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Accountable Care Organizations: The Emperor Has No Clothes, Or, Jeff Goldsmith's Plan B

By David Harlow
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The current all-ACO issue of *Health Affairs* includes a piece by Jeff Goldsmith entitled: Accountable Care Organizations: The Case For Flexible Partnerships Between Health Plans And Providers. It is a proposal for how private sector health plans ought to pay for services, in order to save us all from what Goldsmith sees happening in the near future thanks to the Gold Rush mentality among health care provider organizations working to become ACOs before they've been defined in regulation.

He begins with a précis of how we've gotten into the health care market mess we're in, touching on the concentration of market power in horizontally and vertically integrated health care provider organizations, payors and providers mudwrestling over fee-for-service reimbursement rates, and the rise of the large specialty group and the growing bifurcation of in-hospital and out-of-hospital medical practice into two largely separate populations of doctors. (He appears to be unmoved by the limited, but significant successes of some CMS demonstration projects in improving quality and reducing cost.) He then turns to the panacea du jour, the ACO, and finds it wanting. While one may quibble with some details, his indictment of the ACO model for Medicare is fairly convincing. A product of the usual sausage-making approach to legislation, the ACO -- even if workable in its original conception by Fisher and others -- is a health care camel (a horse designed by committee), and Goldsmith finds it unlikely to yield any meaningful net cost savings to share in the near term. I, for one, believe that physicians could exert greater influence within an ACO than Goldsmith would allow; while the bulk of health care costs are, as he notes, hospital-based, the most expensive piece of medical equipment is still the ordering physician's pen (or, these days, perhaps her iPad). Still, offering providers an upside without exposing them to a downside doesn't really make them CMS's partners in the cost containment enterprise.

I would agree that the time and dollar commitment needed to set up a really humming ACO are quite significant. It could take 5 years or so; folks will be able to meet the bare-bones requirements by 2012, once we know what they are, but most provider organizations will still have a lot of work to do to reap the maximum benefit

from the new organizational structure, and it is not clear whether or when the shared savings will make that investment pay off on the Medicare side.

Goldsmith notes the likely cost-shifting that will occur in order to make up the Medicare losses, as bulked-up provider organizations negotiate with commercial payors (though I must note that some states -- including the People's Republic of Massachusetts -- and now the federales, are imposing stricter controls on premium hikes for health insurance), and lays out a new approach to payment on the commercial side. He presents a set of payment and contracting strategies that he suggests should be adopted by all commercial payors, in order to reduce the administrative costs inherent in our current system, which has every provider dealing with the billing and payment idiosyncracies of every payor. Nice idea but, as they say, that could take an act of Congress. (Maybe this is the right Congress to roll back the antitrust laws just far enough for payors to do this, but of course it is unlikely that all payors would sign on in any event.)

In brief, Goldsmith recommends risk-adjusted capitation payments for primary care, fee-for-service payments for emergency care and diagnostic physician visits, and bundled severity-adjusted payments for episodes of specialty care. Primary care would be provided through a patient-centered medical home model, which would likely have a collateral effect of reducing the total volume of emergency care and diagnostic physician visits. Specialty care would be provided through "specialty care marts," ideally more than one per specialty per market to maintain a little healthy competition.

There is a great deal of merit to this proposal, and in fact, elements of the model are already in place in a number of markets around the country. At the same time, I don't think that it may be easily and quickly implemented as laid out, for a variety of reasons.

I've worked with specialty "centers of excellence" that function much as the specialty care marts that Goldsmith describes, providing integrated services for bundled payments. The ones that work well, work well, but the up-front investment in determining severity-adjusted payments, defining episodes of care, contracting the network of providers, and agreeing on clinical protocols is far from trivial. Furthermore, given the consolidation that has taken place to date, getting a good price may be difficult for payors.

Patient-centered medical homes exist in many locales, though just through demonstration projects for now, and the philosophy may not be consonant with a capitation-only payment model for primary care. The core approach of the Patient Centered Primary Care Collaborative (PCPCC) calls for reimbursement for patient care management, for in-office services, for cost avoidance downstream, and for quality. I believe that some monetary incentive for prevention and quality care must be included; the devil's in the details, but perhaps incentives based on patient panel

health status over time rather than solely based on avoided downstream costs could be developed.

In sum, life is not perfect, we have to play the hand we've been dealt, and we've been dealt ACOs. They will likely be a fact of life for many Medicare beneficiaries this time next year. Commercial payors are in the habit of glomming onto Medicare payment system innovations, so moving them -- and providers -- in a different direction will be difficult, though it may ultimately be a win-win-win for payors, providers and patients.

Depending on how flexible the regulatory waivers -- and Don Berwick promised the federales would be very flexible -- CMS may even be able to contract with ACOs in the manner described by Goldsmith. That could be the real win-win-win scenario.

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