

## Perspectives from the Field Interview Series

Interview with Robert Berenson, MD

Institute Fellow, Urban Institute; Former Vice-Chair of MedPAC

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Interviewer: Jane Hyatt Thorpe

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### Questions:

- 1) Please introduce yourself and tell us about your work related to healthcare delivery, quality, and payment?
- 2) What do you see as the most promising efforts to improve health care delivery and reform payment systems?
- 3) Do you think the increasing ability of providers and payers across the care continuum to track and share patient information in a more longitudinal manner using electronic health records and other forms of health information technology will benefit these efforts?
- 4) What are the most significant barriers to achieving the reforms you noted previously?
- 5) In the health policy literature, you've discussed the threat of market consolidation as a (perhaps unintended) consequence of incentives to improve quality and better coordinate care (including incentives to use electronic health records). Can you explain that concern?
- 6) What do you see as the best solution to that problem?
- 7) Can the health care system increase transparency and realize the benefits of greater exchange of health information to support improved quality of care across the care continuum without creating market conditions that drive up prices?

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### Transcript:

#### Question 1

**JHT:** Welcome to the Health Information and the Law Perspectives from the Field interview series. Today, we're speaking with Dr. Robert Berenson, fellow at the Urban Institute and board-certified internist. Welcome, Bob. Thank you so much for joining us today. Would you please tell us a little bit about your work and how it is related to health care quality, delivery, and payment?

**RB:** (Laughing) That's what I do, I work in health care quality, delivery, and payment. I practiced medicine for twenty years but then made the move into policy, and so I spend most of my time analyzing and making recommendations about new payment models, new organizational delivery models, expressing concerns about overly optimistic use of performance measures on quality, but that's what I do, get involved. My major focus is on Medicare because I spent a number of years at CMS in charge of payment policy in Medicare, but a lot of my work extends to private payers, and to some extent, Medicaid as well.

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## Question 2

**JHT:** Wonderful. So you mentioned a lot of the new reforms and efforts working to improve health care delivery and payment systems. What do you see as the most promising efforts to improve health care delivery and payment reform?

**RB:** Well, I think the efforts around setting up accountable care organizations (ACOs), having physicians (with or without hospitals) taking responsibility for quality and prudent spending I think is a very promising development. I do have some concerns that we're not approaching it with the right payment approach, but that gets down in the details. But basically, getting physicians to move from doing services based on fee schedules to actually doing population-based health, meaning trying to preserve and improve the health of the population for which they're responsible, I think, holds great promise.

**JHT:** As a follow-up to that question, you mentioned moving physicians from a fee-based schedule to more of a population health perspective, what do you think are some of the tools that can help physicians move in that direction?

**RB:** Well, there are tools like electronic health records, like more data about performance, but ultimately, I think it's about culture and leadership. I was actually involved as a private physician doing population-based payment 25 years ago, and we didn't have some of the fancy stuff, the tools I guess we'd call them, that we have today and we were able to do it differently. So I actually think getting financial incentives improved and having a commitment to doing things differently is a good part of what needs to happen. The tools become mechanisms to achieve it.

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## Question 3

**JHT:** So, as we know, there have been incentives for using electronic health records and other forms of health information technology, mainly to support providers and payers in sharing information across the care continuum. Do you think continuing to move down that path of enabling providers to share information more broadly within a care team or even externally to a care team will help move toward a more population-based perspective of health care delivery?

**RB:** I think so, but I think people ignore one of the major obstacles to that which is that, for the most part (and since I don't practice, I'm not daily involved with electronic health records), but people tell me

that the vendors have developed software that is so oriented to the documentation requirements for payment under fee-for-service that the real potential of electronic health records is being missed. And here I'm not referring as much to information exchange as the electronic software not emphasizing enough decision support, registry functions, those kinds of things, it's oriented very much towards documentation for the purposes of getting a high level of office-visit payment, that I think that's been missed as an obstacle to the full implementation of electronic health records. It's become sort of a data dump with lots of cut and paste from previous encounters just to justify coding. I've written about this and yet it doesn't get much attention. But I basically agree with you that there is real potential for information exchange. There I would say it's necessary but not sufficient. There have been estimates of savings that would accrue by reducing the redundancy of tests and imaging and minor procedures, but that redundancy will only disappear if we have payment models that give physicians and other clinicians incentives to reduce that redundancy. So the electronic health records and information exchange if properly used would provide the information, but in a fee-for-service system, there's no reason to reduce that redundancy. So, to just repeat the point, I think the electronic health record and health information exchange is necessary but not sufficient to change physician behavior, or I should say, clinician behavior.

