Comments on Steve Shortell – Larry Casalino and Harold Luft

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Shortell-Casalino

Steve Shortell and Larry Casalino (SC) have described five entities that could become responsible for an entire continuum of care, which they term Accountable Care Systems (ACSs). They believe, and I agree with them, that such entities are necessary to improve the quality of medical care. In their words, we have a 19th century craft system trying to operate 21st century medical technology. Borrowing the first six capabilities from the Institute of Medicine *Quality Chasm* report, they describe seven capabilities a delivery system must have to improve performance, including 1) the ability to redesign care processes; 2) make effective use of information technology; 3) manage clinical knowledge and skills; 4) develop effective teams; 5) co-ordinate care; 6) measure performance and outcome; and 7) ability to adapt to change.[1]

SC - and also Luft in my view - should be treated as a vision for what a better performing health care system might look like and not as a guide about how to move from the present situation to the ideal system. I find SC's taxonomy of five methods of organizing the delivery of services, or ACSs, likely exhaustive of possible models. But I think two of their five models are much more plausible than the other three, and that one of those two may have limited upside potential.

The first ACS SC describe is the multi-specialty group practice, which, as SC say, reformers have advocated as a model delivery system since the 1930s. This model has the strong virtue of existing in the real world. Examples that SC cite include Kaiser Permanente, the Mayo Clinic, and the Henry Ford Medical Group. As I come to below, although these organizations have been with us for decades, their market share has not markedly expanded and from a national perspective they certainly do not dominate the delivery system. Despite their virtues, I am therefore skeptical that they will markedly increase in numbers or size.

SC also describe four other ACS models:

1) The hospital-medical staff organization. This entity would build on the current organization of medical staffs at hospitals in that these entities would receive payment for hospital and medical services and would distribute the funds received to the hospital, the physicians, and others providing services, such as skilled nursing facilities.

2) The physician-hospital organization (PHO). This is similar to the hospital-medical staff organization, but all physicians on staff need not be involved. As with the hospital-medical staff organization, the PHO would receive payment and would distribute funds to the relevant providers.

[1] I agree with SC's singling out adapting to change, although it is arguably covered by the first three capabilities of the IOM report.

3) The health plan-provider organization/network. Under this arrangement the health plan forms a network of providers and distributes payment. Like the multi-specialty group practice, this form currently exists in that health plans receive payments from employers or individuals and contract with networks of hospitals and physicians. The issues here are around the incentives and ability of the health plan to carry out the seven capabilities described at the outset. Those issues, however, seem to me to be of a different character that those surrounding the other forms.

4) The interdependent practice organization (IPO). This is a stronger, more tightly managed version of the current independent practice organization, which was formed initially to compete with multi-specialty group practices. The IPO model would have currently independent physician practices form an organization to receive payment and dispense monies to the practices and other providers such as hospitals.

All of these entities would be accountable for the quality of care delivered, presumably to an enrolled population, although SC are not completely clear on that point. SC's main interest, however, is the several barriers in the way of converting the existing delivery system to greater reliance on ASCs, and I would emphasize two on their list: 1) the lack of or misalignment of incentives to motivate change; and 2) the culture of individual physician autonomy.

Incentives

SC's discussion of incentives is brief, just three sentences, the substance being mainly a reference to bundled or capitated payment. (Perhaps this discussion is so brief because incentives are to be covered by Hal Luft; I do not know.) But the financial arrangements are key. As noted, two or maybe three of the five models now exist in the sense that they receive funds for all, or almost all, medical services, the multi-specialty group practice and the health plan-provider network. Conditional on the current payment system, it is hard to imagine the other models flourishing. All of them require that many physicians and potentially several hospitals pool financial interests, which is unlikely to happen unless the various parties all perceive gains from doing so that are likely to persist over time. At a minimum there are initial capital costs to set up the entities that need to be recovered.

For there to be financial gains to all the parties involved relative to their current positions, there would either have to be a better product at the same cost that would be recognized by the market in its pricing or cheaper production of the same set of services (or both). If there were no competition among the ASCs in a given community, the first alternative, no cost reduction to any provider, would necessarily involve spending more money on the same providers now present in the community; otherwise there could be no

financial gains for all the parties. This case seems particularly applicable to an IPO in a small market with a providers included.

In the case of the hospital medical staff and PHO models, one would have to imagine either that the new ACS could attract sufficient new business to make an additional profit, perhaps analogous to the Japanese automakers entering the US market in the 1980s with a better product than Detroit was offering, or that they could produce the product for their existing patient base at a sufficiently lower cost to cover start up costs while maintaining their current reimbursement levels.

