



Bending the Health Care Cost Curve

By Timothy C. Gutwald

INCENTIVIZING QUALITY AND EFFICIENCY

FAST FACTS:

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In the debate surrounding passage of the Patient Protection and Affordable Care Act¹ (PPACA), there was much disagreement over the individual mandate, “death panels,” and the number of uninsured. Despite these disagreements, there was near-universal agreement on the need for reform to slow the growing cost of health care.² If health care spending trends continued, the Congressional Budget Office estimated that by 2025, one quarter of our gross domestic product would be devoted to health care.³ Armed with this data, politicians and policymakers began to talk about “bending the cost curve.”⁴

Suggestions for lowering costs were varied and numerous, ranging from proposals for national tort reform to a public option to Medicare for all and everything in between. While many in the legal community are familiar with some aspects of the

PPACA—such as the individual mandate and restrictions on exclusion for pre-existing conditions—several portions of the bill have received little publicity.⁵ These lesser-known reforms are getting the most attention within the health care community, and many feel that they hold the greatest promise for bending the health care cost curve.

Current Fee-for-Service System

To fully appreciate the various reform efforts, it is important to understand how the system has worked. Historically, physicians and hospitals were paid under a fee-for-service system. The system is pretty self-explanatory; if a patient undergoes a CAT scan, the hospital or physician is paid a certain fee for performing the

scan and a fee for interpreting the scan.⁶ It is a simple, straightforward concept with which most people, particularly lawyers, are familiar. Over the last few decades, there has been a steady movement away from this system through the incorporation of diagnosis-related groups, bundled payments, and per diem fees for hospitals. With diagnosis-related groups, certain conditions are paid with a lump sum intended to compensate the provider for all the care the provider offers related to the treatment of that condition.

If the fee-for-service system is easy to understand, so are the incentives it creates. Many commentators have correctly noted that the present system encourages health care providers to offer more and more costly treatments, not just those that are effective or cost-effective.⁷ Studies showing overuse of invasive and expensive procedures like coronary artery bypass and pacemakers are often cited as evidence of the problematic incentives built into the fee-for-service system.⁸

This is not to say that physicians or hospitals try to keep people sick or knowingly provide unnecessary care. The specter of medical malpractice lawsuits, governmental audits, and medical ethics would quickly put an end to such attempts.⁹ However, the fee-for-service system offers little motivation to improve quality or efficiency or provide services that have a low profit margin.¹⁰ In addition to the problematic incentives, the risk of rising costs and inefficiencies under the fee-for-service system falls largely on the government and private insurers rather than patients or physicians. Increased inefficiency and more expensive treatments simply lead to more money paid by insurers, both government and private, to physicians and hospitals.

Cost-Saving Measures in PPACA

Recognizing the incentives that the fee-for-service system places on rising costs and who shoulders that risk is essential to understanding the recently enacted reform efforts. Looking at the major reform efforts found in the PPACA, it is clear that legislators and policymakers sought to continue the movement away from

the fee-for-service system and replace it with one that incentivizes improvements in quality and efficiency. The various reform measures also seek to shift the risk of rising costs from insurers to physicians and hospitals. By continuing to alter the incentives and risk built into the system, reformers hope to finally bend the cost curve.

Quality Control Measures

A recurring area of emphasis in the PPACA is the importance of measuring and improving the quality of care. While quality improvement has been steadily growing in importance since the 1999 Institute of Medicine report "To Err is Human" (the Centers for Medicare & Medicaid Services boasts that it has 375 quality measures in place), the PPACA increases this focus.¹¹

Under the PPACA, quality measures will not only be reported, but will increasingly become tied to payment. For example, by 2012 a value-based purchasing program will be in place that will make incentive-based payments to hospitals that meet certain performance standards for five specific conditions.¹² Under a similar program, the government will collect data on certain hospital-acquired conditions and readmission rates. Hospitals will not only be rewarded for meeting quality standards, but will also see reductions in payments for failure to meet minimum quality measurements.¹³ The hope is that these reform efforts bend the cost curve by eliminating procedures that have not been shown to improve outcomes and by creating a healthier patient population.

