



The Health Care Blog

The HMO in Your Future

By JOHN GOODMAN

February 28, 2011

I have not been able to determine how you pronounce the acronym for Accountable Care Organization (ACO). Is it ā' ko? Or ā' so? Or āh so', as in Charlie Chan movies? What about ě' ko, as in a canyon? Or simply ick, with a silent o?

Anyway, this is not a trivial matter because you are likely to be in an ACO at some point in the future and it's probably going to happen sooner than you think.

In Massachusetts, stakeholders are already meeting to develop a plan to push everyone with commercial insurance into an ACO. [Can you guess who doesn't count as a "stakeholder?" If you live in Massachusetts and you weren't invited to the meeting, that's a clue.] Nationwide, Medicare will start paying fees to ACOs, beginning next year. Eventually, the Obama administration would like to see everyone in an ACO.

But if no one had any previous interest in forming ACOs, let alone joining them, what is going to cause us all to change our minds? Money. Insurers won't be able to get premium increases unless they adopt ACO plans. Doctors and hospitals will be paid less if they don't join. Eventually doctors will find they are ineligible to treat Medicare patients or patients insured in the newly-created health insurance exchanges if they are not practicing in ACOs. As for the patients, there won't be any plans to join other than ACO plans.

Oh, and did I forget to mention it? Eventually ACOs will almost certainly have global budgets — a fixed sum of money, used to meet enrollees' medical needs. If all needs can't be met with that sum, they will have to be prioritized. At this blog we don't shy away from the "R" word (rationing). We do tend to avoid the "D _____ P _____" term, however. We call it "end-of-life counseling."

I don't know any advocates of ACOs who are not also advocates of global budgets. See if your experience is the same as mine. Why is that important to know? Because that is the most important thing ACOs are about.

ACOs are sometimes said to be the brain child of Elliott Fisher, who heads the Dartmouth Atlas Project. But as Uwe Reinhardt pointed out the other day, the idea is actually an old idea. It's called Kaiser Permanente.

ACOs have been called “HMOs on steroids.” They will have capitated payments and, like the traditional HMO, the ACO will get to keep any money it doesn’t spend. But the organization will also incorporate all the latest fads in health policy: electronic medical records (EMRs), pay-for-performance (P4P) incentives, quality report cards, etc.

The results from the few demonstration projects with ACOs are lackluster and mixed. But that doesn’t seem to matter to the Obama administration. Medicare will start contracting with ACOs beginning next year.

If that doesn’t strike you as strange, you need to know that “evidence-based medicine” is one of the buzz words among policy wonks these days and is supposed to be the foundation for ACO management. But if that’s a good idea for doctors, isn’t it equally good for policymakers? If we abided by evidence-based policy, would we put all of our marbles in the ACO basket? Basically no.

The latest comprehensive review of all the studies of report cards and other quality-measuring-and-reporting techniques finds they don’t work and may do more harm than good. Just as teachers will “teach to the test” if test results are how they are graded and rewarded, doctors will tend to “practice medicine to the test” if that is how they are paid. If you’re the patient, that may not be good for you. The latest comprehensive review of all the studies of electronic medical records finds they do not live up to their promises. And the most recent study of pay-for-performance from Britain finds that it doesn’t work either.

What about Kaiser? Its integrated medical records system is impressive and Kaiser is also promoting e-mail and telephone consultations. On the other hand, Harvard Business School professor Regina Herzlinger has taken the organization to task for letting people die.

But let’s give Kaiser the benefit of the doubt for the moment. The real question is not: how well does Kaiser perform? There are lots of centers of excellence around the country: Cleveland Clinic, Mayo Clinic, Intermountain Healthcare. The real question is: can the performance be replicated?

There is no law against ACOs (other than Stark restrictions that limit flexibility). So if ACOs can reduce costs and raise quality, why don’t we see them everywhere?

As it turns out, when Kaiser tried to replicate in Dallas what it does in Palo Alto, it failed. This isn’t surprising. If high-quality, low-cost medicine were easy to replicate we wouldn’t be having all the problems we are having.

When health policy experts associated with the Brookings Institution studied the “best” hospital regions around the country, they found few objective (replicable) characteristics. Some had doctors on staff. Some paid fee-for-service. Some had electronic medical records. Some did not. A separate study of high-performing doctor groups found much the same thing.

Evidence-based policy would admit ignorance about what works and why, and would let a thousand flowers bloom. It would pay more for low-cost, high-quality care, regardless of how it is achieved. We have previously suggested ways of doing that.

By contrast, the non-evidence based approach of the Obama administration will force everybody into the same model. As Scott Gottlieb has pointed out, this approach not only will stifle innovation and entrepreneurship, it is already causing venture capital to leave the health care market completely.

So how do we explain the administration's commitment to ACOs? Whether they raise or lower costs, whether they raise or lower quality, there is one thing that ACOs will indisputably accomplish. They will drive doctors into organizations where their behavior can be controlled. For the first time in our history, both the practice of medicine and the way money is spent on medical care will fall under federal control.

ACOs are the portal through which we will all march toward a truly nationalized health care system.