Affordable Care Act's Trying to Save U.S. Health Care Before Baby Boomers Break Us


By Chris Parker | TUESDAY, MAY 3, 2016 AT 5 A.M.

Illustration by: Robert Zammarchi

Our health is our most precious resource, yet our health-care system’s more adept at mining wallets than making us healthy. We pay one-and-a-half to two times what other countries pay for health care without appreciably better outcomes.

America spends more than $9,500 per person annually, more than one-sixth of our gross national product (17.5 percent), or more than $3 trillion on health care. The government alone spends $4,197 per person, more than many countries with universal health care. The United Kingdom, by comparison, spends the equivalent of $2,800 per citizen and covers everyone.

All this spending hasn’t made us healthier.

U.S. life expectancy (78.8 years) trails all our peers, from the U.K. (81.1) and Canada (81.5) to Australia (82.2) and Japan (83.4).

In fact, we aren’t even getting what we paid for. Studies suggest that more than 30 percent of all medical procedures and services are unnecessary, and as much as half the $361 billion spent annually on administrative costs are wasteful.

We don’t have a “health” system. “We have this top-notch disease-oriented system,” says Robert Wergin, American Academy of Family Physicians president. “We spend about 4 percent on preventive health, and our total primary-care spend is about 4-5 percent. Countries that spend more for primary care on the front end spend less on the back end. It’s easier to prevent renal failure than to do dialysis — certainly less expensive.”

But selling bottles of prevention just isn’t as profitable as pallets of cure.

In the end, a patient’s health is almost incidental to the system at large. The more tests, procedures, and visits, the more money the provider makes. And unlike the Best Buy salesman, it’s a lot harder to say no when a physician tells you what you need.

It’s not even really the doctors’ fault.

The system is built to be out of sight, out of mind. Medical professionals are only paid to care for the duration of your visit. It’s so ingrained in the way we receive care that many of us may not even find it strange that there are no inducements for physicians to keep us healthy.

Whether it’s drugs or doctor visits, there’s actually a perverse incentive to make you a regular customer.
Most people are aware of rising drug prices — now double that of America’s peers — but drugs account for less than one-sixth of all health-care spending (hospital care leads with nearly a third). It’s because our system is more focused on costly interventions than preventive medicine, going from crisis to crisis, rather than trying to sustain good health — essentially calling the cops rather than locking the doors.

As if this creeping dysfunction weren’t worrisome enough, we have a burgeoning problem on the horizon: aging Baby Boomers straining the Medicare system past its breaking point.

To help address runaway costs and misaligned incentives, the Affordable Care Act, also known as Obamacare, inaugurated a series of programs focused on pushing aside the current volume-driven fee-for-service (FFS) system in favor of value- and quality-driven alternative-payment approaches, chief among them the Accountable Care Organization (ACO).

The idea behind an ACO is rather than bill the insurer for every procedure, lab test, and office visit, an ACO receives a lump sum (also known as capitation) to coordinate each member’s care and meet certain quality metrics. (Requiring providers to meet benchmarks ensures providers don’t ration their way to profitability.)

It’s the difference between a la carte and buffet. Savings are realized not only by cutting unnecessary procedures, but also by generally monitoring the patient population proactively to keep them healthy enough to avoid expensive and/or lengthy hospital visits or re-admissions.

*Dr. Shaun Anand, Banner Health System’s chief medical officer.*

One of the leaders in utilizing and honing the ACO model has been the local Banner Health System. Banner’s chief medical officer, Dr. Shaun Anande, loves the ACO’s promise of more closely integrated care.

“Historically, there’s been a lot of fragmentation in the delivery system,” Anand says. “One of the key opportunities with the ACO model is to be able to coordinate care and to assure that patients and members and their concerns are taken care of holistically and not just that one time. That’s a paradigm shift, and a great opportunity to revolutionize how we deliver health care.”

**Acknowledging the problem** is not the same as fixing it. Wholesale changes to the way people receive health care are not only potentially disruptive for consumers, but also nearly impossible in the current political climate.