Medical Homes

Another significant reform was the creation of the Center for Medicare & Medicaid Innovation (CMMI), which aims "to produce better experiences of care and better health outcomes for all Americans and at lower costs through improvements."¹⁴ The CMMI has been given \$15 billion to spend by 2019 on projects and health care delivery models aimed at improving the quality of care and lowering costs.¹⁵

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One model set to receive government funding is the patient-centered medical home. While not universally defined, medical homes involve patients having close contact with a primary-care clinician, whether a physician, nurse practitioner, or physician assistant. Medical homes also rely heavily on developing technology such as electronic medical records and health information exchanges, which allow for improved integration between clinicians and increased involvement with patients. The idea behind medical homes is to improve the primary-care system and provide better preventative care, keeping patients out of doctors' offices and hospitals.¹⁶

Medical homes have already been implemented in many parts of the country, and several studies have demonstrated their effectiveness in reducing costs. A two-year study of a 10,000-patient, Seattle-based medical home showed a savings of \$1.50 for every \$1 invested into the system, driven by a 29 percent reduction in emergency department visits and a 6 percent reduction in hospitalizations.¹⁷ Another review showed that medical homes increased patient satisfaction, improved outcomes, and decreased errors,¹⁸ while a separate review of 33 studies was slightly less positive, finding moderate support for the position that medical homes improved health outcomes.¹⁹

Some of the savings of medical homes is driven by increased reliance on physician assistants and nurse practitioners, and patients should be aware that they may see their physicians less often. Savings and improved quality are also heavily dependent on a compliant patient population. The risk of patient noncompliance is borne by physicians who, despite their best efforts, may be unable to meet quality measures if patients fail to follow treatment plans or ignore recommendations regarding lifestyle choices.

Accountable Care Organizations

The reform effort receiving the most attention from the health care community and that may hold the greatest hope for bending the cost curve is the accountable care organization (ACO). Part of the new Shared Savings Program, ACOs are a new government payment system, not an experimental project or pilot program.²⁰ They are rapidly spreading across the country as hospitals and physicians attempt to get out in front of the new payment methodologies in the PPACA.

Despite the lack of a universal definition, ACOs are generally understood to consist of a group of providers—primary care providers, specialty providers, physician groups, hospitals, or some combination thereof—who are jointly responsible for the overall care of a group of patients. Among the relatively vague requirements placed on ACOs is that they include enough primary-care providers to support 5,000 beneficiaries.²¹ ACOs receive a shared savings bonus from the government if they meet certain quality standards and cost-savings goals.²² If they fall short of these standards, not only will ACOs lose the bonus, but, depending on how they are formed, they may also see a reduction in payments.

Like the reform efforts previously discussed, ACOs seek to bend the cost curve by changing the incentives created by the cur-

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rent system. Rather than reward expensive and frequent treatment, the ACO system rewards health care providers that successfully reduce costs and improve quality of care. Under the new payment methodology, providing quality care will benefit ACOs in two ways. First, they will be rewarded for meeting certain quality standards. Second, providing quality care will likely result in a healthier patient population, allowing ACOs to cut costs and entitling them to a shared savings bonus. ACOs also alter the risk allocation in the present system by placing some of the risk of rising health care costs on physicians. If providers are unable to meet spending goals, they will miss out on their shared savings bonuses.

Importantly, ACOs will also address the problem of patients receiving fragmented care from providers that know little or nothing about what the other providers are doing. Utilizing new technology, ACOs will be better equipped and more motivated to collaborate, provide patients with more cohesive treatment plans, reduce duplicative treatments and tests, and identify effective treatments.

A Word of Caution

Many people believe medical homes and ACOs hold great promise for reducing health care costs, but skeptics remain. One basic criticism of the medical home and ACO models is that, in many circumstances, providers will still be rewarded for increasing the volume of clinical services and focusing on expensive and profitable treatments. It is unclear whether the prospect of a shared savings payment will be sufficient to change the behavior reinforced by the longstanding fee-for-service system. Additionally, while *providers* in an ACO will share some risk for rising health care costs and have incentives to seek more efficient and less expensive treatments, no such incentive exists for *consumers*. Patients will also be free to seek treatment from providers outside of the ACO but the cost will be attributed to the ACO, making it difficult to meet spending goals.

ACOs and other payment models will also have to navigate legal obstacles. When hospitals, hospital systems, and large physician groups form an ACO, they will have to be wary of running afoul of antitrust laws.²³ ACOs will also have to structure themselves in such a way that shared savings bonuses do not violate laws against physician self-referrals. ACOs will also face significant initial capital investment to acquire the necessary technology, facilities, and clinical personnel to report quality data, meet quality requirements, and care for the minimum 5,000 patients.²⁴

Conclusion

While the programs, pilot projects, and payment models within the PPACA are varied, a clear emphasis has emerged on incentivizing quality, efficiency, and collaborative care. Both medical homes and ACOs incorporate these areas of emphasis, continuing the shift away from the current systemic incentives while improving continuity of care. The reforms also shift some of the risk of rising costs onto health care providers who face the prospect of reduced payments if they fail to meet quality and spending goals. Whether and to what extent these changes in incentive and risk allocation will be sufficient to bend the cost curve remains to be seen. However, there is no question that PPACA has attempted, in dramatic fashion, to address a significant societal challenge by delivering more affordable and accountable care to more people. ■



Timothy C. Gutwald is an attorney in the Troy office of Hall Render Killian Heath & Lyman. He counsels clients in numerous aspects of health care law, both regulatory and in litigation. His work involves day-to-day counsel and representation regarding corporate matters, CMS and Joint Commission matters, medical staff and peer review, contracting matters, regulatory compliance, reimbursement and self-disclosure issues, and EMTALA compliance.