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#### **Question 4**

**JHT:** So it sounds like, from your perspective, two of the significant barriers to achieving a more population health-focused perspective of care delivery as well as payment reform are the fact that the electronic health record and perhaps other health information technology solutions aren't necessarily geared towards true care delivery transformation and are more oriented towards the current payment system which then acts as an additional barrier to truly achieving payment reform.

**RB:** Yep, I think that's exactly right

**JHT:** And do you think there are other barriers to achieving these reforms that we've talked about?

**RB:** Well, there's a related barrier that we haven't talked about, which is, taking my premise that the real potential lies in accountable care organizations (ACOs) built on primary care (which is sometimes called patient-centered medical homes), the danger is that instead of achieving efficiency, reducing costs, improving quality, and passing that back to consumers in the form of reduced premiums, that those integrated entities decide to keep the savings for themselves, and by being able to achieve market power to raise prices. So it could well be that the ACO might be more efficient - there are at least theoretically some economies of scale, better access to capital to get better electronic health records and other technologies - but they also have the ability to raise prices on payers, and we've seen evidence of that. We've seen consolidation in the provider market, horizontally, with hospitals forming mega hospital systems, and now through ACOs, we're seeing vertical integration with doctors becoming either employees of the hospitals or part of joint ventures with hospitals. Unfortunately, as long as we have a predominantly fee-for-service system, that results in raising prices and in fact raising the cost of health care rather than reducing it. So we have to move towards integrated care but we also have to address this concern about market power that consolidation and integration produce.

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## Question 5

**JHT:** So it sounds like what you're saying is that the potential for market consolidation that may be happening through the formation of these patient-centered medical homes, accountable care organizations, where physicians are coming together and perhaps taking advantage of the incentives that are available for use of electronic health records as well as these new care delivery models, that there may be some unintended consequences of that, namely raising prices on the consumer. Is that correct?

**RB:** Yeah, I think so. I'm less concerned about medical homes, that primary care practices would have that kind of market power, as I am about integrated hospital/physician organizations or single specialty groups that get market power, but that's the general concern, that this is an unanticipated policy consequence. I'm a little suspicious that some of the hospitals that are employing physicians in the name of forming integrated care to do population health and be more efficient, that that's just the public presentation of what they're doing, and in fact, what they're really doing is just taking advantage of the flaws in the rules around fee-for-service. One of the examples in Medicare and for private payers is that a hospital gets paid about twice as much for the identical service performed in the outpatient department as it would be paid for the service performed in a physician's office. So in some cases, you have the physician who used to be independent now has a plaque on the door saying they're part of the outpatient department. It's in the same location, it's got the same personnel, the services are identical, but now they get twice as much money because there's a facility fee associated with it. So, it is hard and challenging to figure out which hospitals' systems are really developing new models like accountable care organizations with integration to actually change their business practices, change their business model, and which ones are really doing it to just take advantage of flaws in fee-for-service.

**JHT:** Thinking in addition to the payment mechanisms here, particularly fee-for-service, with the formation of accountable care organization and other integrated forms of care, one of the benefits often can be easier sharing of patient information, or access to patient information across the care team. However, on the flip side, thinking from a market perspective, we've seen some instances where the information has been hoarded to maintain market share or patient share, so to speak. Is that something you're encountering in the work that you do as well, seeing the hoarding of information for market power as well?

**RB:** That's interesting. No, I'm not aware of that phenomenon but I don't find it surprising. I do find surprising that some of the IT systems don't talk to each other even when they are from the same vendor. There doesn't seem to be a commitment, as we've proceeded with meaningful use, to actually get information exchanged, but the part about hoarding is not one that I'm aware of.

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## Question 6

**JHT:** Going back to the question dealing with the impact of market consolidation as a consequence of the multitude of incentives that are available, when you're thinking about changes to the fee-for-service system, the underlying payment system, what do you think are some of the best solutions to address payment mechanisms that might break down some of these concerns with market consolidation?

