

Forbes

How Obamacare is Destroying Accountable Care Organizations

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The Apothecary Blog

August 19, 2011

“Accountable care organizations” is the health wonk phrase *du jour*. Obamacare’s advocates point to its support for ACOs as one of the important cost-control initiatives in the law. Except that, like nearly everything about Obamacare, the truth isn’t so simple. It turns out that the government’s idea of an accountable care organization is completely unworkable, to the point where nearly all leading health providers have declared it dead on arrival.

Right now, the average Medicare patient has two primary care physicians and five specialists; the average is 13 for those with chronic illnesses. Typically, these physicians aren’t coordinating with each other. On top of that, better-coordinated care that saves costs ends up leading to reduced Medicare payments, creating a disincentive for reform.

ACOs, in theory, are supposed to change all that, by better coordinating care, and by reorganizing the way in which providers are paid, to focus more on health outcomes instead of simply performing tests and procedures. However, as Gene Lindsey, president of a non-profit health provider alliance, puts it, “An ACO is like a unicorn: everyone thinks they know what one is, but no one has ever seen one.” In addition, as [John Goodman](#) points out in a new piece, ACOs aren’t as revolutionary as they sound:

The Obama administration has told us how it intends to change Medicare many times and in many places.

It wants to replace fragmented decision making by independent doctors with coordinated care delivered by doctors working in teams, connected to a medical home. It wants Medicare to purchase quality, not quantity. It wants decisions to be evidence-based. It wants electronic records in order to standardize care and reduce errors.

So how does the administration plan to get all this done? It plans to spend hundreds of millions of dollars on pilot programs to try all these ideas out and then

Wait a minute. Aren’t these ideas already being tried out somewhere? Yes. In Medicare, as a matter of fact. How well are they working? As a long-time critic of managed care, I admit the results look pretty good.

“So,” John asks, “if the Obama administration’s core ideas have already been tried and tested and they are well underway, why are we spending hundreds of millions of dollars reinventing the health delivery wheel? I thought you’d never ask. If you are practical and pragmatic, you wouldn’t — especially when the government is running out of money anyway.” Well, except that these ideas are being tried in the market-oriented Medicare Advantage system, which many on the Left dislike because it is a privatized system.

John provides more background on how these programs work today:

Before going further, let me clear up an important point about the organizations that are involved in Medicare Advantage.

About one in every four seniors has enrolled in a private insurance plan, offered by such entities as Aetna, United Healthcare, Humana, Cigna, etc. Medicare pays these plans a risk-adjusted premium (reflecting the expected cost of the enrollee, based on age, sex, previous medical history, comorbidities, etc.). Sometimes these plans pay for medical care the same way the conventional Medicare program pays. But for the present discussion, a more interesting arrangement is one in which the actual delivery of care is carried out by an entirely separate entity.

At the risk of overwhelming you with acronyms, these entities are variously called Independent Practice Associations (IPAs), Medical Services Organizations (MSO) or Integrated Delivery Networks (IDNs). Let’s just settle for IDN. Under a typical arrangement, the insurer will specialize in the insurance aspects of the plan (benefit design, actuarial analysis, claim adjudication, marketing, accounting, etc.) and the IDN will specialize in health care delivery. This is important to know because it is typically not the insurance company that is experimenting and innovating with new designs in how to deliver medical care. It is a group of doctors in an IDN who are doing it.

An example of an IDN that is already doing what the Obama administration wants to try out with expensive pilot programs is [IntegraNet](#) of Houston, an organization with a network of about 1,200 doctors. Every Medicare patient has a medical home. The physicians follow evidence-based practices. Care is integrated and coordinated. Electronic records are being introduced. It appears that quality is higher and costs are lower than in conventional Medicare.

So what’s not to like? If the folks at CMS had any sense, they would camp out in Houston and try to find out how all this works.

Except that the government chose a different approach. On March 31, Donald Berwick’s Centers for Medicare and Medicaid Services issued [427 pages of proposed rules and regulations](#) that will govern how ACOs will operate.