Yet the status quo is untenable as well. Ever-rising health-care costs have squeezed raises for many employees. Meanwhile, the high cost of employer-provided health care puts American companies at a disadvantage globally when competing against companies mostly from countries with government single-payer health-care systems.

Recognizing the forthcoming collision of demographics and rising costs, the Centers for Medicare & Medicaid Services (CMS) has moved toward what are known as value-based contracts. There are a variety of related programs, but the most important are ACOs and bundled payments, which offer hospitals a flat fee for all the care associated with (for example) a knee or hip replacement, from the day of the procedure until 90 days out.

Last January, CMS set an aggressive goal of making 30 percent of Medicare’s payments through these value-based alternative-payment models by the end of this year and 50 percent by 2018. (At the time, one-fifth of the payments were made through alternative models.) The hope is to
reach 75 percent by 2020. In March, CMS announced it already had hit that 30 percent benchmark — nine months early.

Meanwhile, it's limiting FFS providers to 0.5 percent yearly cost increases through 2019 while promising alternative payment models will enjoy 5 percent bumps for at least the next two years. Similarly, beginning this year, many urban hospitals will have to accept bundled payments for lower-extremity surgeries, and soon FFS providers will need to meet performance benchmarks just like ACOs.

“Helping people transition toward a payment model that’s responsible for the total cost of care, contingent on improving quality, looks like a really good direction to go, and there’s a strong bipartisan consensus for that,” says Dr. Elliott Fisher, director at Dartmouth Institute for Health Policy & Clinical Practice.

Fisher has been the principal investigator for Dartmouth Atlas of Health Care, which has been tracking medical spending for decades, with access to CMS data. The insights gleaned from the data form the basis for the creation of Accountable Care Organizations, a term he coined in 2006.

Fisher discovered large regional disparities in cost that bore no relation to outcomes — indeed, often just the opposite: Patients in higher-spending communities were more likely to see more doctors, undergo more procedures, and suffer more complications.

It’s a case of less is more.

Jim Hinton, president and CEO of Presbyterian Healthcare Services.

Few understand this better than Jim Hinton, president and CEO of Presbyterian Healthcare Services, a private, not-for-profit health-care system in New Mexico, the state with the lowest health-insurance premiums in the country. (Arizona is 13th.)

“Your health-care costs are determined by where you live more than anything else, and if you peel that onion back, it tends to be the supply of physicians and hospitals that drive that demand,” says Hinton, who got his master’s degree in health-care administration from Arizona State University.

“In most businesses, demand drives supply. When there is demand for lots of cheeseburgers, there are a lot of places that sell cheeseburgers, but in health care, it’s actually the supply of physicians and hospitals that drives demand because physicians and hospitals suggest what you should have done,” Hinton explains. “They’re not bad people or strictly trying to optimize their own personal gain, but there have been very few constraints on what physicians and hospitals do.”

Fisher’s work also uncovered the value of coordinated care in avoiding unnecessary procedures and keeping a better handle on patients’ health. The fewer different doctors patients saw, the better their outcomes. The less cooks in the kitchen, the better the chance for consistent quality. That philosophy is at the core of ACOs.

Like any other health network, they feature a collection of physicians, health centers, and hospitals that have contracted to work together. Like an HMO, the primary-care physician is expected to guide care, though in this case, more as a liaison than gatekeeper.
Some ACOs are led by hospitals, but most are physician-led, achieving much of their savings by avoiding hospital stays and specialists, and limiting unnecessary lab tests and medical imaging (MRI, CT scans) — all typical hospital cash cows.

Data collection is crucial both for monitoring the health of the entire plan’s population and for mining it for cost-saving correlations. It’s hoped that leveraging payment and claims data will decrease utilization without necessarily reducing access.

ACOs also use the data and current medical knowledge to establish evidence-based best practices for physicians, particularly for diseases capable of producing serious downstream complications, such as diabetes. It’s a different orientation from patients essentially having an open bar tab.

“Just like utility companies can’t just keep cranking out watts and volts, [healthcare providers] have to start thinking about managing demand,” says Dr. David Introcaso, former vice president of policy and operations for the National Association of Accountable Care Organizations. “Save more in costs than the decline in demand, and you’re going to make a profit. It’s the same in health care.”

