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ACCOUNTABLE CARE ORGANIZATIONS: ACCOUNTABLE TO WHOM

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The talking heads of healthcare are at it again: A new acronym to save healthcare has arrived -- the ACO, or accountable care organization. These amorphously defined entities are likely to become the centerpiece in the war over healthcare dollars.

Disraeli commented that there are lies, damned lies, and statistics. It's time to add acronyms to the list.

Words do matter. They are a chief element in propaganda. After all, who would argue with "accountable" - - we all want accountability, right? We all want "care," don't we? After all, isn't that what *healthcare* is all about?

But *accountability* to whom? And for what *care*, exactly? Lastly, and most importantly, who runs the *organization*?

Back to the future

The fact is that we've been here before. We just used a different acronym: the PHO, or physician hospital organization.

In the mid-1980s into the early 1990s, hospitals needed a way to assure that they, and not their competitors, other hospitals and the then nascent ambulatory surgery centers, would capture referrals from primary care doctors both directly to their facility and to the specialists within the hospital's "world."

Remember, too, that in many parts of the country, the other significant healthcare trend was the growing penetration of managed care. As a result, these same hospitals needed to assure their position in managed care networks.

One solution that proved popular was the creation of physician hospital organizations -- a type of integrated delivery system. In the PHO model, the hospital sponsored the creation of a linkage between primary care, as well as limited specialty, physician practices and the hospital.

In some instances, this included the acquisition of physician practices, either directly by the hospital or indirectly via related tax-exempt foundations. In other instances, it included management services organization (MSO)-like arrangements in which the PHO provided a broad range of space, equipment, and personnel support. In all instances, it included a participating provider structure such that the PHO could bind the physicians to the terms of managed care deals.

In other words, the PHO became a one-stop shop under the *de facto*, if not *de jure*, control of the hospital, for managed care contracting with the physicians and the hospital.

Many of the PHOs formed during the heyday of the growth of managed care failed, especially those that embraced an employed physician model. The formerly independent practitioners who had built successful practices through focused work and entrepreneurial skill were frustrated by the hospital's multiple levels of bureaucracy and mind-numbing internal politics; they quickly understood how to game that system: just enough work, not more.

Enter the ACO

Over the past decade, significant focus has been given to the notion of paying for quality care as opposed to simply the volume of care. Think pay-for-performance, for example.

Of course, quality in terms of overall patient outcome is linked to treatment across many providers: multiple physician practice specialties, ancillary care providers, and the hospital, to name but a few. This, of course, has led to the pundits suggesting that organizations linking hospitals, physicians, and other providers can be used to contract together, take risk based in part on achieving quality (however quality is defined), and distribute the income. *Ah, distribute the income.*

Although policy-makers love to toss the idea around, and have broad definitions for an ACO (according to the Robert Wood Johnson Foundation, an ACO is a "local healthcare organization and a related set of providers -- at a minimum, primary care physicians, specialists, and hospitals -- that can be held accountable for the cost and quality of care delivered to a defined population"), absolutely no one knows what exactly, in terms of its definite structure, an ACO will be in operation.

Of course, that didn't stop Congress from including in the newly enacted Patient Protection and Affordable Care Act authority for the Secretary of Health and Human Services to utilize "innovative payment mechanisms and policies" including ACOs. The new law even includes a pilot program for the payment of care through those organizations. But, again, the bill contains no set definition of an ACO -- it does state that an ACO is an organization to provide, in part, physician services and *may include a hospital* and other providers.

In other words, an ACO is a PHO with a few bells and whistles. On its face, it's about quality, combining physicians and facilities, patient-flow, contracting, and payment. But at its heart, it's about contracting and payment, the same notion as a PHO.

The Golden Rule

The reality is that there is only one acronym at play here: PCN -- Power, Control, and Naiveté. Issues of power and control underscore all levels of healthcare. As to the "N" for naiveté, it's yours that they are counting on.

An ACO, is about power and control over physician services rendered and, importantly, power and control over physicians' incomes. ACOs are the intended funnel of payor funds -- they serve as a mechanism to distribute those funds and, as such, invoke the Golden Rule: He who has the gold makes the rules.

As a radiologist, if you think that it's difficult to negotiate with third-party payors or to obtain stipend support from the hospital to shore up declining reimbursement, think what it will be like when there is one real payor in town, the hospital-controlled ACO.

Physicians long ago abdicated much of their power in controlling the future of healthcare in favor of other tradeoffs. The American Medical Association's (AMA) sponsorship of Obamacare and many physician specialty societies' support of the various healthcare "reform" bills are leading physicians down the path of less control than before.

Hospitals and their associations are scrambling to build ACO networks. Don't for a minute think they have your interest at heart. Although the Patient Protection and Affordable Care Act caps existing physician investment, and prohibits future physician investment, in hospitals participating in federally funded healthcare programs, ownership is generally not the key: control of the cash is.

The opportunity exists to seek physician control of ACO's: There is no rule that requires that control run one way, from the hospital to the physicians. Difficult, yes. But what's the real alternative?

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