FOOTNOTES

1. Pub L 111-148, 124 Stat 119, 42 USC 18001.
2. The White House, Remarks of President Barack Obama—As Prepared for Delivery—Address to Joint Session of Congress, February 24th, 2009 <http://www.whitehouse.gov/the_press_office/Remarks-of-President-Barack-Obama-Address-to-Joint-Session-of-Congress/>. President Obama noted that “[t]he cost of health care eats up more and more of our savings each year. . . .” All websites cited in this article were accessed May 5, 2011.
3. Congressional Budget Office (CBO) publication, *The Long-Term Outlook for Health Care Spending* <<http://www.cbo.gov/ftpdocs/87xx/doc8758/MainText.3.1.shtml>>. In 1960, 5.2 percent of the gross domestic product (GDP) was spent on health care. By 2009, the amount spent on health care had more than tripled to 17.6 percent of the GDP. See U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, *National Health Expend Summary Including Share of GDP, CY 1960–2009* <http://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp#TopOfPage>.
4. President Obama used the phrase in an interview with the *Washington Post*; see <<http://www.washingtonpost.com/wp-dyn/content/article/2009/07/22/AR2009072202522.html>>.
5. There are approximately 34 different projects and programs either created or extended by the PPACA. See sections 1201, 2702, 2704, 2706, 3023, and 3024.
6. These payments can go to one provider as a bundled payment or be separated and paid to different providers. A more thorough explanation of reimbursement is well beyond the scope of this article.
7. Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians* (4th ed, 2009), 227; see also Steinbrook, *The End of Fee-for-Service Medicine? Proposals for Payment Reform in Massachusetts*, 361 *New Eng J Med* 1036, 1036 (2009).
8. Lo, n 7 *supra*, at 227.
9. The role of audits to review whether procedures are medically necessary is addressed in “One Year Later: Health Care Reform’s Impact on Health Care Provider Audits and Compliance Programs” in this issue of the *Michigan Bar Journal*.
10. Steinbrook, n 7, *supra*.
11. Inst of Med of the Nat’l Acad, Report, *To Err Is Human: Building a Safer Health System*, available at <<http://iom.edu/Reports/1999/To-Err-is-Human-Building-A-Safer-Health-System.aspx>>; see also Centers for Medicare & Medicaid Services, *Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program*, at 3, available at <https://www.cms.gov/QualityInitiativesGenInfo/downloads/QualityMeasurementRoadmap_OEAI-16_508.pdf>.
12. PPACA §3001.
13. PPACA §§3008; 3025.
14. See Center for Medicare & Medicaid Innovation, *About the Innovation Center* <<http://innovations.cms.gov/>>.
15. PPACA §3021.
16. Robeznieks, *Modern Health Care.com, Hospitals Consider Medical Homes’ Costs, Benefits* <<http://www.modernhealthcare.com/article/20101129/NEWS/311299996>>.
17. Reid, et al., *The Group Health Medical Home at Year Two: Cost Savings, Higher Patient Satisfaction, and Less Burnout for Providers*, 29 *Health Affairs* 835, 835–843 (May 2010), available at <<http://www.leg.wa.gov/JoinCommittees/HRI/Documents/Sept2010/HealthAffairsYear2.pdf>>; see also Villegas, *Studies: When Doctors Take More Responsibility, Care Becomes Cheaper and Better*, *Kaiser Health News*, May 2010, available at <<http://www.kaiserhealthnews.org/Stories/2010/May/04/medical-home-shorttake.aspx>>.
18. Sutton, et al., *Is deleting the digital rectal examination a good idea?*, 155 *Western J Med*, 43, 43–46 (July 1991), available at <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1002909/pdf/westjmed00095-0045.pdf>>.
19. Homer, et al., *A review of the evidence for the medical home for children with special health care needs*, 122 *Pediatrics*, e922, e922–e937 (October 2008), available at <<http://pediatrics.aappublications.org/cgi/content/abstract/122/4/e922>>.
20. Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 *Health Affairs* 32, 33 (January 2011), available at <<http://content.healthaffairs.org/content/30/1/32>>.
21. PPACA §3022.
22. *Id.*
23. In addition to antitrust issues, the formation of ACOs may decrease competition in the health care market and actually drive up costs.
24. It is widely believed that a patient population needs to be much larger than the 5,000 patient minimum for ACOs to realize any shared savings bonus.

