue Service has issued new guidance for tax-exempt hospitals seeking to participate in the program.

The CMS will be accepting comments on the proposed rule. The agency also plans a series of open-door forums and listening sessions to explain the proposal and to get feedback from the public. ■

Malpractice Bill Divides House Committee

BY ALICIA AULT

FROM A HEARING OF THE HEALTH SUBCOMMITTEE OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE

WASHINGTON – Republicans and Democrats found little consensus on reforming the medical malpractice system during a hearing on legislation to institute a federal torts policy.

The Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2011 (H.R. 5) was introduced in January by Rep. Phil Gingrey (R-Ga.), who is a physician. It has more than 100 cosponsors so far, as well as the backing of most major medical professional societies.

But at the hearing, Democrats said they could not support the bill for a number of reasons.

"This is a bill we've heard before, a bill on which we've disagreed before," said Rep. Lois Capps (D-Calif.). She said that Democrats support the Republicans' goal of overhauling the malpractice system, but that "it is also clear that differences in our [approaches] remain."

Rep. Frank Pallone (D-N.J.), the subcommittee's ranking minority member, said, "I can't support and never have supported H.R. 5." He agreed that the malpractice issue needed attention, but said he objected to the bill's extension to cover drug and device companies, and also to the bill's cap on noneconomic damages. Rep. Pallone said it would be more important to control malpractice premiums directly.

Democrats also said the bill would preempt the states' ability to make policy and regulate the insurance business.

Rep. Henry Waxman (D-Calif.) released a letter from the National Conference of State Legislatures that was sent to the subcommittee expressing its opposition to H.R. 5.

It is the NCSL malpractice policy that federalism "contemplates diversity among the states in establishing rules," said the letter. "The adoption of a one-size-fits-all approach to medical malpractice envisioned in H.R. 5 and other related measures would undermine that diversity and disregard factors unique to each particular state."

Republicans, however, said that H.R. 5 is modeled on what they deemed successful state models in California and Texas. "I do not believe we need to study this anymore," said Rep. Michael Burgess (R-Tex.).

"In Texas, we know what works," he said, citing gains in the number of new physicians practicing in the state and reductions in malpractice litigation since a reform model was put into place in 2003.

Physicians who testified at the hearing said that the threat of malpractice suits drove up the cost of care by encouraging defensive medicine. And they testified that the litigious climate had contributed to increases in malpractice insurance premiums.

The environment is causing many ob.gyns. to change how they practice, testified Dr. Lisa Hollier of the University of Texas, Houston, who testified on behalf of the American Congress of Obstetricians and Gynecologists (ACOG).

She said that on average, ob.gyns. are sued 2.7 times over the course of their working career. A third of ob.gyns. are decreasing the number of high-risk patients they take, and an almost equal number are increasing the number of cesarean deliveries they perform or ceasing to offer vaginal birth after a cesarean, said Dr. Hollier.

Dr. Troy Tippett, a Florida neurosurgeon who spoke on behalf of the Health Coalition on Liability and Access, said that the group "believes there can be no real health care reform without meaningful medical liability reform."

H.R. 5 would limit lawsuits to within 3 years after an injury, cap noneconomic damages at $250,000, limit attorneys' fees, and eliminate the concept of joint and several liability, which means that the plaintiff could not sue all the potential parties who may be responsible for the injury.

The bill would extend the protections to drug and device manufacturers, nursing homes, and other health care providers. ■

HHS Invests $1 Billion In Quality

BY MARY ELLEN SCHNEIDER

Federal officials are pouring a $1 billion into a new initiative aimed at reducing hospital readmissions and preventable injuries.

The "Partnership for Patients" brings together physicians, nurses, hospitals, patient advocates, insurers, and employers for a 3-year project that will help spread the lessons of successful quality improvement initiatives across the country and provide tools for health care providers.

Many hospitals have already had success in reducing readmissions or nearly eliminating hospital-acquired infections, but those initiatives haven't been adopted widely enough, Health and Human Services Secretary Kathleen Sebelius said at a press conference to launch the Partnership for Patients. "The challenge is how to figure out how to make these models spread and accelerate this care improvement," she said.

The goal of the program is to reduce preventable hospital-acquired conditions by 40% compared to 2010 rates by the end of 2013. Officials are also seeking to lower hospital readmissions within 30 days of discharge by 20% compared to 2010. HHS officials estimate that the quality initiative will save 60,000 lives and up to $35 billion in health care costs, including up to $10 billion for Medicare alone.

The $1 billion investment of federal funds comes from the Affordable Care Act. HHS officials said they were making $500 million available right away through the Community-Based Care Transitions Program to support efforts to improve care transitions between hospitals and physicians in the community.

Hospitals and community-based organizations that team up to provide transition services can submit applications to HHS for funding. An additional $500 million will come from the CMS Innovation Center to fund demonstration projects aimed at reducing hospital-acquired conditions.

Under the Partnership for Patients, HHS officials are asking hospitals to focus on nine types of adverse events including drug reactions, pressure ulcers, childbirth complications, and surgical site infections. HHS officials also plan to recruit a group of "pioneer" hospitals that would seek to improve care for all forms of harm and complications, said Dr. Donald Berwick, administrator of the Centers for Medicare and Medicaid Services. Dr. Berwick said these hospitals would go beyond the list of nine conditions and seek to transform themselves into "safer, high-reliability organizations."

"By assembling this partnership and committing to these ambitious goals, we're sending a clear message that we can no longer accept a health care system in which only some Americans get the best possible care," Ms. Sebelius said. ■