In May, ten groups that participated in an ACO pilot program called the Medicare Physician Group Practice Demonstration, including leading centers like Dartmouth-Hitchcock, Geisinger, and the University of Michigan, told CMS in a letter that it would be “[difficult, if not](#)

impossible" to participate in Obamacare's ACO program, due to its incessant federal micromanagement and high start-up costs.

The American Medical Group Association, which represents various provider stars like the Mayo Clinic, the Cleveland Clinic, and Intermountain Healthcare in Utah, said that 93 percent of its members wouldn't participate in the program, because "on its face, it is overly prescriptive, operationally burdensome, and [has unattractive] incentives."

The *Wall Street Journal* described how Obamacare's ACOs are practically designed to fail, with a "kitchen sink" of bureaucratic mandates:

The providers that are already closest to being an ACO have rejected the Administration's handiwork.

And no wonder, since the 429-page rule is a classic of top-down micromanagement. ACOs will need to comply with a kitchen sink of 65 clinical measures that are meant to produce efficiencies, like reducing infections or ensuring that patients take their medications after hospital discharge. If care at an ACO costs less than Medicare predicts it will cost under the status quo, then the ACO will receive a share of the savings as a bonus payment. The rule also includes financial penalties if an ACO misses its targets.

Incredibly, the ACO teams won't know in advance which patients they're supposed to manage. Seniors will be "retrospectively assigned" to an ACO at the end of every year, based on an arbitrary algorithm, for the purposes of calculating costs.

Think about that one: The Geisinger model works because Geisinger patients are treated by Geisinger physicians. Yet this rule is written to ensure that seniors can take "advantage of the full range of benefits to which they are entitled under the Medicare FFS program, including the right to choose between healthcare providers and care settings." So ACOs are going to transform health care, but individual patients don't need to be part of the transformation if they don't feel like it.

Oh, and HHS reserves the right to conduct site visits and audits and "to inspect all books, contracts, records, documents, and other evidence" to ensure that health systems are complying with the ACO rule. The mystery is why even 7% say they'll participate.

John Goodman notes that IntegraNet of Houston, part of the new wave of integrated systems, won't even qualify for the government ACO program:

There is no doubt in my mind that IntegraNet doesn't satisfy all the government's requirements by a long shot. For one thing, it pays its doctors fee-for-service. The Obama folks are convinced fee-for-service payment is the problem, not the solution. For another, IntegraNet intentionally pays doctors more than Medicare's standard rates. Yet the administration's Plan B for cost control is squeezing provider payments, not increasing them.

A third problem is that it is producing a medical loss ratio (MLR) of 70% or less for its insurance company clients. As [previously reported](#) that is 10 percentage points less than the minimum MLR the Obama administration thinks insurers should have. But that extra 10 percentage point profit (shared by the IDN and the insurer) is the whole reason IntegraNet is in business. No one is going to take risks and try new things if they can only get a [regulated-utility rate of return](#).

IntegraNet is not alone. In many other Medicare Advantage plans practitioners are already doing what the Obama administration says it wants to do with Medicare as a whole — without any prodding or nudging from the federal government. That is, many of these plans are using coordinated/integrated/managed care systems to achieve [fewer admissions, fewer readmissions and fewer hospital days than conventional Medicare](#). (See the latest summary of the evidence by Jeff Lemieux in a [comment at the Health Affairs blog](#).)

Of particular interest to me is the opportunity to give money back to patients who make cost-effective choices (a subject I will consider at great length in the future). A number of IDNs are way ahead of me — rebating some or all of the senior's Part B premium if they will cooperate and choose a medical home. As Larry Wedekind, IntegraNet CEO, explains:

It is the beauty of competition in a marketplace with several competitors all bidding for additional business from seniors. The ones that we have seen in the Houston market have ranged from a full Part B premium give-back to seniors to a 20% portion of it...I've seen as low as \$20 per month give-back to full premium give-back of \$96 per month in the past. The Part B premium this year is \$110.50, but no one is giving more than \$50 per month back this coming year. The give-backs are often related to a Medicare Advantage Special Needs Plan such as a diabetic plan to help defray the higher costs of drugs.

"The sad irony," **John concludes**, "is that many of these plans, along with their innovative ideas, may be pushed out of existence by the very administration that is touting the techniques they have pioneered."

PDF? Yes