By Barry P. Chaiken, MD, FHIMSS

Show Me the Money

The most important lesson in medical care comes from a bank robber who stole more than $2 million and spent more than half his life in jail. Named for Willie Sutton, one of the most prolific bank robbers in history, Sutton's law grew out of a famous response to a reporter's question attributed (perhaps falsely) to Sutton. When asked by a reporter why he robbed banks, Sutton allegedly replied, "Because that's where the money is." In reality, he probably said, "Go where the money is… and go there often."

Applied to medicine, Sutton's Law states that when diagnosing, one must consider the obvious. Diagnosticians should first conduct those tests that will confirm the most likely diagnosis, and order them in a sequence that has the highest probability of delivering an accurate diagnosis. This approach also minimizes unnecessary tests and reduces costs.

Now that the Affordable Care Act of 2010 is law, signifying the completion of the first legal phase of healthcare reform, the work is just beginning to transform the delivery of healthcare. To understand where this transformation is headed, attention must be focused on where the money is and how the money flows. Show me the money, and I will show you what will unfold.

Capitation Fail

More than 20 years ago, payors and providers experimented with capitated arrangements where IPAs—Independent Practice Associations, often constructed from a broad swatch of primary care and/or specialty physicians—contracted with payors to provide services to a population of insured individuals. The IPA, or in some cases individual physicians, were paid on a per-member-per-month basis, with much of the financial risk associated with care assigned from the payor to the provider. The IPA, owned by the providers, paid the physicians either on a capitated, fee-for-service, or hybrid reimbursement arrangement.

Medical economists at the time believed that shifting the risk to the provider would change the behavior of the clinicians, as their net compensation was no longer solely based upon providing services. Incentives existed to withhold care as such behavior led to increased profits for the IPA and in turn the practices. Economists assumed that the care withheld by the providers would only be inappropriate care and not care withheld solely to increase compensation.

Although numerous variations of capitation were tried during that time, capitation arrangements did not succeed in reducing costs, increasing provider compensation, or improving quality of care. Many physicians continued to over-utilize services.

Managing the financial and clinical risk proved too difficult for IPAs and individual providers as adequate information technology was not available to guide those modeling costs, monitoring care, and working to change provider behavior. Many IPAs lost large amounts of money as costs of care exceeded per-member-per-month payments. Some physicians took large personal losses after taking on this risk, souring any further interest in these types of risk arrangements.

ACOs and Medical Homes

Like so many ideas in healthcare, the old, after a time of dormancy, becomes the new. The excitement around accountable care organizations (ACOs) and patient-centered medical home projects is based upon much of the same thinking that excited healthcare policy makers 20 years ago. With ACOs and patient-centered medical homes, primary care physicians would be responsible for both the care and cost of care for patients assigned to them.

The old becomes new.

Those physicians able to keep their patient population healthy while reducing the cost burden associated with treating their population would share in the savings to the payor. Although not all medical homes are established to take on financial risk, the model is useful within this context, and it is expected that over time most medical homes will incorporate a financial risk component.

The National Committee for Quality Assurance (NCQA) recently codified the patient-centered medical home with input from the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Osteopathic Association. The patient-centered medical home is a healthcare setting that facilitates partnerships between individual patients, personal physicians, and patient families. It utilizes information technology such as electronic medical records, health information exchanges, and patient registries to coordinate and manage patient-centered medical care. The NCQA established nine Physician Practice Connection standards with 10 must-pass elements that the NCQA uses to award one of three levels of distinction to practices.

ACOs are a super-set of medial homes in that they expand beyond the primary care physician by including specialists and hospitals, offering a more all-inclusive, global approach to providing care where incentives for most if not all of the stakeholders are aligned. Many practices within the confines of an ACO follow the medical home care principles. Provisions in the healthcare reform legislation evolved from principles inherent in the structure of ACOs and medical homes.

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What our healthcare system will look like at the end of 2014, when the final provisions of the Affordable Care Act of 2010 become active, may be fuzzy today, but a rough picture of it can be drawn by following the flow of financial incentives. By 2014 the effects of removing lifetime caps on medical costs, eliminating the process of denying coverage due to pre-existing conditions, emphasizing the use of proven disease treatments, and reducing reimbursement for preventable medical errors and readmissions shifts the care incentive from providing more care to providing only care that is needed.

Regular assessment of quality performance will identify those providers who might be withholding care or over-utilizing care, helping to balance the equation between clinical and financial objectives. Entities such as ACOs and patient-centered medical homes will either take on the financial risk and therefore share in the savings generated by their transformed care delivery processes or receive added payments, along the lines of current pay-for-performance schemes, for delivering predetermined clinical and financial outcomes.

Healthcare information technology will play a critical role in delivering these new models of care delivery and financing. Only through robust information technology can we track and report on performance, offer clinical decision support to enhance safety and quality, and monitor the health of populations of patients. Healthcare information technology offers the critical tools to move clinicians from their focus on episodic care, where financial incentives were based upon piecework, to much broader population-based care, where financial incentives promote the delivery of favored clinical outcomes that efficiently utilize resources. Therefore, to understand the current and future changes to our healthcare system, you need only to know where the money is and where it is flowing. PSQH

Barry Chaiken *is the chief medical officer of DocsNetwork, Ltd. and a member of the Editorial Advisory Board for* Patient Safety & Quality Healthcare. *With more than 20 years of experience in medical research, epidemiology, clinical information technology, and patient safety, Chaiken is board certified in general preventive medicine and public health and is a Fellow, and former Board member and Chair of HIMSS. As founder of DocsNetwork, Ltd., he has worked on quality improvement studies, health IT clinical transformation projects, and clinical investigations for the National Institutes of Health, U.K. National Health Service, and Boston University Medical School. Chaiken also serves as an adjunct assistant professor in the Department of Public Health and Family Medicine at Tufts University School of Medicine. He may be contacted at bchaiken@docsnetwork.com.*

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