

Healthcare Reform 3.0

Hey, I'm sure you've heard—the Massachusetts Legislature is considering “new and improved” healthcare reform legislation submitted by Governor Patrick that purports to revolutionize the way providers are paid for the delivery of healthcare services. It pledges to save money and improve healthcare. This change calls for the development of Accountable Care Organizations (ACO) essentially to replace the current fee-for-service model that has been around since the first hominid dropped a rock on his toe and had to be taken to the local shaman.

This traditional payment arrangement will be replaced by Global Payments, known in a previous incarnation as Capitation . The condensed description of this arrangement is that an ACO will be given a lump sum of money, which it must use to serve all of the health needs of a specified population. If the ACO manages to serve its mission for less money than it is allotted it will be allowed to share in the leftover “profit”, and if it costs more than what it had been allotted it will have to absorb the loss up to the certain point when a catastrophic stop-loss insurance provision would prevent the ACO from “bankruptcy”.

So why is this change in payment model a good idea? Well the truth is that it is the proverbial case of “only time will tell.” However, there is some reasoning behind this proposal:

- The management of the money will be in the hands of provider organizations such as hospitals and large clinics. These organizations are presumed to be able to understand the healthcare needs of their patient constituencies better than the Managed Care Organizations (MCOs) that are owned by insurance companies, and in a better position to decide what is wasteful and what is cost-effective in patient care. They are also in a better position to experiment with service innovations, and will be highly incented to do so because of the “profit” potential. This model should also cut down on the paperwork and preauthorization burdens for provider organizations and give them some freedom to innovate.
- The previous incarnation of this model (known as Capitation) failed and took some provider organizations down for the count. We have supposedly learned from that experience and the current proposal has some features that are intended to protect ACOs from financial disaster and to be sure that patients are not denied the care they need:
 1. Only very large organizations will be eligible to become ACOs and they will have to meet requirements including asset size and protection, stop-loss insurance, perhaps bonding, and fully integrated electronic patient records, to name a few of the requirements. A minimum size will be in the range of 5000 active patients.

2. There will need to be mandated coverage for all patients so that cherry-picking by ACOs or self-selecting out of coverage by younger, healthier patients will not be permitted.
3. There will need to be some reduction in the breadth of patient choice of healthcare providers.
4. There will need to be explicit metrics developed to measure process and outcomes to be sure that patients are not denied care or the level of care needed to serve them well.
5. Provider networks will now be developed and managed by the ACOs, and the performance of these providers will need to be monitored to insure adherence to the ACOs standards of care, costs of care and expected outcomes.
6. There may be a growing use of paraprofessionals to deliver care when this will not compromise patient safety or outcomes.
7. The reform will probably be introduced first with demonstration projects intended to examine the efficacy of this model in real life application (though there are already more than 10 States that have started this “experiment” in healthcare payment reform, and even some small experiments underway in Massachusetts in partnership with Blue Cross/Blue Shield). This in an effort to uncover issues before the entire reform package is operationalized.

So what could possibly go wrong? Unfortunately, the list is probably unimaginably long. Consider what has happened historically in any endeavor, not just in healthcare, when the following ingredients populate the stew: (1) money and the potential for profit, (2) politics and the many motives that will influence what the final legislation and regulations look like, (3) trying to get the various stakeholders to endorse and support the changes rather than undermine them for their own interests, (4) the vagaries of the ever-changing landscapes of economics, politics and regulatory agencies, (5) the shortcomings of managing a new, large and complex venture when you have no experience with it, (6) unmanaged and/or loosely regulated systems that influence the reform, in this case such systems as the pharmaceutical industry and its pricing structure, or the cost of newly developed medical diagnostic and treatment technologies and devices, (7) population growth and distribution, and (8) environmental-social-political conditions that influence wellness, morbidity and life-span in the general population.

So what’s the bottom line? Is this a good idea or not? I have a third option in this multiple choice, i.e., it is better than doing nothing if it is not diluted by politics, distorted by greed, or undermined by the internecine battles among stakeholders. However, it is a detour from the objective that I feel we must reach in order to have a credible and effective healthcare system, and that is universal coverage with a single-payer system.

If you are 55 years old or younger, you will probably live to see the scrambling, hand wringing and posturing for Healthcare Reform 4.0. Stay tuned. In the meantime do the best you can to support the present effort because it’s the best we’ve got, and the current model is completely unsustainable!