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Before

The United States Senate Committee on Finance
Hearing on
“Aligning Incentives: The Case for Delivery System Reform

Sept 16, 2008

Chairman Baucus, Senator Grassley, and Member of the Committee:

I very much appreciate the opportunity to provide testimony to the Committee as it undertakes an important inquiry into the crucial topic of incentives to promote health care delivery system reform. It is a subject that I have been deeply involved with through most of my professional career. I practiced general internal medicine for over twenty years, twelve of which were in a small group practice I co-founded located a few blocks from here. I have been medical director of a D.C. area preferred provider organization and helped organize and oversee two physician-owned independent practice associations.

In the latter part of the Clinton Administration, I had operational responsibility for provider payment systems at the Centers for Medicare and Medicaid Services (CMS) and was in charge of contracting with Medicare Advantage plans. In recent years, as a Senior Fellow at the Urban Institute, I have been studying the effects of the Medicare Physician Fee Schedule as well as important innovations that offer promise to improve how care is provided to Medicare beneficiaries and the American public, including the Patient-Centered Medical Home.

For the more than 30 years that I have been in and around discussions of health care system reform, the idea of organizing physicians, hospitals, and other professionals and providers into integrated and accountable organizations better able to manage the complexity of patient needs has usually assumed the policy high ground. The original concept of health maintenance organizations, developed by Paul Elwood and colleagues, assumed the development of integrated physician groups, and Alain Enthoven's vision of managed competition assumed replacement of unaccountable and independent physicians and hospitals with organizations that were better able to improve quality and manage costs. Over the years, these organizations have been variously labeled "multispecialty group practices," "integrated delivery networks," "physician-hospital organizations," "accountable health organizations" and "organized delivery systems," or other term to reflect changing fashion and nuanced differences in their configurations.

Proponents of this form of health care delivery have pointed to real-world examples of organizations that exemplify the best of breed and the potential of new organizational forms to improve care. Indeed, for most of my career, the same organizations have been cited: the Permanente Medical Group, the Mayo Clinic, Intermountain Healthcare, and the Geisinger Clinic, now the Geisinger Health System. Recently, there has been one interesting addition to the list of cutting-edge organizations that are reengineering how health care is being delivered to improve value – the Veterans Health Administration -- which demonstrates that government programs also can get it right.

As others on the panel are better able to discuss, integrated delivery systems can promote collaborative team-based care to better serve patients' complex care needs especially in the area of chronic care management; promote adoption and enhancement of electronic health records, including patient access to a personalized health record via customized

Web portals, and can mount and sustain systematic quality improvement and patient safety efforts.

And at a time when health care costs are rising at a pace that robs workers of well-earned wage increases because their employers must first pay the price of double-digit premium increases and is beginning to threaten the fiscal sustainability of the Medicare and Medicaid programs, offer the potential of reducing costs, while maintaining or even improving quality. A major problem is that because they are dependent on current payment approaches, these organizations are often penalized financially for undertaking activities that reduce costs. The result is that the potential of these organizations is not being realized.

It is striking that the same exemplary organizations that have been prominently identified over a number of decades as leaders are the same ones at the cutting edge of care improvement today. I have pondered why there has been relatively little uptake nationally into this form of health care delivery.

With colleagues at The Center for Studying Health System Change (HSC), I have conducted research documenting that in recent years physicians have been much more active in forming single specialty groups than in organizing and joining multispecialty groups. Single specialty consolidation provides them more negotiating leverage with health insurers and permits the requisite organizational size and scope to be able to own and self-refer lucrative ancillary services, such as MRI and PET scans.¹ Similarly, HSC has found that collaboration between hospitals and particular physician specialties, often in joint ventures based around construction of new facilities, has focused on developing and promoting profitable service lines and not on meeting the challenges of caring for an aging population and the challenge of patients with multiple chronic illnesses.

This understandable but unfortunate orientation, in my view, reflects distorted incentives, the subject of today's hearing, and explains much of why the organization of health care delivery actually is actually heading in the wrong direction, despite the occasional success stories of excellent organizations like Geisinger. Although I think altering these incentives will go a long way to changing the direction of change, I first want to offer a few observations of some other barriers I think stand in the way of adoption of integrated care models of health care delivery.