Introcaso, a former acute-care physician and ASU undergrad, finds hope in the different attitude and slowing health-care cost growth over the past five years. “We’ve managed cost growth better than we did before, which was basically not at all.”

According to David Sayen, Medicare administrator for Region IX, the key has been advances in technology, such as electronic medical records and the smartphone, which allow for great coordination of care, easier communication with the patient, and better tracking of trends and outcomes. “There’s a disruptive innovation going on here because of the availability of digital technology that didn’t exist when I started working here 34 years ago,” says Sayen, whose jurisdiction includes Arizona, California, and Nevada. “You couldn’t have done this before. The question is, can we make it work and how far can you go with it?”

**Medicare accounts for one in five** health-care dollars, giving it significant market influence. The money’s a big inducement for more organizations to go the ACO route, or to expand their ACO into the private or public market, as circumstances dictate.

Three years after establishing a national trade group, there are more than 750 ACOs, including more than 100 in California alone. There are 13 ACOs headquartered in Arizona, according to Leavitt Partners, and eight participate in Medicare. Overall, ACOs care for 26 million beneficiaries, roughly 10 percent of the insured population, and more than half through private insurers.

Some ACOs deal directly with employers, signing contracts featuring quality-care benchmarks. Others feature partnerships between physicians and insurance groups. In some cases, hospital- and physician-led health groups have chosen to self-insure.

“ACOs like North Shore-LIJ Health System [now rebranded NorthWell Health, the 14th-largest health system in the country based in Great Neck, New York] came out with a plan — so they’re a hospital that’s become an insurance company,” Introcaso says. “It’s so dynamic that delineation of roles is decreasing. There are more hybrid organizations blurring the lines. Payers are becoming providers and vice versa, and that’s probably not a bad thing.”
Once you’re managing risk, whether it’s from the delivery or payment side, there’s not a whole lot of difference, just a separate batch of actuarial numbers. This is where a hospital-led group has a big advantage over a physician-led one; they have more experience managing risk and greater access to capital.

Commercial ACOs have more flexibility in the design and execution of their health plans than those contracting with Medicare. Indeed, current Medicare ACOs aren’t like most of their private brethren in that payment is not based on capitation but still operates on the fee-for-service chassis.

CMS’ idea was to ease the transition by reimbursing ACOs based on their ability to save money over what the government would’ve paid in an FFS arrangement. When launched in 2011, there were two tracks. One shared in upside but not risk; it’s known as the Shared Savings program, with more than 300 ACOs participating last year.

The Pioneer ACO program shared in both savings and losses. Of the original 32 Pioneer ACOs when the program began three years ago, only nine remain, chased away by the challenges and increasing difficulty realizing savings.

Hinton’s Presbyterian Health System was in the Pioneer program but dropped out while Banner Health is one of the last standing and has generated more annual savings than any of the remaining Pioneer ACOs.

The problem is that it’s hard to live in both worlds. Coordinating care requires robust investments in technology and time. It also requires an entirely new mindset from physicians. They’ve gone from medical “tellers” to sheepherders, forced to think of their flock not just the customer before them.

Dr. Daniel Derksen, director of the University of Arizona Center for Rural Health.

“Those that dropped out of the Pioneer ACO realized this is only a portion of our clinical enterprise, and we can’t control enough of the variables to mitigate our fiscal risk,” says Dr. Daniel Derksen, director of the University of Arizona Center for Rural Health. “You can’t move the needle if it’s a very small part of your business.”

This is one of the driving reasons why Presbyterian Health dropped out. The already low cost of care in New Mexico also made it exceptionally difficult for it to create the level of “savings” to make the effort worthwhile.

“I’m not really going to change the way I manage patients based on 20 percent of my practice,” says Hinton, whose system may have had trouble creating savings in an already low-cost state. “But if 80 percent of your practice is value-based, it certainly changes behavior.”

That’s the direction health care is going; it’s only a matter of when.

