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ESCAPE THE CARNAGE OF THE ACO

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A new acronym to save health care has arrived: the ACO, or "accountable care organization."

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

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

Back to the Future

If all of this sounds familiar, it's because we've seen this movie before. We just gave it a different acronym. In the mid-1980s to the early 1990s, hospitals needed a way to ensure that they, and not their

competitors—other hospitals and upstart ambulatory surgery centers—would capture referrals from primary care doctors both directly to their facility and to the specialists within the hospital's sphere.

At the same time, managed care was making increasing inroads into the market. As a result, these same hospitals needed to ensure their position in managed care networks.

One solution that proved popular was the creation of physician hospital organizations, or PHOs. 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 through related tax-exempt foundations. In other instances, it included management services organization-like arrangements, in which the PHO provided space, equipment and personnel support. In all instances, it included a participating provider structure for the PHO to bind physicians to the terms of managed care deals.

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

Many PHOs formed during the rise 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 hospitals' multiple levels of bureaucracy and mind-numbing internal politics. They quickly understood how to game that system: just enough work, and no more.

Enter the ACO

Over the past decade, significant attention has been devoted to the notion of paying for quality care, not simply lots of it. The recent push for pay-for-performance is one example of this trend.

Of course, quality in terms of overall patient outcomes, as opposed to the few measurable instances within a hospital-based physician group practice, is linked to treatment across many providers. As a result, analysts have suggested that organizations linking hospitals, physicians and other providers should band together, take risks based in part on achieving quality (however that term is defined), and distribute the income.

Although policymakers love to toss the idea around, no one can pin down what structure an ACO will take in operation. Indeed, the variation in how ACOs are defined is dizzying. According to the Robert Wood Johnson Foundation, for instance, an ACO is a "local health care 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."

But wait. The Medicare Payment Advisory Commission's June 2009 report to Congress, states: "In our model, the ACO would consist of primary care physicians, specialists and at least one hospital. It could be formed from an integrated delivery system, a physician–hospital organization or an academic medical center. The defining characteristic of ACOs is that a set of physicians and hospitals accept joint responsibility for the quality of care and the cost of care received by the ACO's panel of patients."

Of course, ambiguity didn't stop Congress from including in the newly enacted Patient Protection and Affordable Care Act authority for the secretary of the Department 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, although 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.

From Many, One

The reality is that there is only one acronym here: PCN—Power, Control and Naiveté. Issues of power and control underscore all levels of health care. As to the naiveté, it's the physician's that they are counting on.

An ACO is about power and control over physician services rendered, and importantly, power and control over physician incomes. ACOs are the intended funnel of payer funds: They serve as a mechanism to distribute those funds.

Anesthesiologists who think that it's difficult to negotiate with third-party payers or to obtain stipend support from the hospital to shore up declining reimbursement, consider this: What it will be like when there is one real payer in town, the hospital-controlled ACO?

Physicians long ago abdicated the power of controlling the future of health care in favor of other tradeoffs. Health care reform is leading physicians down the path of less control than before.

Hospitals and their associations are scrambling to build ACO networks. Do not for a minute think they have the interests of physicians at heart. Although the new health care law caps existing physician investment and prohibits future physician investment in hospitals participating in federally funded health care programs, ownership is generally not the key—control of the cash is.

The opportunity exists to seek physician control of ACOs. After all, 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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