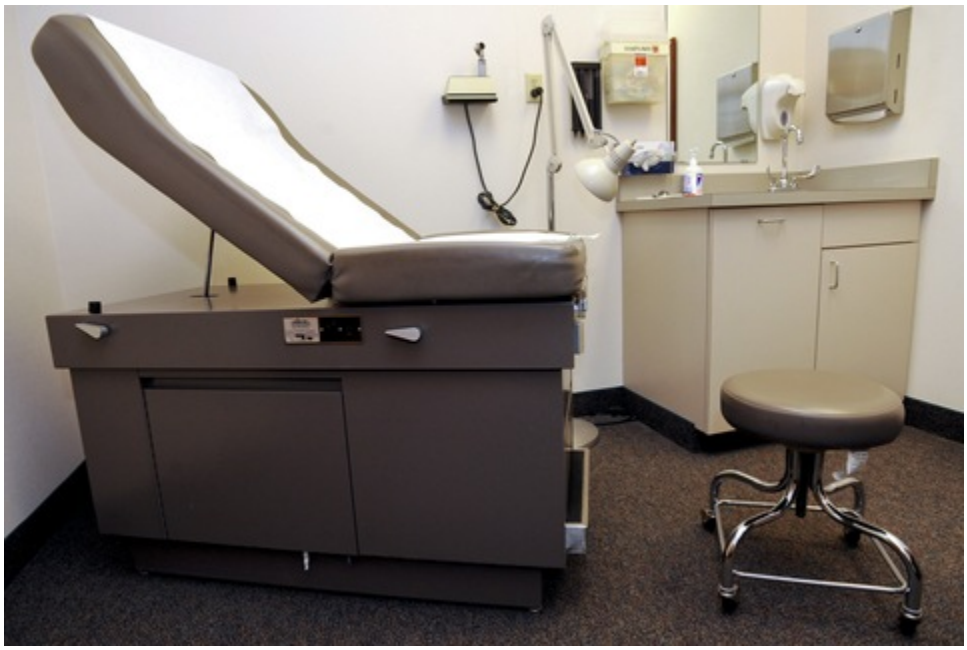
PBS NEWSHOUR

HEALTH REFORM -- May 3, 2011 at 12:00 PM EDT

Accountable Care Organizations in Health Reform Decoded

By: Betty Ann Bowser



Anybody who's got more than one medical condition knows the drill. You go to the cardiologist with a heart problem. You go to the orthopedic surgeon if your back hurts. You find an oncologist if you need chemotherapy.

They all get paid by an insurance company or the government (if you're on Medicare or Medicaid) or by you. But it's rare when all three doctors talk to each other and they almost never compare notes. You see each one of them in a kind of vacuum. And you, the patient, are left to figure out what each piece of your medical puzzle means to the other.

Meanwhile, the chances are good that all three doctors have ordered expensive tests that may duplicate each other.

It could be that the back problem has something to do with your heart problem or the cancer is causing one of the other two conditions to get worse. But the only way you'll ever find out is if you take all of your doctors out to dinner, sit them down at the table and lock the restaurant door.

Fragmentation and unnecessary testing are two of the hallmarks of medical care in the United States. They're also a major factor in what's driving the cost of health care through the roof. The Kaiser Family Foundation has just released its annual report on health care spending in the United States and found that $7,538 a year is now spent on each American. That's at least $2,535 more or 51 percent higher than Norway, the next largest per capita spender.

The rate of growth in health care spending is also going up faster than any other industrialized nation. If this trend keeps up it won't be many years before health care accounts for more than a quarter of the nation's gross domestic product.

Enter a new idea: The Accountable Care Organization (ACO), a key provision in the new federal healthcare law.

One of it's promoters is Dr. Eliott Fisher who for 30 years has headed the Dartmouth Atlas which painstakingly has documented the discrepancies in American health care, and although questions have been raised in some quarters about the research, most health policy professionals rely on the work.