Cheaper production at first blush seems like a more likely scenario because of the non-trivial amounts of over use, at least in some areas (Fisher et al. 2003b; Fisher et al. 2003a). Reducing production cost implies reducing either some providers' revenues or excluding higher cost producers of the service. But the medical staff model would seem to preclude reducing any existing provider's revenue since those with reduced revenues would simply opt out. Even the PHO or the IPO models, which allow for exclusion, could founder on the market power of some providers.

The market power of providers is demonstrated by experience with hospitals and health plans in small markets. For example, rural hospitals have the highest reported margins of all types of hospitals (Medicare Payment Advisory Commission 2006). And the increased Medicare health plan payments in rural areas that began in 1998 have been largely unsuccessful in luring plans to rural areas, at least health plans of the HMO variety. I think this is because the health plans realized that the market power of providers in those areas meant the local providers would appropriate the additional monies and foreseeing that did not enter.

Even in larger markets providers may be able to consolidate or differentiate themselves sufficiently to maintain market power. For example, in Boston it appears impossible to have a successful health plan without the Partners Health Care System in the network. More generally, health plan networks are now generally inclusive, probably because individuals do not wish to change providers and a limited network would force some new enrollees to change. Thus, in practice the ability of a PHO to exclude may be more limited than it seems.

The one example I can think of that supports a variant of either the PHO or IPO model is the large physician group in California that accepts risk contracts from health plans. Although I am not sure this is the model SC have in mind by a PHO, it is close enough that arguably three of the SC models now exist. As is well known, the physician group taking risk contracts has had a somewhat checkered history in California, but it clearly persists. It has not to my knowledge, however, spread outside California, which suggests some important barrier. Some PHOs did arise in a number of communities outside California perhaps a decade ago, but to my knowledge they have not flourished and are not now a prominent part of the national landscape. My take is that they could not sufficiently improve the product so as to attract additional patients or obtain a higher

price from their existing patients. In many cases they took risk contracts and could not earn sufficient returns from them.

In sum, then, other than the large physician group in California that takes delegated risk, the only two of the five SC models that now exist are the multi-specialty group practice model and the health plan model. As a result, I am skeptical that there is a business case for the other entities given the current payment or reimbursement system.

The multi-specialty group practice models that SC cite are clearly well established. The problem with using them as a model for large scale delivery system reform is that they have not much expanded, even in their local markets (in some cases such as Geisinger this is undoubtedly a ceiling effect), and their efforts to expand geographically have been limited and often unsuccessful. In particular, Kaiser has largely not been able to expand past its West Coast base. The Mayo Clinic expanded to Phoenix and Jacksonville several years ago, but has not expanded past those two cities. Harvard Community Health Plan in Boston essentially gave up its staff model HMO organization and merged with another plan some fifteen years ago in order to compete in the Boston market.

Moreover, the existing multi-specialty group practices to my knowledge are either not-for-profit or are physician partnerships. For profit entities probably are at an advantage in raising start up capital, but whether for profit entities could legally enter and, if they could, whether they would succeed in the market is problematic. As a result, my overall conclusion is that multi-specialty group practices have a real but limited market. It is hard for me to imagine that they will anytime soon achieve a dominant national market share.

These entities could, however, potentially influence other parts of the delivery system, but it is not clear to me that there has been a marked spillover from these entities to the rest of the local delivery system (excepting those cases where these entities essentially are the local delivery system such as the Mayo Clinic in Olmsted County). One might treat the existence of the large physician groups in California that accept delegated risk as a response to Kaiser, but Kaiser existed for many years before these groups appeared. The classic independent practice organization was initially a response to Kaiser, but it is clear from SC's discussion of the interdependent practice organization that the classic independent practice association is not what they have in mind.

I find the comparison of spillovers with autos striking. Not only did the Japanese market share grow rapidly in the 1970s and 1980s, in spite of federal policies to tamp it down, but American automakers responded by improving their products in ways that I doubt have occurred among the providers in the local markets where the multi-specialty group practices operate. For example, is there any evidence that medical care in Phoenix or Jacksonville became more efficient after Mayo entered?