Merging Different Cultures

Organization of health care professionals and institutional providers does not occur naturally or easily. Forming and supporting the types of multidisciplinary, collaborative teamwork that lies at the heart of integrated care delivery requires altering the cultures of physicians, other professionals, and hospitals, all of which have developed mostly in hard siloes over many decades. Battling for their share of the health care dollar and coming

¹ Robert A. Berenson, Thomas Bodenheimer, Hoangmai H. Pham. Specialty-Service Lines: Salvos in the New Medical Arms Race, *Health Affairs*, Web Exclusive, 25(5), 2006, W:337-W343.

from their separate cultures with different attitudes towards basic approaches to how care should be delivered, tensions have arisen between primary care physicians and specialists, between physicians and other professionals such as nurse practitioners, and between physicians and hospital administrators.

Indeed, one of the harmful effects of having separate payment systems for each category of provider is to reinforce the cultural differences that already exist across the spectrum of providers which need to work together in patients' best interests. In practical terms, this means that even if the incentives become better aligned, developing organizations that can surmount long-standing disputes and cultural differences requires unique leadership and communication skills, not only at the top of the organization but in other senior management positions.

Need for New Organizational Ethics

A particular challenge for development of accountable care systems is taking on the culture in which most physicians have been nurtured in their medical education and practice environments. That culture in effect emphasizes heroic individualism, which often has well served patient's needs. However, this emphasis represents a distorted view of professional ethics emphasizing autonomy and independence, deference to other professionals' independence, and resistance to collaboration, transparency, and accountability. Physicians as professionals are taught to adhere to standards of care, whether or not adherence to those standards actually produce the desired results. Less emphasis is given to focusing on how to actually contribute to collaborative efforts to produce outcomes that best serve the interests of their patients and the public.

A modified professional ethics that emphasizes collaboration, accountability for performance, responsibility for conserving finite financial resources, while preserving the core element of professionalism – fidelity to the patient's best interests, ideally grounded in a mutually trusting relationship – has been promulgated.² It may be that integrated care organizations with appropriate physician leadership actually may be in a better position to follow this revised and updated set of ethical principles than many individual practices that unfortunately now seem inordinately focused on income maximization.

If the health care system begins to rely much more on the expansion of integrated provider systems, there is need to assure that the organizations adopt codes of ethics specific to their unique roles while assuring fidelity to serving patients' best interests. Further, policy makers need to assure the public that any recognition and support of accountable health systems as separate entities supported by their own, unique payment approaches vigilantly guard against the possibility that some of these organizations would have unsavory conflicts of interests and would not do their share to serve the underinsured and uninsured. In moving from a system relying on siloed physicians and

² ABIM Foundation, ACP-ASIM Foundation, European Federation of Internal Medicine. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136:243-246.

hospitals to one relying on integrated organizations, the public needs assurance that their interests as patients and as citizens are being protected.

Building on the Responsiveness That Characterize Many Small Practices

Another barrier that many multispecialty medical groups face, I believe, is that many patients prefer the familiarity, convenience, responsiveness, and trust they often find in community-based small practices to the more structured but often more imposing and less responsive environments that may characterize organizations with centralized clinics located some distance from where patients live and work. Even if the accountable delivery systems can document better performance on objective, but inherently limited, measures of quality and make the health care dollar go farther, patients may appropriately give priority in their own health care choices to small, “relationship-centered” practices.

Some multispecialty groups, such as Geisinger and the Billings Clinic in the Chairman’s home state, include in their networks primary care physicians practicing in community locations outside of the main hubs in which many of the group’s physicians, especially specialists, practice. Recent developments in health information technology, with interoperable electronic health records offer the very real potential that organizations can retain the patient responsiveness that characterize decentralized small practices while taking advantage of the organized group capabilities for expert referral networks, chronic care management support, quality improvement activities, pharmacy management, and other benefits that derive from what inelegantly has been called “systemness.”

