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Zachary F. Meisel
University of Pennsylvania

Jesse M. Pines
George Washington University

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Post-HMO Health Care: Are ACOs the Answer?

By Dr. Zachary Meisel and Dr. Jesse Pines

"Remember the 1990s" retrospective lists always include Nirvana, Monica Lewinsky and *Wayne's World*, but leave out another major product that defined American life in the '90s: the health maintenance organization, or HMO — that nefarious health-insurance plan that seemed expressly designed to prevent you from seeing the doctor of your choice or receiving the treatments recommended by doctors, all under the guise of lowering costs and "improving" medical care. Of course HMOs are still around, but they are no longer central to the national discussion on health care. Why? For the most part, HMOs have eased limits on patient choice and treatments.

Good news, right? Well, yes, except that Americans are still stuck with a health care system that is fragmented, uncoordinated and incredibly expensive. Doctors and hospitals don't really do a good job talking to each other, sc patients get duplicate tests and treatments, while necessary and preventive care frequently falls through the cracks.

Now it's 2011: enter the accountable care organization (ACO), a major new Medicare initiative and an important part of Obama's health reform law. As envisioned, ACOs will take many different forms. But they will ultimately make specific groups of primary care doctors, specialists, and hospitals all part of the same "team," financially speaking.

An observation: in 1995, you may have found yourself cursing out HMOs at the office water cooler. But unless yo work in health care, in 2011 you probably aren't discussing ACOs at the workplace Keurig. And that is sort of the point. Policy makers are seeking to do what HMOs promised to do (slow the growth of health care costs) *without* infuriating patients. How? Unlike HMOs, ACOs are not going to restrict people's choice of a doctor. In fact, patients might not even be told that they are "in" an ACO.

HMOs cut costs by letting bureaucrats decide what care would and would not be reimbursed, essentially pitting the insurer against the doctor and ticking off patients in the process. In ACOs, doctors can work closely with their

patients and together decide what treatments are necessary — but there is a real incentive for the doctor to improve quality and reduce costs. Teams of doctors and hospitals, who all take part in the same ACO, get to share in the savings when you use less medical care, presumably by staying healthy.

Take the case of people with chronic conditions. Patients with diabetes or congestive heart failure stay healthier when the hospital to which they were admitted takes an active role in providing timely follow-up appointments with doctors during the patients' stay, when health-care providers have easy access to patients' tests. This saves money in the long run because better care in the hospital means patients can stay well and avoid having to go back in the hospital later.

Since ACOs haven't happened yet, there are many opinions about what ACOs will or will not do successfully. Some are worried about the consequences, intended and unintended, of the push toward accountable care. To summarize, here are a few of those concerns:

1. ACOs will measure processes, not hard outcomes. Take a look at this list of measures that ACOs will need to do well in order to qualify for Medicare rewards. The list includes things like percentage of doctors in the ACO who use electronic prescriptions and records, percentage of patients who get the flu and pneumonia vaccines, how often patients are getting body weight measurements and smoking cessation counseling. These measures capture aspects of quality medical care, but they don't actually measure which patients are actually healthier.

2. The poor will get burned. Some say that patients who live in poor and medically underserved communities will get cut out of ACOs. This concern was articulated in a *Journal of the American Medical Association* article last week. Wealthier hospitals and medical practices that serve richer patients will team up to form ACOs and will get rewarded. But independent or isolated medical practices that often serve poor urban or rural communities will get left out and not be able to share in the cost savings from Medicare, and will become even more financially stretched, in turn making things harder patients who may actually need the most help with coordinated medical care.

4. There are too many regulations. Earlier this month, the American Medical Group Association (AMGA), a trade group that represents many health care networks, sent a letter [PDF] to the administrator of the Centers for Medicare and Medicaid Services complaining that the ACO rules were too burdensome and prescriptive. This is interesting because some members of this trade group include the very integrated health delivery systems (such as Geisinger Health or Mayo Health) that are held up as examples of what ACOs should look like. So, even the organizations that will have the easiest time becoming ACOs are threatening to refuse to become one.

5. HMO redux. Some experts have suggested that patients should be able to get in on the cost savings of ACOs, for example by paying smaller copayments if they choose a doctor who is connected with an ACO. Of course, the other way to think about an incentive to get patients to keep their care inside a single ACO to make it more expensive to seek care elsewhere. This sounds to some awfully like what you get with a networked HMO that

makes it much more expensive to get care from outside the network.

All of these concerns are valid. And doubtless, there will be pitfalls to ACOs. Specifically, communities will need to be able to foster ACOs that best fit the type of patients and providers that they represent.

But in the end we must start with the big problem: with the old-school fee-for-service system, doctors and hospitals got paid the most for doing the most stuff (which was usually is for the sickest patients). Therefore there was no financial incentive for a hospital to keep the patient from getting sick and coming back.

For hospital stays, the reaction to this fee-for-service problem in the 1980s was bundled payments that reimbursed hospitals a set amount for care based on the diagnosis. This system sometimes promoted cutting off [PDF] necessary care and sending patients home from the hospital before they were ready. ACOs won't get rid of either fee-for-service or bundled payments, but they will overlay a structure that asks doctors and hospitals to put more skin in the game — hence, be accountable toward the goal of keeping patients and populations healthy.

Now, the hospital will have to worry about you, even after you leave. And your doctor will get penalized if she can't accommodate you with an appointment after hospital discharge and you wind up back in the ER or get readmitted. If ACOs get us even part of the way toward breaking down the silos that separate primary care, specialists and hospitals, it will be a great victory.

Dr. Meisel is a Robert Wood Johnson Foundation clinical scholar and an emergency physician at the University of Pennsylvania.

Dr. Pines is the director of the Center for Health Care Quality, an emergency physician and an associate professor of emergency medicine and health policy at George Washington University Medical Center.