This year, CMS will launch a new next-generation ACO program that allows for even greater flexibility in care, delivery, and payment, while taking most of the savings and risk. Starting next year, those 21 next-gen ACOs will even be able to choose capitation (lump per-capita payment) as an option. (Optum Healthcare is the sole NextGen ACO in the Phoenix area.)

“We are definitely headed toward some form of capitation. It’s inevitable, and pretty much everyone is on board,” Introcaso says. “The question is, is it five minutes to midnight for me, or
is it still twilight? When do I have to jump? And that's very dependent on each system’s particular circumstance.”

**There’s no real magic behind how** an ACO saves money. Healthcare spending typically follows the 80/20 rule, where 80 percent of the money is spent by 20 percent of the population. (Retailers have a similar rule.)

But it’s even simpler than that. Just 5 percent of the population receives nearly half (49 percent) of the care. This makes it really easy to find a cost center.

The suggestion that you go out much like you come into this world is borne out by hospitals costs; the biggest-ticket items are at the beginning and end of life. This naturally segues into the kinds of issues that produce plenty of political smoke that’s often more hot air than fire.

“I’m happy to have a logical conversation, but the political side will push it into death panels pretty quickly,” says Dr. Daniel McCabe, CEO of Arizona Connected Care. “Then we lose the ability to talk rationally.”

The typically limited role of preventive medicine and monitoring heretofore hasn’t served our elderly population well. Fee-for-service pads pockets without addressing incipient issues and downstream cost. Eighty-seven percent of U.S. adults age 65 and older have at least one chronic illness, and 68 percent have two or more, the highest rate in the annual 13-nation Commonwealth Fund report.

Changing this requires greater outreach and a more proactive system, which FFS doesn’t account for because nobody gives it money for keeping you healthy.

ACOs just scratch the surface of this, though their technological timing is right. A recent study in Australia found that patients with chronic conditions were twice as likely to take their meds if prompted by a text message — patients said they found the messages made them feel like they were supported.

Banner Health is exploring similar initiatives to engage patients in the process, particularly those who may be homebound or have difficulty getting to a doctor’s office.

““We wanted to focus on the most vulnerable population, the [people who] have a lot of chronic conditions and who have historically been part of a fragmented health-care-delivery system,” Anand says. “We’ve supported them with a great tele-health program called I-Care. Imagine being given a Phillips tablet [where] at the push of a button, you can have an entire health team available for you.”

The other key to the ACO model is empowering the general practitioner. He or she is the shepherd of population health, and the vessel through which change is wrought. It’s incumbent on the system to keep these physicians informed and in the loop.

“We have packs of books and journal articles and teams focused on what’s the best evidence and getting the information out to the providers so they can apply that,” Anand says. “We’ve brought in the claims and electronic medical-records data to give providers useful [information] that they can act on. We have a data scorecard for them so they can track their progress.”

In the past, there wasn’t any real reason for doctors to know the costs of the procedures and pills they prescribed, and this lack of transparency contributed to a price spiral. But it’s not just the
cost that hurts but the frequency of interventions. GP referrals have a chance to tame that if properly educated to the price and value of various specialists.

By combing through claims data, systems are able to locate these inefficiencies. Arizona ConnectedCare uses Practice Enhancement Teams to influence primary-care physicians on qualitative care in their areas. McCabe cites the example of spinal surgery, where orthopedists cost one-and-a-half times what neurosurgeons charge.

“The orthopods like to put in lot of hardware, and the neurosurgeons tend to be more conservative,” says McCabe. “I put it that one guy is a volume-based surgeon and the other is a value-based surgeon. There’s some sub-specialties where the cost of surgery or the rate of procedures can be 30 percent different, but the outcomes are the same.”

One of the big challenges is that ACOs have higher front-end costs than their FFS counterparts, which further benefit on the back end from indifferent preventive care. Start-up costs are estimated to exceed $1 million.

These needs include installing data collection, and processing and sharing technology across the system, incorporating management tools, as well as identifying nascent medical issues in the population and proactively addressing them. Those efficiencies pay off down the road in better care and healthier patients, but it takes time to realize the benefits.