Altering Payment Incentives

Although these and other challenges faced by current and would-be accountable delivery systems will not disappear if public and private payers altered their basic payment approaches, I agree with many others that the current incentives embedded in current common payment approaches have made it very difficult for integrated physician and hospital systems to succeed and to realize their potential. Their ability to increase value for patients and society are not rewarded, and their need to respond to current payment incentives undercuts what they are configured to accomplish.

In short, incentives must be created to encourage physicians, other professionals and institutional providers to become part of accountable care organizations, and then incentives must be created for those organizations to improve value for purchasers. As a prime example, whether or not the kinds of organizations I have described develop broadly throughout the country, delivery system reform of any kind will not succeed if hospitals continue to be rewarded for increasing the volume of inpatient admissions and penalized for working with physicians and other clinicians to avoid hospitalization for large numbers of patients with so-called “ambulatory care-sensitive conditions.”

If these patients receive appropriate ambulatory care, many would not need to be hospitalized, but currently hospitals have no financial interest in joining collaborative efforts to develop the needed alternative delivery approaches that would among other

things reduce the number of hospitalizations they experience. A primary objective for delivery system reform should be that hospitals assume their proper role as essential and valued community assets with a mission to improve community health instead of continuing to rely on revenue-maximizing strategies built of profitable service lines, regardless of population needs.

Decreasing Preventable Readmissions

The perversity of current payment approaches is well demonstrated in the problem of avoidable hospital readmissions. MedPAC, which has done important work on this topic, has found that about 18 percent of all-cause Medicare admissions result in readmission, accounting for \$15 billion in spending annually. MedPAC further found that Medicare spends about \$12 billion on these potentially preventable readmissions. Researchers at 3M have found comparably disturbing findings for patients with commercial insurance. Although harder to document, the need for readmission shortly after discharge suggests poor quality that might compromise patients' long-term health and well-being; surely some patients die before they can be readmitted.

Virtually all payers provide hospitals entirely new payments for a readmission, even one that takes place on the same day. (Sometimes, as in Medicare, payment is denied on a case-by-case basis if medical review determines there was a quality of care problem that led to the readmission.) Perhaps the most striking finding of all in this research is that about half of Medicare patients who experience a readmission within 30 days have not had a visit with a physician or other provider in the interim between discharge and readmission. Patients who are sick enough to have needed a hospitalization or have undergone a major procedure requiring an inpatient stay are then "lost in transition," with, apparently, no one taking responsibility for their care in the crucial, initial post-hospital days.

This lack of attention results from the current of siloed payment system, which penalizes no one for faulty "handoffs." Hospitals take no responsibility for the patient post-discharge and achieve entirely new inpatient payments when the patient needs to be readmitted within days. Similarly, under public and private payer fee schedules, physicians do not receive payment for reassuming responsibility for the patient post-discharge outside of a face-to-face visit. But office-based physicians who often do not go to the hospital any more to care for their own hospitalized patients may not even know that the patient has been discharged, much less the details of their clinical status and care recommendations, which may have been handled by a hospitalist. The hospitalists, for their part, may feel no responsibility for communicating the patient's discharge status to the patients' regular physicians, who after all has been absent during the hospital stay.

Hospitals could administer dramatically improved discharge planning and patient education, assure that hospitalists communicate with patients' regular practices, promptly "push out" discharge summaries to patients' physicians, and follow up with patients by phone or in person in home visits shortly after discharge to help coordinate patient's return to their home and community. A crucial part of this enhanced transition planning

needs to include detailed medication reconciliation with patients and their families because patients understandably are often confused about what which set of medications they are supposed to be on – the one prescribed in the hospital or the one that they had been on prior to hospitalization.

Simply, hospitals should not receive a full DRG payment in Medicare for readmissions that occur within short periods of time for large numbers of diagnoses that are amenable to better transition activities that would result in reduced rates of readmissions. One can think of it as robust pay-for-performance but able to be implemented without major new data collection requirements. And patients' regular physicians should be reimbursed, even fee-for-service -- for their activities outside of standard visits to assure a high quality transition and resumption of their patient responsibilities, possibly as a Patient-Centered Medical Home.

