The Challenge of ACOs:

ARE PHYSICIANS WILLING TO STEP UP TO THE PLATE?

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One of the cornerstones of President Obama's health care reform law is the authority to establish Accountable Care Organizations (ACO) – networks of Medicare providers including physicians, hospitals and health systems. The goal of ACOs is laudable: to increase the quality of care while lowering health care costs. But there are early signs that physicians may not be ready to buy into the concept. And even the most well-respected health systems that are viewed as models of coordinated care – Cleveland Clinic, Geisinger, and Mayo Clinic – have given ACOs a chilly reception.

ACOs represent top-down approach by the government to incentivize providers to furnish more efficient, high quality care through a teamwork approach. In this respect an ACO is radically different than consumer or market oriented approaches that are designed to encourage patients to become more savvy shoppers for "better" or "cheaper" health care services.

Most of the objections to ACOs simply boil down to money issues. For example, many physicians remain leery of governmental programs designed to save costs. After all, one man's cost is another man's revenue. Will health care cost savings mean lower incomes for physicians? Will the ACO arrangement reduce revenue (a cost) by $1 and then give back 50 cents at some future date through the shared savings program? If so, where is the net benefit for physicians to participate in the ACO?

Many providers are willing share the financial benefits from shared savings, but are reluctant to assume any downside risk for losses. CMS rejected a gain-sharing approach, however, because it feared that a one-sided model would not create a sufficiently strong incentive to improve the efficiency of healthcare delivery. Therefore, CMS took a hybrid approach which allows ACOs two different kinds of arrangements.

An ACO can enter into a three-year agreement with CMS in which the ACO would not be responsible for any losses incurred during the first two years. In

the third year, however, the ACO would share in both savings and losses. Alternatively, the ACO can enter into an arrangement to share in savings and losses in every year of participation. This latter model offers a higher shared savings rate than the one-sided model.

Physicians in private group practices are also concerned that an ACO would be forcing them into partnerships with hospitals with which they now compete for various kinds of medical services, e.g., imaging services, outpatient surgeries, and radiation oncology.

As with past managed care models – IPAs and PHOs – the ACO would be focused around primary care physicians who would coordinate the activities of other providers. But almost two-thirds of all physicians are specialists, many of whom are doing fine in the fee-for-service environment and may have little interest in becoming subordinated in a primary care driven model of health care.

The cost to establish an ACO may be substantial – and much higher than initially anticipated by CMS. The American Hospital Association recently commissioned a study which estimated the investment for starting an ACO at between $11.6 million and $26.1 million, dwarfing original CMS estimates of $1.8 million. Moreover, these cost estimates were prepared before CMS released its proposed ACO regulations in April and therefore do not take into account the costs of meeting those specific requirements. Where will that money come from and how long will it take an ACO to recoup its investment?

Major health systems such as Mayo and Cleveland Clinic also believe that the proposed ACO regulations unduly handicap them because their savings would be measured against current expenses. They claim to be high quality, low cost providers who will not be able to squeeze out additional savings as easily as less inefficient, higher cost providers.

For many providers, it may take a leap of faith to participate in an ACO, a leap made more difficult by memories of past health care delivery models that failed to live up to their lofty expectations.

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