Published on ImagingBiz.com
April 25, 2012

THE ABCS OF ACO ECONOMICS

BY: MARK F. WEISS, J.D.

If the hospitals at which your group provides services haven't already approached you and your fellow members of the medical staff about ACO formation, the chances are high that they will in the not too distant future.

Expect that pressure to be great. After all, the hospital will argue, ACOs, or "accountable care organizations," are all about increasing the quality of care through collaboration.

But recall that Benjamin Disraeli, the great British Prime Minister, once commented that there are lies, damned lies and statistics. I say that it's time to add acronyms to that 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?

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 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.

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.

What Gold?

For a brief moment, let's set aside the notion of the power struggle and look simply at one of the central financial issues that you need to consider even before you are approached by an ACO.

When radiologists consider the subject of accountable care organizations, the usual context is that of the ACO as a Medicare payment mechanism introduced as an element of the Patient Protection and Affordable Care Act, a/k/a Obamacare. However, to fully understand the economics of an ACO, you need to appreciate the fact that the model is not designed to be constrained to the Medicare arena. In fact, the economics of the creation of a functional ACO dictate that it must focus on a larger market.

ACO formation is both capital and time intensive. By way of limited example only, there's the legal and financial work in planning the structure, creation of the necessary entities, building the management and compensation structures, and developing relationships with physicians and convincing them, cajoling them, or even outright pressuring them to join.

Given these high transaction costs – and once again, setting aside (at least for a few nanoseconds) the thoughts of shifting power and control—hospitals that create ACO structures will be predisposed to use them other than simply for purposes of chasing Medicare dollars: They will pursue private payer dollars as well.

Radiologists who become providers in an ACO believing that what is intended is simply another way of collecting and allocating Medicare dollars will soon find that a huge proportion of their entire book of business is now ACO business.

As a radiologist, if you think that it's now 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.

When that happens, will you still be running an independent practice?

Of course, this has significant economic implications for your financial future. It also has significant political implications vis-à-vis the medical staff: If all physicians are dependent upon the hospital for their livelihood, how independent can the medical staff ever be?

And, remember, that the reason – or excuse – that the model's proponents use for the creation of an ACO is a drive to quality care. But if physician practice becomes more and more subject to the economic control of the hospital, what will happen to physicians' satisfaction with medical practice and, therefore, with the quality of care that they give — even assuming every physician has patient care at the forefront of his or her thoughts?

You may consider these issues to be theoretical. However, my advice is that they are only theoretical until an offering memorandum for participation in an ACO hits your desk. Then you have 30 to 60 days to decide whether you're in or out.

The time to begin influencing how an ACO is structured is now, as is the time to begin setting your strategy in respect of ACO participation.

Difficult? Yes. Expensive? Yes. But there is no viable alternative.

—

Mark F. Weiss is an attorney who specializes in the business and legal issues affecting radiology and other physician groups. He holds an appointment as clinical assistant professor of anesthesiology at USC's Keck School of Medicine and practices with the Advisory Law Group, a firm with offices in Los Angeles, Santa Barbara and Dallas. He can be reached by email at markweiss@advisorylawgroup.com and by phone at 800-488-8014.