There are few policy initiatives which at the same time can improve quality of care, enhance patient experience with care, and decrease system costs. Reducing avoidable readmissions is one. Learning how to get these incentives right, initially even relying on siloed providers, will help policy makers learn how to make more systematic payment changes to promote enhanced provider performance.

The Need to Internalize Savings to Provider Organizations

Altered incentives can be a key to enhancing provider willingness to become more vigilant, not only to improve care transitions but also to reduce inappropriate provision of many services, to reduce errors, and to implement chronic care management programs to better support patients with complex health care needs. Diagnosis Related Group (DRG)-based case rates for hospitals and sixty day, episode-based case rates for home health agencies provide models for payment approaches that internalize to the organization the rewards for increasing efficiency.

A number of case studies have documented examples of organizations that have initiated programs improving quality and decreasing costs for patients and payers only to find that they could not sustain the direct costs of running the program and the decreased revenues that resulted from their success. Payment approaches need to reward rather than penalize cost reducing behavior. In this regard, the approach used in the Medicare Physician Group Practice (PGP) Demonstration – the “shared savings” approach that permits the group and Medicare to share in financial savings when the group successfully reduces total Part A and B spending – seems most practical for adoption initially for large organizations, especially for the kinds of integrated ones I discussed initially, but also for hospitals who might be allowed to share savings with physicians through gainsharing approaches.

It is time to move away from a “one size fits all” payment system relying on a Medicare Fee Schedule for physicians and Prospective Payment based on DRGs for hospitals. Over time approaches that derive from the PGP approach to shared savings might include forms of direct capitation to large provider organizations but without relying on private

health plans intermediaries. These alternatives need to be adopted and emphasized by traditional Medicare as a way to encourage accountable care organization development, while initially maintaining a parallel system for providers who have not decided to integrate. If anything, these new payment constructs might be tilted gently to encourage accountable care systems, for example by maintaining some form of expenditure cap on physicians receiving fee-for-service payments according to the Medicare Fee Schedule, while exempting physicians in integrated systems, because their performance is subject to the discipline of the shared savings or capitation incentives. The main point is that integrated delivery networks should be supported with payment systems developed specifically to take advantage of the added value they provide.

Payment Reforms for Non-Integrated Providers

On the expectation that even with new payment approaches that reward the development of accountable care organizations most physicians and hospitals initially will remain independent and not part of integrated systems, current payment methods used in Medicare and commercial insurance need to be altered. In the short run, paying “smarter” can reduce costs directly. In addition, new payment approaches that better align physician and hospital payment incentives might foster collaborative experience that could result in an interest in more formal collaborations to establish real integrated organizations.

One approach to encourage the internalization of cost-saving efficiencies and promoting greater collaboration between hospitals and physicians lies in bundled payments, for example combining Part A and Part B payments associated with a surgical procedure and its accompanying hospital stay. Bundling makes policy sense and needs to be vigorously tested.

At the same time, I have a concern about how the bundling of Part A and Part B services should occur. That is, bundling approaches need to also consider the appropriateness of the services being paid for, albeit now in a bundled manner. Health services research, especially the important work on appropriateness conducted at Rand and the decades of work on practice variation conducted by Jack Wennberg and colleagues at Dartmouth, document that even services provided expertly and efficiently may not have been needed in the first place. Bundled payment approaches, for example for cardiac procedures, need not only consider price and quality, but also appropriateness of those procedures for the patients in whom it is being provided.

In this regard, condition-specific, episode-based payment for physician services and bundled payments for physician and hospital services has inherent appeal, again because it internalizes to the providers the benefits of improved efficiency, in contrast to pure fee-for-service. There are, however, important implementation issues regarding bundling services involving procedures. Any episode-based payment system should guard against the inherent bias that exists in fee-for-service toward over provision of discretionary procedures. Although the costs of an episode needs to take into account the direct and substantial costs associated with providing the procedure, the valuation of condition-

specific episodes should attempt to reduce payment differentials that reward clinical decisions to provide the procedural intervention in preference to other strategies that do not include the procedural intervention. As an example, the payment for treating an episode of back pain that involves a surgical procedure should not be orders of magnitude more than payments that rely on conservative approaches to pain management.

