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Northeast Ohio Medical University
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PUBLISHING OFFICES
Quadrant HealthCom, Inc.
7 Century Drive, Suite 302
Parsippany, NJ 07054
Telephone: (973) 206-3434; Fax: (973) 206-9378

Don't bet the ranch on ACOs

I am amazed by the excitement surrounding the push for primary care physicians to join the Accountable Care Organization (ACO) bandwagon. Before my peers take out loans so they can do so—and see their credit scores decline as a result—I'd like to examine the facts behind this government-sponsored initiative and explain why I believe it is doomed to fail.

Medicare spending, the largest driver of federal entitlement costs and federal debt, is expected to rise from \$523 billion in 2010 to \$932 billion in 2020.¹ Yet Medicare's long-term unfunded liabilities—the total cost of benefits promised but not paid for—amount to \$36.8 trillion.² Congress responded to this almost unimaginable deficit by creating the ACO program as a means of managing Medicare health care delivery without losing another dime (at least for the Medicare Trust Fund). And hospital and provider groups responded by preparing to form these ACOs, even as they complain that the program has onerous reporting requirements.

With so many political adversaries and self-interests involved in local and regional medical politics, many insiders believe that the ACO concept cannot possibly succeed.

The Department of Health and Human Services predicts that ACOs could save Medicare up to \$940 million during the first 4 years of implementation.³ ACOs that succeed in delivering high-quality care and reducing costs will receive a share of the money the government saves on patients registered to the organization.

But how likely is that?

Each ACO must have at least 5000 “attributed beneficiaries” (otherwise known as patients), as well as the technological ability to report data on cost and quality for Medicare fee-for-service patients. As in the classic movie “The Dirty Dozen,” every ACO will attempt to

unify a large group of providers with at least one hospital, for the benefit of all. Yet some provider groups are fierce competitors. With so many political adversaries and self-interests involved in local and regional medical politics, many insiders believe that the ACO concept cannot possibly succeed. Among the reasons:

■ **Fewer tests=lower income.** In Medicare's traditional fee-for-service payment system, doctors and hospitals are compensated based on the number of tests and procedures they perform. This gives physicians an incentive to order more ancillary services and procedures, which increase their income. Doctors know, too, that in a fee-for-service system, the winners are those who schedule the most appointments. The realities of the fee-for-service system are at odds with the foundation on which ACOs' financial goals are based.

For ACOs to succeed, physicians will need to see fewer patients (but spend more time with them), perform fewer procedures, and keep patients out of the hospital—and accept less money for doing so. In the end (theoretically), every-

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one wins: The patient gets better care and the doctor gets a big-time bonus for helping Medicare control costs.

The trouble is, there are some rules providers need to play by. You see, “attributed beneficiaries” are assigned to specific primary care physicians within a particular ACO. But—and this is where it gets interesting—the patients are unaware of their ACO affiliation or loyalties. So, while the ACO is working to reduce health care costs, Mrs. Jones—an attributed beneficiary with diabetes who is unknowingly assigned to that ACO—is free to seek consultation from any clinician of her choosing. She can even go to the leading diabetes center in the country. But ultimately, any costs for Mrs. Jones’s care generated by the center would be credited as money spent not by the specialty diabetes center, but by the ACO to which she is assigned.

■ **Providers will be the losers.** Congress was smart when the ACO concept was legislated, as there could be only one loser in this game. If costs are not contained or performance and savings benchmarks are not met, the ACO—not the government—is penalized. After all, Medicare has \$36.8 trillion in unfunded liabilities. Why should this entitlement program take on any additional debt when liability can be passed to a third-party conglomerate, such as physicians, lawyers, and hospitals?

■ **The field test failed.** The ACO concept has already been field tested, as mandated by Congress. Ten of the nation’s most respected large multispecialty groups were selected as test sites, including 2 that are associated with academic medical centers. Each group was required to attain 32 quality metrics and exceed a savings threshold of 2% to qualify for bonus compensation.

Only 2 of the 10 were able to generate savings in all 5 years. One major health system required 3 years before exceeding the savings threshold. Another—a prominent health system that has more than 30 years of managed care experience—qualified for bonus compensation in just a single year.⁴

If most of these 10 respected institutions struggled over 5 years to generate incentive payments from Medicare, the prospect of other ACOs succeeding financially is grim indeed.

This is sobering news for physicians, hospitals, and other providers who are planning to invest their time, money, and efforts into forming ACOs. Based on the data derived from the government’s own pilot project, successful implementation of the ACO concept will be very difficult—and will lead to higher overall health care costs.

The government has already demonstrated that the ACO concept is doomed to fail. Let’s heed the warning signs. Resist the urge to put your hard-earned cash at risk with a government-sponsored health care system—especially one that protects Congress and fails to adequately address issues such as preventive medicine, cost-effective care, and tort reform.

JFP

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