If the multi-specialty group practice cannot be the foundation of major delivery system reform and three of the other models face large barriers getting off the ground, we

are left with the health plan model. Here I see some modest beginnings at delivery system reform. Some health plans are tiering networks of specialists in ways that include quality as well as price. In practice, quality and price may not be so opposed. Higher quality may mean lower total cost to the health plan or self-insured employer, since better performing physicians and hospitals may lower total cost through less re-work. In addition, many health plans now have made modest beginnings on pay-for-performance contracts, and some large employers are trying to have reward certain dimensions of higher quality through the health plan market, for example Leapfrog and Bridges to Excellence. Disease management and case management have taken hold in the commercial market, and Medicare is running a large scale experiment with them. Other than the recent report of results in the Premier demonstration (Lindenauer et al. 2007), I do not see a lot of evidence either way that these efforts have made substantial improvements in efficiency, but on balance they seem headed in the right direction. That said, the small group and individual markets are largely price driven, and even in the large group market, success is likely to require that some non-trivial number of patients be willing to alter their choice of providers - perhaps encouraged by tiering - in order to provide sufficient financial rewards to motivate the kind of change SC have in mind.

Physician Culture

I agree with SC's assessment that the traditional culture of physician autonomy is an important barrier to change. Its importance was apparent in the initial debates over Medicare. The designers of Medicare had in mind bundling payments for hospital-based radiologists, anesthesiologists, and pathologists (RAPs) with payment to hospitals under Part A (Somers and Somers 1967). The AMA and the RAPs argued that this would infringe their professional autonomy and won the day politically; to this day they are reimbursed with all other physicians under Part B. Though this happened 40 years ago, I suspect it is still relevant, meaning that any kind of mandates that physicians effectively should subcontract with other physicians or with non-physician entities will be strongly resisted politically and are likely not possible.

SC say, and I agree, that comprehensive reform can do little *directly* "to achieve greater balance between individual physician autonomy and the need for greater teamwork…" (their emphasis). But they believe it can have an indirect effect through forming ACSs. Even if this were true, it strikes me as assuming the answer. If ACSs are not about to take over the delivery system without large changes in financing (and the health plan model probably does the least to change the culture of autonomy), then SC seem to be saying that physician culture is not likely to change or will only change slowly. In effect, there is a chicken-and-egg problem.

SC also point to potential changes in physician training as possibly affecting culture, but they do not elaborate on that point, and it is not obvious to me how any such changes would be brought about. In any event, changes in training would surely take many years to have an important effect.

Conclusions on SC

I agree with SC's view that the delivery system falls far short on many performance dimensions and that ACSs are likely necessary to achieve significant gains. I also think their taxonomy of potential ACSs is probably exhaustive. Where I stumble is how to get there from here. In any event, if we are to get there, major changes in financing and reimbursement seem like a necessary condition, which logically leads on to the Luft paper.

Luft

Hal Luft proposes a change in how health care providers are reimbursed. Relative to today's fee-for-service (FFS) system, payments would be bundled to a substantially greater degree and grouped into four broad classes: episodes of major illness (typically involving a hospitalization); routine care for a chronic condition; minor acute care; and preventive services. Although Luft does not spell out details, payment for various conditions and/or type of patient within each of these four classes would presumably vary. Payment would be made to a Care Delivery Team (CDT), which seems to be the next level down from SC's ACSs. In terms of feasibility, many of my comments about SC also apply to Luft. In particular, it is not clear that financial arrangements can be such that all parties on the CDT perceive themselves as gaining nor that physician autonomy will not be a problem.

Although I have a number of somewhat technical issues with what Luft has done, in the large I think he is probably headed in the right direction with his notion of how health care services should be paid for. A key issue that he does not address is the tradeoff between the efficiencies possible with greater bundling and additional possible selection by providers (Newhouse 1996; Newhouse 2002). In short, with heterogeneity across patients within bundled services, for example more and less severely ill patients with the same chronic disease, there are obvious incentives to select against predictably higher cost patients. Very disaggregated fee-for-service payments minimize the selection incentives, whereas greater bundling increases them.

The possibilities for selection lead to the various risk adjustment schemes found in Medicare's payments to health plans and drug plans. But since risk adjustment is imperfect, the optimal payment scheme at either the level of the health plan or the care delivery team is most likely not a purely capitated or pure (very disaggregated) FFS system, but some combination of the two.

Luft's proposals can be seen as one type of combination, but likely something more will be required. Consider, for example, an annual payment for individuals with a given chronic condition, say diabetes mellitus. Clearly individuals vary in their degree of compliance. Although the additional costs of the relatively non-compliant individual may mostly fall into the major illness episode bin and not the routine bin, this is unlikely to be completely the case. If not, the non-compliant patient could be costlier, and the risk adjustment scheme will have difficulty adjusting for that. This example also raises the issue of how easy it will be to distinguish which services go in which bin unless the

chronic illness payments are for a well specified set of services such as two visits per year and any necessary medications. But even the latter bundle raises possible selection issues. For example, suppose a depressed individual does not tolerate a generic anti-depressant well but does respond to a branded anti-depressant. One can tell the same story for a patient with elevated cholesterol. Does the risk adjustment scheme account for the non-tolerance of the generic medication? Further, co-morbidities are likely to complicate matters considerably.