Further, as with all episode or time period-based payment approaches, clinically sophisticated case-mix adjustment is needed to prevent perverse outcomes, such as physicians giving preference to less severe patients within a cohort with a particular condition or “over-diagnosing” relatively minor complaints to generate compensable episodes. All payment approaches present “gaming” opportunities; the work of developing payment bundles and episodes needs to actively protect against such behavior. Fortunately, in recent years, we now have much more sophisticated approaches to case-mix adjustment such that payment approaches, including capitation, that often did not work very well in the past should be more successful if adopted now.

The Need to Revise the Medicare Physician Fee Schedule

The Committee deserves credit for actively promoting the concept of Value-Based Purchasing (VBP) for Medicare. CMS is making progress in promoting VBP concepts for a range of provider types. However, some have interpreted VBP in a restricted fashion -- focusing on the quality and costs of the services being provided and not considering more broadly whether beneficiaries are receiving the right kind and mix of services, which should be a core concept in considerations of value. VBP has attempted to reward providers through public recognition and add-on payments, mostly for improving the provision of primary and secondary prevention activities. While useful, this approach does little to address the problems of misuse and overuse of services that create serious cost and quality problems in Medicare and, indeed, that affect the entire population.

At a programmatic level, the logic of Value-Based Purchasing would be to ask, for example, whether Medicare beneficiaries need more advanced imaging studies or more geriatricians to serve the increasing number of beneficiaries with complex chronic conditions and geriatric syndromes such as falls and memory loss. The current Physician Fee Schedule, based on estimates of the costs of production of the more than 6000 carefully defined services for which physicians submit claims, provides payment signals that have produced many years of double-digit annual increases in advanced imaging services and exponentially increasing rates of increases for some other discretionary tests and procedures, while evaluation and management services provided by primary care physicians, nurse practitioners and physician assistants have been increasing quite slowly. This suggests that current policy is producing a mismatch between beneficiary needs and the mix of services that are being provided to them.

Further, many of the activities that comprise chronic care coordination cannot be specifically reimbursed easily by fee-for-service. Patient-Centered Medical Home demonstrations by Medicare and private payers are beginning and will help policy

makers shape payment policy to support practice activities that better assist patients faced with the complexity of multiple prescriptions and often conflicting advice from different physicians, while reducing unnecessary emergency room visits and avoidable hospitalizations.

In the meantime, there is need to correct the current distortions in public and private fee schedule prices that not only produce the wrong mix of services for patients, but also frustrate efforts to develop integrated care organizations. Despite the promise of the Resource-Based Relative Value Scale to better reward so-called evaluation and management services compared to procedures and tests, the Medicare Fee Schedule, which is also a guide for health plan schedules, continues to pay more generously for tests and some procedures than for basic evaluation and management services, some of which are provided not just by primary care physicians but also by other important specialties. For example, a recent *Wall Street Journal* article described how current fee schedule values has contributed to shortages of neuro-ophthalmologists, who do not perform profitable tests or procedures to cross-subsidize the lengthy, expert evaluations that lie at the heart of their professional activities.³

The result is that public and private fee schedules reward niche specialists disproportionately well, at the expense of physicians who provide evaluation and management services or core surgical services. Thus, distorted fee schedule prices not only contribute to shortages of primary care physicians, including family physicians and general internists, but to a shortage of general surgeons as well. One result of the payment disparities in most public and private fee schedules is that medical students are advised to “follow the **road** to success,” that is, enter the specialties of Radiology, Orthopedics, Anesthesiology, and Dermatology, which in addition to being highly remunerative also support gentler lifestyles usually without emergencies outside of regular work hours.⁴

In short, the problems with the Medicare Fee Schedule are not limited to figuring out how to finance the financial shortfall created by overriding fee cuts that otherwise would take place according to the Sustainable Growth Rate (SGR) formula, although that naturally has been Congress’s primary focus. MedPAC has now identified a number of reasons for mis-pricing within the RBRVS-based fee schedule. These distortions not only result directly in excess spending related to a number of specific services but also alter physician behavior to increase the volume of profitable services that do not overly harm patients in order to increase practice revenues.