Dartmouth found that a person who lives in one county could have health care costs of more than $15,000 a year, while his neighbor one county over with the same condition costs $5,000 a year. And the guy who has the $15,000 tab is no better off health wise than the neighbor who cost the system $5,000.

So Fisher suggests that doctors, hospitals and other providers get together and coordinate care for their patients. The idea is that these ACOs would improve medical care to patients and save money.

Theoretically, these health care providers would get together and decide what the average cost per year is to treat people who live in that part of the country, and stick to that amount. At the end of the year, providers who can prove their patients got better care and didn't spend all of the pre-set amount of money would get to pocket the savings.

Dartmouth found that a person who lives in one county could have health care costs of more than $15,000 a year, while his neighbor one county over with the same condition costs $5,000 a year.

That would mean you would no longer have to go one place for your heart, another for you back and still another to get chemotherapy. You would get one stop shopping all within this group of doctors. And guess what? The doctors would all TALK to each other about your various medical conditions.

Some so called integrated health systems have been practicing this kind of medicine for years. The Cleveland and Mayo Clinics come to mind, along with the Geisinger Health System in western Pennsylvania. But they are hospital systems where the doctors are on

salary, not paid for each service they provide like most of the rest of the country. That's called fee for service.

Under the new ACO concept doctors would still be paid on a fee for service basis. But Fisher and other supporters of this idea believe better coordinated care would spell less expense because there would not be so many duplicative tests performed. And another point, these ACOs would all have electronic medical records so the computers could talk to each other.

Rules from the federal government on how to do these Accountable Health Organizations recently were made public after months of anticipation in health policy circles.

Basically, they say there should be at least 5,000 patients in each ACO. Groups of doctors would form networks where patient information was shared. There would be doctors, health care providers and Medicare recipients on each ACOs board of directors. And the population of each ACO would consist entirely of Medicare patients at the outset.

When the rules were announced, Health and Human Services chief Kathleen Sebelius said Accountable Care Organizations will "improve the quality of care patients receive and help lower costs."

Another major figure in the movement to ACOs is Dr. Mark McClellan who heads the Engelberg Center for Health Care Reform at the Brookings Institution. He also knows his way around the federal government, having served as both Commissioner of the Food and Drug Administration and head of the Centers for Medicare and Medicaid Services.

Dr. McClellan told the PBS NewsHour online that ACOs will "enable care providers to get paid more when they do what they really want to do for patients--provide better care at a lower cost."

"It's not a silver bullet," he said, but "done right it can be an important new resource for health care providers."

Dr. Jay Goldsmith, who's an associate professor of Health Science at the University of Virginia is not so sure. He is not a fan of ACOs. He thinks the new networks will be nothing more than "a cost containment compact between ad hoc care providers and Medicare," and he says "this is going to be something that is done to patients, not WITH them."

After reading 102 pages of the new regulations which cover 472 pages, Dr. Goldsmith said: "I have this huge headache. I'm going to get up at 5:30 tomorrow morning, drink three cups of coffee and see how much father I make it before I get another headache."

Goldsmith doesn't see that much difference between Accountable Care Organizations and Managed Care plans run by Health Maintenance Organizations in the 1980's, which were

a flop because they were a "value system" which made doctors make choice to compromise care.

Some members of the American Medical Association are also skeptical of ACOs. Dr. Jeremy Lazarus, speaker of the AMA's House of Delegates, told American Medical News ACOs will only work is doctors want to participate. "For this to happen," he said, "significant barriers must be addressed, including the large capital requirements to fund an ACO and to make required changes to an individual physician's practice."

Michael Cannon, director of health policy studies at the libertarian CATO Institute was more blunt. He said he gives the concept of ACOs "zero percent" chance of making significant savings and he doubts doctors will want to join because they "will get paid less."

So the verdict is out. But it doesn't take rocket science to understand the U.S. must do something about the amount of money it's spending on everyone's health care. Experts on both sides of this ACO argument agree on that -- so starting soon the Accountable Care Organization will get its day in court.