In addition, there is a chicken-and-egg problem here as well. Suppose a private or public insurer wanted to pay in this fashion. The insurer obviously would need care delivery teams to contract with. And, with the exception of the existing multi-specialty physician groups taking a full (perhaps risk adjusted) capitation rate, they are mostly not there. Alternatively, suppose an existing entity wanted to incur the set up costs and be paid in this fashion, it would run the risk that plans would not want to contract with them in this manner.

One response might be for public plans, and in particular Medicare since it is so large, to pay in this fashion. I think there are three problems in doing so. The first is really a corollary of the discussion above on selection versus efficiency. I think we simply do not know the optimal contract, although it is clear that the optimal contract is a function of the ability to risk adjust (with more bundled payments optimal as the ability to risk adjust increases). Since most of the existing risk adjustment work has been done in the context of a monthly capitation, similar work would have to be done within the context of Luft's various bins (e.g., how would payment vary for different chronic diseases?). Risk adjustment would probably be better as the amount of clinical information (e.g., lab values) improves, and one could reasonably expect this will improve as electronic capabilities spread.

The second and related issue is the politics of reimbursement, especially in public plans. Precisely because of the scale of Medicare, even modest changes in reimbursement can cause noticeable levels of redistribution across providers and Congressional districts. For example, it clearly would have been fairer and very likely more efficient to have an increased the number of DRGs because within-DRG variation in spending would be lower and incentives to select would have been less. But for several years Congressional delegations from predominantly rural states have blocked such a change because it would transfer about one percent of revenues away from rural hospitals. (Rural hospitals tended to treat simpler cases within a DRG because more complicated, expensive cases tended to be transferred.) A process has now begun that will increase the number of DRGs modestly and may even substantially increase them (Ginsburg 2006). Nonetheless, it is clear from this experience that Medicare payment methods, once established, are difficult to change.

Finally, Medicare Advantage plans are the entities that could adopt such methods if CDTs existed that wished to contract with them in this fashion. But even if there were, Medicare Advantage enrolls only around 17 percent of beneficiaries nationally, and it is hard to imagine at present that it would ever enroll the majority of beneficiaries, in part

because many beneficiaries like traditional Medicare. But this brings us back to the prior point; at least for the next several years traditional Medicare will be the dominant part of the program, and it is precisely in that part of the program that changing payment methods is most difficult.

What about commercial insurers adopting these payment methods? Again if entities wish to contract with them on this basis, one could imagine that happening. But the large national insurers tend to have modest market shares in most local markets. Thus, if an insurer with say 10 percent of the market offers such a contract, that may be insufficient to stimulate action by the delivery system. The dominant plan in most local markets is typically a Blue Cross plan, but such plans vary considerably across the country in their market shares (e.g., California vs. Rhode Island), and in many markets there is no plan with a majority share.

I would also like to mention some technical issues with Luft's proposal though they do not bear on his central thrust:

1. Luft focuses on the marginal payment level, but the average payment level in general matters as well to the provider (Hodgkin and McGuire 1994). The intuition is that the provider can influence the number of treated cases as well as the intensity of treatment.

2. Not only the provider but also the consumer is affected by conditions away from the margin. Consider the patient with a $1,000 deductible and full insurance above the deductible who is contemplating a $5,000 procedure. The price of this procedure to the consumer is $1,000. Of course, it is $1,000 whether the price is $5,000 or $6,000, but if the value of the procedure to the consumer is only $800, she will not undertake it. For this reason in the RAND Health Insurance Experiment we observed effects of a $1000 stop loss on gross spending up to around $10,000 to $12,000 dollars.

3. Related to the points made above, I think it is an overstatement for Luft to say that FFS assumes that all services provided are necessary or agreed. Partial reliance on FFS could be better than a second best system because of selection, with the first best unattainable.

4. Are preventive services capitated? Such services would seem to be the ideal case for capitation because there is little or no unobserved heterogeneity across patients, but the British National Health Service has gone to fee-for-service payments to increase the use of certain preventive services such as mammograms.

5. As a minor point, would income based subsidies for insurance and premiums replace Medicaid?

6. As another minor point, almost all Medicare patients who are hospitalized pay a fixed dollar deductible (ignoring supplementary insurance); it is only the one percent or so who stay more than 60 days who make a per day payment.

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