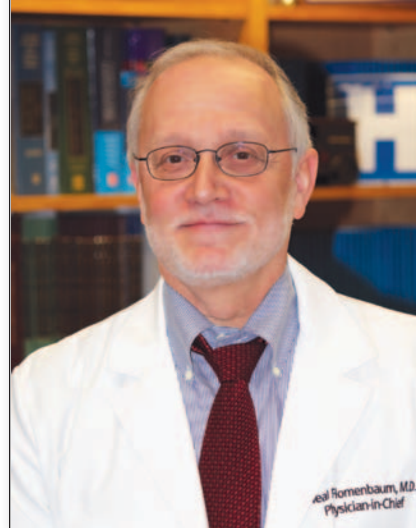
EDITORIAL

Neal Flomenbaum, MD
EDITOR-IN-CHIEF



Episodes of Care

If this editorial were an episode of *Sesame Street*, it would be brought to you by the letter *A*—as in *ACA*, for "Affordable Care Act"; *ACO*, for "accountable care organization"; and *ACE*, for "acute care episode." *A* is also the first letter of the word *anxious*, which is how most of the country is feeling now while it awaits the Supreme Court's decision on whether the ACA is constitutional. But regardless of that decision, provisions of the ACA intended to reduce health care costs will probably survive and may soon be implemented. One such model specifically mentioned in ACA is the accountable care organization (ACO) to manage acute care episodes (ACE). Commentaries in two journals address this model: In the *New England Journal of Medicine* (2012;366:1075-1077), Cutler and Ghosh detail the predicted cost savings, and in *Annals of Emergency Medicine* (published online ahead of print Sept. 29, 2011), Wiler et al ask if emergency medicine is ready for episodes of care.

Doubts about our country's ability to sustain increasing medical costs are not new, and even the most ardent ACA supporters must have considered that implementation of all of its provisions might make ACA into an "unaffordable care act." To help control costs, the ACO model requires CMS to allow bundling of Medicare Part A and Part B payments for either continuous care of a patient population or episodic care of certain acute conditions (ACE). Under the latter plan, an ACO composed of providers and services would receive a capped payment from CMS to cover everything typically necessary to treat a newly defined condition from 3 days prior to hospitalization until 30 days after discharge. The ACO would then distribute appropriate amounts to its care and service providers. The more efficient an ACO is in managing such conditions, the larger the amount available to distribute and, conversely, the more times a patient requires readmission or ED care, the more costly to the ACO.

All of these new proposals are bound to affect the delivery of emergency care, and any problems they create will almost certainly play out in EDs. Yet, as Wiler et al point out, "To date, none of the episode of care projects (other than acute myocardial infarction) have considered emergency care delivered during an episode." Since managed care first appeared, just about every proposal to streamline health care and lower costs has included a promise to reduce or eliminate ED visits. Though none have managed to do so, the newest plans continue to make this promise and then see no reason to include provisions for necessary emergency care.

Why are health care planners so antipathetic toward emergency departments? The answer always is "the high cost" of ED care. But the real cost of emergency care is not necessarily as high as it might appear. If reimbursements for the proportion of hospital admissions spent in EDs were credited to EDs along with government reimbursement for the charity care provided in EDs, the true cost of ED visits would be less, though not as low as in facilities not open 24/7 or not subject to the same regulatory requirements as are hospital-based EDs and walk-in facilities. Even these considerations, though, may not address the underlying problem EDs present to third-party payers, which is their patients' right to obtain emergency evaluation and care whenever they believe they are symptomatic enough to require it. Non–hospital-based facilities can demand payments or copayments up front; EDs cannot. But heavy-handed attempts to "cure" such ED accessibility will be too bitter a pill for Americans to swallow.

Will ACA survive the "supreme test" and can ACO and ACE help reduce health care costs? Watch for the next "episode of care" brought to you by the letters *EM*. **EM**