Why accountable care organizations are like vegan barbecue

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Jeff Goldsmith

Accountable care organizations are one of the key elements of the federal health reform law popularly known as ObamaCare, but many physicians and health policy experts think ACOs are a disaster waiting to happen.

Count Jeff Goldsmith, PhD, among them.

Goldsmith is president of Health Futures, a Virginia-based consulting and advisory firm he founded. An author, public speaker and former national advisor to Ernst & Young, Goldsmith wrote a recently issued white paper from The Physicians Foundation that lays out a "blueprint" for resdesigning the U.S. health system.

In the Q&A below, Goldsmith talks about why it'll take more than just higher compensation to relieve the primary care shortage, what needs to happen for direct primary care to take off and why ACOs are "like vegan barbecue."

Q: Most physicians we talk to seem very skeptical of accountable care organizations. Looking into the future, do you see the ACO model succeeding in lowering costs and improving quality of care?

A: Physicians are right to be skeptical. ACOs aren't about reducing costs, but moderating the rate of increase. And doing it without anyone sacrificing anything. And ignoring the fact that we're massively overpaying for many services. The vast majority of ACOs are one-tailed - managed care without the risk, which is like vegan barbecue. It's the risk that forces us to make choices. The main problem *isn't* the rate of increase in costs, but that healthcare has become absurdly expensive. And because the ACO has become dominated by the most expensive care providers, hospitals, it's unlikely to achieve significant cost reductions. The only way to reduce costs is to reward physicians *and* patients for making high-value choices. ACOs are a fundamentally paternalistic model that marginalizes both of the key actors in medicine.

Q: Do you believe that the small independent primary care practice will soon be a thing of the past? Why or why not?

A: There's sort of a Darwinian issue here. Can the 1950s-style small primary care-based office practice survive? Probably not. It's a cliché to say that primary care needs to be reinvented. There is definitely a scale issue: Primary care practices either need to get bigger, or to connect virtually in independent physician association models to work with payers. They are probably not sustainable otherwise. But when the rest of the world is 24/7 connected, it begs some questions about leveraging asynchronous communications with patients and real-time connectivity to the payment system. Not every patient wants or needs a "medical home." So we need diverse primary care

models that map more closely to what specific subgroups of patients need. Physicians need to choose the models that work for them *and* their patients.

Q: You say that the primary care shortage is a real thing and it could bring about a "train wreck" for U.S. healthcare. Do you see any way of alleviating the primary care shortage that does not involve higher compensation for primary care physicians (PCPs)?

A: Higher compensation for PCPs is a necessary but not sufficient condition of alleviating the impending shortage. We also need new products and new relationships that are worth the additional money. The Brits more than doubled PCP compensation and that's what we're going to have to do. But there are a lot of ways to do it. We (patients and payers, including Medicare) need to begin paying (monthly) for PCP relationships, not as a shadow system that retains all the chickensh*t, check-the-box fee-for-service documentation burden, but as a substitute. We need to free up about a day a week of clinician time by simplifying how we pay for care, so that per-hour clinician comp rises, but also we also get longer and deeper visits when they are needed.

Brits doubled PCP compensation,

US halved specialist compensation

Q: If health costs must decrease and we're saying primary care physicians should make more money, then the only logical conclusion I can see is that specialists' salaries have to take a nosedive. What do you think about that?

A: That is the "crabs in a barrel" fiscal logic of Part B budget rules at work, where the only way to free up resources is to ignite a civil war in medicine. It's a flawed and destructive premise. Our payment system is fundamentally out-of-balance right now. The return on capital (e.g. fancy technology) and institutional support (e.g. hospital overhead) is way too high in ambulatory medicine, and the return on human judgment is way too low. I think many specialists (radiologists, cardiologists, etc) are presently being overcompensated for the technical component of their work and undercompensated for what we need from them the most: sound diagnostic decision making. We need to fund increased evaluation and management and diagnostic activity by physicians by reducing hospital outpatient payments and technical fees or, better, by reducing unnecessary hospitalizations and testing in the first place.

Q:What do you think of the direct primary care model? Could it gain any widespread traction?

A: I'm a big fan of the direct primary care model, but until insurers open up a little, it isn't going to grow fast enough to accommodate all the physicians that want to adopt it. There an "off-the-grid" mindset among the direct pay adopters, and sadly, there isn't a lot of cash off the grid. That's why we had a recession in the first place: People ran out of cash. This anemic "recovery" has not put a lot of fresh cash flow into household budgets. That's why insurers need to enable "relationship-based" payment models that actually put some of the benefit into cash equivalents - like health savings accounts (HSA), which patients can direct to practitioners, or that enable patients to designate a monthly subscription payment to the direct care provider of their choice. Like I said earlier, it needs to *replace*, not overlay, fee-for-service, or it defeats the purpose. If we ask the direct care provider to become "core measures" clerks as well, we're not going to get where we need to go. We also need urgently to clarify the tax issues related to using Health Reimbursement Arrangements or HSA funds for relationship-based payment.

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