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Topic
Accountable Care Organization

Comment
Elliott Fisher, the demoted Dartmouth professor, coined the phrase “accountable care organization” even when it had no definition; he sold the amorphous concept to the Obama administration as a way to control costs in an unrestrained private insurance model; Congress embedded the idea into the Affordable Care Act and made hundreds of millions of dollars available for start-ups; Vermont legislators, without understanding what the new entities would actually do, put ACOs into statute.

Here we are almost a decade later, untold millions spent on data collection, regulators, consultants, and an orgy of unnecessary administration, and this is what Elliott Fisher, in a gross understatement, now says: “…we must admit that their [ACOs’] overall impact has been less than what we hoped for.” He goes on to state what has been obvious forever: “Our current system can be seen as a balloon push on one part and the expansion simply continues somewhere else.” (Both quotes from Medical Xpress, August 5, 2020.)

The truth is that ACOs are managed care in disguise, the same managed care that was discredited in the 1990s, but now the management is not done by insurance companies but by new, hidden administrative entities. As we learned then, managed care can only save money by way of the three D’s: denying care, delaying care, and discouraging care—three things that are at odds with most quality measures—and by paying doctors less. The three D’s are accomplished by capitation, case rates, pay-for-performance, bundling, and so forth, all of which, with ACOs, is done behind an enormous smokescreen of complexity and obfuscation.

Although managed care failed in the 1990s, nevertheless Vermont’s section 1115 waiver, the “global commitment to health” in 2005 converted Vermont Medicaid to a “managed care entity” and thus laid the basis for paying providers for other than fee-for-service. Vermont’s stated goals for the waiver are: (1) to increase access, (2) to improve access to primary care, (3) to improve health care for people with chronic disease, (4) to contain costs, and (5) to provide choice in long-term services and support, including expanding home care alternatives.

How well have these goals been met? The state’s annual reports to CMS on the 1115 waiver reveal that primary care visits among all members went precipitously down between 2008 and 2016, while total expenditures per capita went up faster than inflation. Median travel time to access pediatric care went up. These numbers appear to indicate that managed care has neither increased access to primary care nor contained costs.

Addressing the opiod crisis is identified as a key aspect of the 1115 waiver, but recently Northwestern Medical Center shut down its substance use disorder treatment center, citing the unaffordable cost of ACO dues. Another treatment facility recently shut down in Brattleboro. We’ve also learned that the economic effects of the pandemic have doubled Vermont’s number of uninsured, while the number of underinsured also grows. All this points to a failure of the state’s payment reform efforts, in part

implemented by OneCare.

Purely in the realm of cost containment, if the state wants to do something other than push the balloon in one spot, then it should change the all payer initiative from an ACO model to a rate-setting model in which all payers reimburse at the exact same percent of Medicare rate. This has been successfully accomplished with hospitals in the state of Maryland, and is far simpler in design than funneling payer revenue through an ACO that uses a complicated rubric to establish how much each provider should be paid.

On the issue of access, it is now evident that the ACO has accomplished nothing. The uninsured are not "attributed lives" and therefore do not get the supposed benefits of care coordination. Medicare/Medicaid dual eligible people are excluded. Neonatal care is excluded. Meanwhile the underinsured avoid necessary care for fear of cost. People stay in jobs they dislike or in unhappy marriages just to maintain employer sponsored coverage. And the tragic personal bankruptcies for medical debt continue. There is no equity or justice in our health care system.

We have wasted a decade in our fixation on fee-for-service as the bogeyman, oblivious to the fact that the following countries reimburse primarily by fee-for-service yet cover everyone and have per capita costs half as high (or less) as ours: Canada, Germany, Japan, South Korea, Taiwan, Belgium, Switzerland. Any payment mechanism, with the possible exception of salaries, is subject to perverse incentives, but to focus only on payment methods while ignoring the problem of access and equity is to miss the fundamental point of health care reform.

The Green Mountain Care Board is bound by statute to administer the all payer model and to regulate the ACO. But the Board is also given a statutory role in evaluating the impact of state programs on access and in making policy recommendations to the legislature to increase access in accordance with the principles of Green Mountain Care. The annual review of OneCare's budget is therefore an opportunity for a reality check: We are in the middle of a public health emergency. For the public good and in keeping with the values of a humane society, everyone should have access to health care. To this end, the ACO is superfluous, if not downright wasteful and counteractive.

The Green Mountain Care Board should begin now to chart a new course for health care reform that ends the erroneous emphasis on payment methods and concentrates instead on expanding health care access to every Vermonter.