

How I Was Wrong About ObamaCare

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The law's drafters wanted consolidation: 112 hospital mergers last year. But smaller practices have improved care better.

By BOB KOCHER

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I was wrong. Wrong about an important part of ObamaCare.

When I joined the Obama White House to advise the president on health-care policy as the only physician on the National Economic Council, I was deeply committed to developing the best health-care reform we could to expand coverage, improve quality and bring down costs. We worked for months to pass this landmark legislation, and I still count celebrating the passage of the Affordable Care Act with the president one balmy spring night in 2010 as one of my greatest Washington memories.

What I got wrong about ObamaCare was how the change in the delivery of health care would, and should, happen. I believed then that the consolidation of doctors into larger physician groups was inevitable and desirable under the ACA. I joined my White House health-care colleagues—Ezekiel Emanuel and Nancy-Ann DeParle—in writing a medical journal article arguing that “these reforms will unleash forces that favor integration across the continuum of care.” We added that “only hospitals or health plans can afford to make the necessary investments” needed to provide the care we will need in a post-ACA world.

Well, the consolidation we predicted has happened: Last year saw 112 hospital mergers (up 18% from 2014). Now I think we were wrong to favor it.

I still believe that organizing medicine into networks that can share information, coordinate care for patients and manage risk is critical for delivering higher-quality care, generating cost savings and improving the experience for patients. What I know now, though, is that having every provider in health care “owned” by a single organization is more likely to be a barrier to better care.

Over the past five years, published research, some of it well summarized on a Harvard Medical School site, has indicated that savings and quality improvement are generated much more often by independent primary-care doctors than by large hospital-centric health systems.

Look at accountable-care organizations (ACOs), in which doctors and health-care providers come together to provide complete care for an individual and are compensated for keeping them healthy and generating savings. Based upon the latest data the Centers for Medicare and Medicaid Services has released, from 2014, independent physician-led ACOs, like the Rio Grande ACO on the Texas border, are outperforming ACOs from many of the most famous health systems. Johns Hopkins Hospital in Baltimore has been ranked as one of the top three health systems in the nation, but its ACO failed to achieve shared savings in 2014.

Small, independent practices know their patients better than any large health system ever can. They are going up against the incumbent and thus are driven to innovate. These small businesses can learn faster without holding weeks of committee discussions and without permission from finance, legal and IT departments to make a change.

More often than not, one of the most important changes these practices make is embracing technology. The ability to store, analyze and make sense of data has now become so easy and inexpensive that all physicians can use “big data.”

In my White House days, we believed it would take three to five years for physicians to use electronic health records effectively. We were wrong about that too. At every opportunity, organized medicine has asked to delay and lower thresholds for tracking and reporting basic quality measures; yet they have no reason to delay.

In the ACOs run by Aledade, which advises small medical practices (I sit on its board), we have found that independent primary-care doctors are able to change their care models in weeks and rapidly learn how to use data to drive savings and quality. For small practices, it does not take years to root out waste, rewire referrals to providers who charge less but deliver more, and redesign schedules so patients can see their doctors more often to avert emergency-room visits and readmissions.

Recognizing the strength in the small practices, the federal government needs to write rules that make it easier for them to thrive under ObamaCare and don't tip the scales toward consolidation. That means introducing payment models that limit losses for small providers to the Medicare dollars they receive rather than total spending, and which rely on multiyear benchmarks instead of single-year swings. It also means comparing small practices to other small ones—instead of to large health systems with large balance sheets—when determining if a practice deserves bonus payments for savings.

Large health systems deliver “personalized” care in the same way that GM can sell you a car with the desired options. Yet personal relationships of the kind often found in smaller practices are the key to the practice of medicine. They are the relationships that doctors want to forge with patients, and vice versa. It may sound old-fashioned, but what I have learned is that we do not need to sacrifice this unique feature of our health-care system as we move forward in adapting new value-based payment models and improving the health of patients.

Dr. Kocher was special assistant to President Obama for health care and economic policy from 2009 to 2010. He is now a partner at Venrock, the venture-capital firm.