In other words, reducing prices where appropriate would not only save money directly but, in some situations, as with advanced imaging, would also reduce the financial stimulus to physicians to provide services when the clinical indications are equivocal or even nonexistent. Some of the savings from reducing overpriced services are needed to better support evaluation and management and other generalist services; however, some

³ V. Fuhrmans, “Medical Specialties Hit By A Growing Pay Gap,” *Wall Street Journal*, May 13, 2008.

⁴ In some versions of this advice the “O” stands for Ophthalmology

of the savings should be able to partly mitigate the financial hole created by the SGR score.

Fee schedule reform is also needed to further the objective of promoting the expansion of multispecialty medical groups, rather than single specialty groups, a change conducive to delivery system change as discussed earlier. Multispecialty groups have a different mix of primary care and specialty physicians than the unorganized fee-for-service sector. Current fee schedule payment disparities make it more difficult for multispecialty groups to recruit highly paid fee-for-service specialties or to narrow incomes for physicians to develop the needed collaboration and collegiality across specialties; highly remunerated fee-for-service niche specialists can do much better financially by staying out of multispecialty groups.

Combined with the impending shortage of primary care physicians, multispecialty groups face a challenge in recruiting the right balance of generalists to specialists. The well-known, successful groups may be able to recruit successfully and are helped by the fact that younger physicians are more likely to seek employment relationships rather than want to enter private practice. Nevertheless, the paucity of new multispecialty groups in recent years results partly from the major income disparities that make recruitment and collaboration within a multispecialty group problematic.

The Impending Crisis in Access to Primary Care

Whatever the blue print for delivery system reform, it is likely to fail unless immediate steps are taken to address the likely collapse of the primary care physician workforce infrastructure in many parts of the country. Primary care physicians have not been responsible for the volume increases in Medicare physician services yet have experienced the same payment freezes as those who have generated the increases. Baby boomer family physicians and general internists are approaching retirement along with many of their patients, while younger primary care physicians, who will find themselves in greater demand because of primary care shortages, will feel little personal commitment to serving Medicare patients, especially if Congress continues to flat-line their payments. Virtually no geriatricians are going into practice despite the manifest need for their expertise.

The trends to decreased family practice and general internal medicine residencies are stark, and many programs survive only by the entry of foreign-born graduates of overseas medical schools. So we are robbing developing countries of vital and needed professional workforce while ignoring the opportunity to develop an indigenous workforce more attuned to issues of health disparities and cultural competence.

A substantial body of evidence documents that countries and parts of the U.S. which rely more on primary care produce higher quality at lower costs than those with more reliance on specialty care.⁵ One study specifically showed a linear decrease in Medicare spending

⁵ B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly*, Vol. 83 (3), 2005, 457:502.

along with an increase in the supply of primary care physicians, as well as higher quality of care scores. In contrast, the supply of specialists was associated with more spending and poorer care.⁶

No matter what specific delivery system reform initiatives this Committee chooses to promote, whether those that would seek to promote development of accountable care organizations or others, there will be need for a stable primary care workforce willing and able to take on the challenge of providing care to the growing share of the population, with serious chronic conditions. Because of the long pipeline required to train physicians, Congress needs to address this issue immediately. Without action to alter the payment disparities inherent in the Medicare Physician Fee Schedule and, possibly, to refine graduate medical education payments to academic health centers to alter the mix of residents the federal government supports, efforts to reform health care delivery to improve quality and reduce costs will likely fail.

⁶ K. Baicker and A. Chandra, "Medicare Spending, the Physician Workforce, and Beneficiaries' Quality of Care," *Health Affairs*, 2004, W4:184-97