It’s something that goes beyond spreadsheets; it requires a different mentality, particularly from caregivers who now must monitor and meet new and evolving quality benchmarks.

Todd Ricotta, executive director of the Arizona Care Network.

“We’re in our third year of the Medicare Shared Savings program and have made a whole host of changes over the course of the last couple years,” says Todd Ricotta, executive director of the Arizona Care Network. “There’s a learning process that organizations go though, and in addition to working with Medicare, we’ve grown the network to include pediatric and adult services, as well as entering into similar relationships with other commercial payers in the market.”

The hope is that quality care is something that will scale nicely, once the infrastructure is in place and the population’s medical issues are managed more proactively. However, three years in, returns aren’t the coup everyone hoped for.

Medicare savings in the first three years were about $1.5 billion, or about 0.5 percent of health-care spending, an exceptionally modest amount. While most systems saved money, a good proportion wound up costing more than the FFS baseline. If this was supposed to tame the cost tiger, they need to bring back Siegfried and Roy.

“It’s definitely improving quality, and it’s improving cost; it’s just not doing as much as we’d like,” Fisher says. “The challenge is with benchmarking the financial models. Only about half the systems are achieving any savings against the benchmarking that we used. And only about a quarter of them are getting serious savings, which has everybody kind of discouraged, especially if you’re in the three quarters that didn’t get a bonus.”

It’s hard not to appreciate the desire to align the financial incentives toward health instead of sickness, as ACOs do. It’s a solid concept, and it seems like something that would ultimately save money and provide better care. But there’s a vast gulf between theory and practice.
Dr. Robert Berenson understands this as a former executive in charge of payment and contracting with CMS and onetime vice chair of the Medicare Payment Advisory Commission. He’s also studied and written about health-care pricing for the Brookings and Urban institutes. He’s sympathetic to ACOs but questions the mad rush into alternative payments.

“Billions of dollars have gone out the door to test a theory model while we wait to get results,” Berenson says. “You would think that the last six years didn’t exist; the rhetoric still is ‘spending is out of control, the incentives are all screwed up.’ Well, five years in a row spending has not been out of control per capita. The problem with Medicare is that the number of capitas is doubling.”

It’s unclear what has caused the slower growth in health-care costs over the last half decade, but it’s certainly been dramatic. Health-care costs haven’t grown this slowly in 50 years. There’s been plenty of debate why, with the recession, Obamacare, and even Medicare’s alternative-payment models cited as contributors.

As noted earlier, Medicare has frozen the growth of procedure costs at a half-percent annually. Because reimbursement rates for many insurers are informed by Medicare’s rates, this cost freeze has rippled through the commercial market. Others suggest Medicare’s move to alternative-payment models has catalyzed the private sector to change and experiment with its approach to help rein in cost growth.

“Yes, the growth in health-care costs have slowed since the financial collapse, and we don’t know why that is,” Fisher says. “We don’t know if the ACO thingamajig is contributing to the overall slowing of health-care costs. We do know that every one of the large studies that’s been done show real savings compared to what was going on in the rest of the market.”

Fisher feels that, because of spillover effects, ACO contributions often are under-counted. Certainly the lack of gatekeepers limits how much savings any Medicare ACO is able to achieve, which Derksen cites.

“It’s very hard for us to control quality and fiscal outcomes if we can’t in any way influence where people go for their care. It’s one of the major weaknesses,” Derksen says. “When people can say, ‘It’s two days before I can get in to see my primary-care doctor so I’m just going to show up in the emergency room,’ it’s really hard to control costs.”

CMS has taken this particular criticism to heart and will allow next-gen ACO operators to offer financial inducements to their beneficiaries to shape their behavior. They’re also looking to change the payment rates and benchmarks to reflect regional cost differences to better reward savings.

“The relatively efficient guys have a much harder task to get savings. A lot of the savings occurred in the areas where they have higher per-capita spending,” Berenson says. “People who are at the low end of spending should have some reason to stay with it. They should get rewards for efficiency that they’ve been giving back to the government for free.”

