Will Accountable Care Organizations Just Become HMOs in Drag?

PAT SALBER

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Accountable Care Organizations (ACOs) are supposed to be provider-led (physician groups +/- hospitals) and, they are supposed to inject a new accountability, at the provider level, for the value of services delivered. You know the old equation. VALUE=QUALITY/COST. Those of us inside the health policy "beltway" know this mantra well. We have been talking about it for years (decades, really).

I spent almost 6 years working as a consultant to General Motors Corporation starting in the late 90's. My job was to systematically evaluate health plans' quality programs so that GM could determine the value the plans were bringing to their employees. My team and I helped develop an elaborate Request for Information process that is now known as eValue8.

Frustrated by the slow pace of change, Bruce Bradley, my boss at GM, and other large employer health benefit leaders, such as Chuck Buck and Bob Galvin from GE and Vince Kerr from Ford, formed the Leapfrog Group in an attempt to drive quality improvements more quickly. The idea was to focus initially on Patient Safety. This was a compelling choice as the IOM report, "To Err is Human,"

had just been published and everyone was now aware of the alarming number of deaths being reported as due to medical errors. But despite years of focus on the problem, patients still aren't safe and we are still trying to figure out how to improve value.

Somewhere along the way, some bright people, like Elliott Fisher, MD, Steve Shortell, Larry Casalino, MD and Mark McClellan, started talking about how we need to focus our improvement efforts directly on the delivery system – the doctors and hospitals – as opposed to trying pressure health plans to do the work. And, they said, we ought to realign the payment system so that providers are paid for producing good outcomes – not just providing a bunch of services. Put these two concepts together and…voila! a new idea is born (or as some think, an old idea is repackaged and, I guess we would more accurately say, reborn). The concept was christened "Accountable Care Organizations," and, as I mentioned above, it has become the hottest thing in health care. A whole industry has grown up around the dream of ACOs: conferences, newsletters, webinars, journal publications, and, of course, consultancies, like my company, ZOLO Healthcare Solutions.

As my team and I have dug deep into what it will take to transform the cottage industry of health care – small to mid-sized group practices and hospital systems – we have begun to worry that folks more influential than ourselves are developing long lists of things these organizations will have to have in place in order to be successful as an ACO. Here are some examples:

- A new or enhanced organizational infrastructure that includes physician and hospital leaders *working together* to deliver better outcomes at the best price possible (no small feat, this one!)
- The capability to generate data about the ACO's population, including lists of people with chronic illnesses, so that you can proactively reach out to them to provide assistance with managing their care
- Sophistication in financial management so that the ACO can handle a single payment for all of the services provided in certain types of hospitalizations (aka bundled payments) – and divvy the dollars up fairly amongst the people and institutions that provided the services
- A care management infrastructure that includes medical teams, case managers, and non-clinical support people
- Utilization management capabilities that ensure patients get what they need (right thing, right place, right time), but also ensures they do not get stuff they don't need or that could even be harmful (e.g., things that bring no "value" like duplicate tests, advanced imaging for self-limited conditions, antibiotics for colds, hospitalizations that could be prevented with more intensive upfront care.
- Electronic health records (a good thing) and ways for doctors to communicate electronically with pharmacies, other doctors, and patients

Ability to oversee, in a consistent way, any services the ACO chooses to delegate to another organization

I could go on and on – and indeed some of the ACO readiness checklists that I have seen (our own included) have identified a hundred or more complex capabilities the organization will need to have or buy. I have worked with a lot of health plans over the years and I can say that many of them would have trouble demonstrating that they could do everything that appears on these lists.

Now, I am not saying that these things don't bring value. Indeed they do – or at least they can – if they are done right. But what I am saying is that all of this stuff must be designed *and implemented,* in a way that keeps the patient's experience and outcomes – meaningful to patients and their families – front and center.

ACOs should not be denying payment for a service just to save a buck. Rather, they should be redirecting care to a service likely to bring the most value to the patient. This will be easy in some areas of care, for example high tech imaging, because professional organizations, like the American College of Radiology, have developed detailed evidence-based guidelines, to help doctors order the right test the first time. So, an ACO, instead of telling a doctor they won't get paid for a CT scan, would instead have processes in place to redirect the doctor to a (more expensive) MRI as will yield the best answer to the clinical question. This type of approach will be harder – but not impossible – in some other areas of care, particularly, end-of-life care, as the value of the last few months of life are clearly different depending on whether you are the dying patient, the loved one, or the organization paying the bill.

All of this leads me to the point of this post, as captured by its title: Will ACOs (and the organizations that help them develop and grow) just move a laundry list of health plan functions out of the plan and into a new organization? Or will they instead develop into a more effective way to deliver better value?

A friend sent me a recent blog post by Pauline Chen, MD, from the New York Times, titled "The Missing Ingredient in Accountable Care." In the post, Dr. Chen describes going on and on about ACOS to a group of her friends, saying things like this:

- Not just another pilot project or policy pipe dream, A.C.O.'s will be legal partnerships between clinicians and hospitals that will be part of Medicare by 2012.
- As a partnership, these providers will be responsible for all the health care needs of a specific population of patients who are assigned, but are not necessarily restricted, to them.
- Unlike fee-for-service, payers will give A.C.O.'s a lump sum to cover all care, but the A.C.O.'s will be able to keep any savings that result from more efficient and better care.

When she got done describing the benefits of ACOs, she "took a deep breath then looked around. One friend had stood up and was excusing herself to go to the bathroom. The other was looking into her bag, rummaging around for her cell phone." "Thanks for the explanation, Pauline" one of her friends said, as she pulled her phone out and quickly glanced at its screen. ""I hate to break it to you,"" she continued, ""but whatever that care plan is called, it still sounds like an H.M.O. to me.""

In our wonky-inside-the health policy beltway," I worry that we will once again forget that patients, people who use the health care system, want to feel cared for…they want to feel ***valued.*** As Jay Crosson, MD, former Executive Director of the Permanente Federation and former Vice Chair of MedPac, noted in a talk to a gathering of his colleagues at Kaiser Permanente:

"It's really pretty simple from the members' perspective. It amounts to this: 'Answer the phone; meet my needs; and treat me with dignity and empathy.' If we do those things, we will succeed. If we don't do those things, then no matter what else we do, we will not succeed."

Yes, Dr. Crosson, you are right. If we fail to build that type of ***value*** into these new organizations, then ACOS may come to be viewed, in the minds of our most important customers – the patients – as just another HMO in drag.

Pat Salber, MD, MBA is Managing Principal of Zolo Healthcare Solutions. She writes at The Doctor Weighs In.