Berenson argues that Medicare’s ACO programs should’ve started smaller, with seasoned organizations like Kaiser and Mayo, which already have a firm handle on quality care. This would’ve allowed them to hone quality benchmarks and care protocols to create a more turnkey template once the time came for wide implementation.

Berenson also feels any program without downside risk isn’t much of a program.
“Hospitals may develop a congestive-heart-failure [system] to prevent what are not money-generating patients ... from going back into the hospital,” he says. “But they are not calling in the orthopedics and telling them they’re doing too many joint replacements. They’re not bringing in the cardiologist and telling them to stop doing unnecessary stent surgeries.

“They’re doing easy stuff at the margins, but they aren’t changing their business model. I don’t think there is a lot of commitment, especially with an upside of only a shared-savings model. You’re not going to get a culture change. You’re not going to get a change in the business model,” he says. “So I don’t know what it is that we’re accomplishing.”

All change is incremental; it’s all in how you size your expectations. Introcaso doesn’t believe health providers get enough credit for the difficulty in adding risk management to their responsibilities. Nor does he believe it necessarily solves some of the systemic issues.

“I certainly appreciate the logic that you’re more focused if there is more risk. I will say providers don’t take an actuary class in medical school, they just don’t have that expertise,” he says. “When you talk about aligning payments … the question becomes whether primary-care physicians, who don’t go into medicine to make a lot of money to begin with, are intrinsically or extrinsically motivated.

“To say that financial incentives are the be-all and end-all to get Medicare on a stable path — I think that’s asking too much,” he concludes.

Health care is complex, with a variety of different industries carving out an advantage against a backdrop of politicians trying to score points. Change in some circumstances is tough, and to some extent, there should be excitement that we’ve gotten this far.

“It’s come down to the health plan getting ready to start reimbursing providers for the activities that will keep a population healthy, as opposed to only paying for the patients who come into the office and are sick,” Ricotta says. “That’s a really big deal.”

So if it hasn’t had the effect on prices yet that everyone’s hoping, there’s still reason to believe our country is moving in the right direction.

“Nobody in the world does it quite this way, but nobody does a lot of things the way we do. We have the opportunity to set the bar higher,” Sayen says. “Interestingly, in a country where everyone criticizes the government, wanting to be in fee-for-service Medicare amounts to trusting the government more than you trust the health plan.”

There’s another question further down the road: How sustainable are these efficiency savings in health care?

Many believe that once ACO-style “best practices” take hold and health systems peel back inefficiencies, it will become harder and harder to produce savings while hitting Medicare’s benchmarks. Even Fisher acknowledges this, though he doesn’t feel that cost and value curves are close enough to converging for anyone to worry yet.

Nonetheless, moving from volume- to quality-based care really only is a first step.

“It’s a model that contains the seeds of its own destruction, because there is only so much you can save,” Sayen says. “That’s why I think of it as being kind of evolutionary, in that maybe, it’s a stage we go through, and then something else happens after that.”
CMS already has begun adapting its lessons from the qualitative care paradigm, inaugurating a program, Comprehensive Primary Care Plus, that reduces Medicare red tape, pays an additional stipend, and offers shared savings reimbursements to primary-care physicians in exchange for meeting new metrics and offering 24-hour access to care and information.

Whatever comes next, it won’t be one size fits all. Our health-care market is unique, and the solutions it requires will differ from what works for Target or Walmart. CMS thinks, quite simply, that good health is the killer app.

“The instinct is to get the best-possible result because of the fundamental belief that the road to efficiency goes through quality,” Sayen says. “If you’re better, you’re going to be cheaper. It’s not like the Tesla Model X or a Mercedes [where bells and whistles cost more]. Health care doesn’t work like that.”

Hinton agrees that the first step is simply facing in the right direction and creating the impetus to move, a feat in itself.

“The stumbling block is that we’re dealing with human beings who are slow to change, regardless of their position,” he says. “The good news is that the models are out there and have been proven now to work. So we just need to continue to keep our eye on the prize and see what we can do to ply them more consistently.

“The future is here — it’s just not evenly distributed.”