**RB:** Well, this does get into the nitty-gritty of the new payment models. If, in fact, one moved to a payment model that's akin to what used to be called capitation (that's become a dirty word so we don't use it much anymore) but the equivalent of that is, let's say, a percentage of premium deal, where the provider system gets a percentage of the health plan's premium that they're marketing in the marketplace, then there's a counter-incentive against raising prices. That premium is established as a community-wide premium, any health care system that demands higher prices for their services in that thing would be self-defeating, because all they're getting is a percentage of that premium. So that is the kind of payment mechanism that could address pricing. Clearly, the systems that are already getting high prices will resist that. They would much rather have what's currently being used in Medicare and amongst most private payers, which is comparing spending to your historic spending. In other words, taking your historic spending, trending it forward by some inflation factor, and then comparing whether your new spending is more or less than that target. That essentially builds in the pricing distortions that already exist in the marketplace. The point I would want to emphasize here which I haven't done so far is that there are extraordinary pricing differentials that are basically unjustified. This was well documented by the Attorney General of Massachusetts report from 2011, which found that hospital prices varied 100%, 150%, from each other, based not on the quality of care produced, not by the teaching mission, not by socioeconomic factors of the patients, but simply as a function of market power. And so, some hospitals were getting Medicare or a little more than Medicare as their rates, and others were getting 2 times Medicare or even more than that. There has recently been documentation of some hospitals that are getting 500% of Medicare. And what's the justification for that? It's because they can. It's a market negotiation between a health plan and hospital, and in some cases the health plan has no alternative but to use that hospital or health care system, and the result is paying extraordinarily high prices. I guess my point is that this is not an issue that has gotten a lot of attention, and it deserves it. One could ask the question whether not-for-profit hospitals deserve their not-for-profit status if they are able to negotiate payment rates that are exorbitant like that and pay their executives huge salaries, it's not clear what the social benefit is, but that's another issue that one could look at.

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## Question 7

**JHT:** So, you mentioned the Massachusetts Attorney General report that involved greater transparency of price information, there are obviously a lot of efforts underway to increase transparency of price information as well as quality information, and some of these efforts are supported by the exchange of health information to yield this information. Do you think these efforts to continue to increase

transparency of price and quality information will be a benefit, or do you think they will have unintended consequences related to market conditions that are driving up prices?

**RB:** I think both. One of the real values of that transparency is to shine a spotlight on the issue. I think it's embarrassing to a hospital system if that kind of data reveals outrageously high prices at a time when people's premiums are still rising significantly, I think that is useful. At the same time, in terms of actually affecting behavior, there's some reason to believe that when you publicly release hospitals prices (I'm picking on hospitals because that's the easiest area to produce prices and hospitals do represent a significant percentage of health spending), when you produce everyone's prices, the hospitals that have been relatively low-priced look and say "I want what that guy's got!," and in fact, it can have a perverse effect to increase prices. Indeed, the Federal Trade Commission (FTC) says that in some circumstances, not just in health care but across other sectors of the economy, transparency of prices can be anti-competitive. So it's something of a complicated topic. I think that the pressure for transparency is such that we'll go there and then the question is what do we do with those entities whose prices are extraordinarily high. There are probably market-based and regulatory approaches to dealing with that. On the quality side, again, generally, I'm in favor of transparency of information. My concern is that in many important areas of health care delivery, we don't have good measures of quality. I've been concerned and have written about my concern about taking measures that we do have and exaggerating their importance. The most absurd, which is now current law, is that by 2017, CMS (Centers for Medicare and Medicaid Services) will be obligated by law to provide a value-modifier, an index of every physician's value - they're supposed to consider both quality and spending to determine a value index for every physician. Well, it's crazy. We don't have measures that can do that. CMS has to pick a handful of measures, some of which have very little to do with the physician's overall quality, and somehow attribute spending through the whole system to an individual physician and come up with this value index. It's quality measurement run amok! I think there are some good measures and I'm all for publishing those measures but I have great concerns about overdoing or not recognizing the limitations of the quality measures that we now have. In very many important areas, we do not have good measures of quality, so the concern is that we're going to use marginally important ones to fill in the gaps, and that will be very misleading.

**JHT:** Wonderful. Well, we very much appreciate your expertise and the perspectives that you've shared with us today. Thank you!

**RB:** Ok!

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**Further Resources:**

- Urban Institute Health Policy Center
  - [http://www.urban.org/health\\_policy/](http://www.urban.org/health_policy/)
- Health Affairs Blog Posts by Bob Berenson
  - <http://healthaffairs.org/blog/author/berenson/>

- “Grading a Physician’s Value,” New England Journal of Medicine
  - <http://www.nejm.org/doi/full/10.1056/NEJMp1312287>
- Health Information & the Law Resources on Quality Measurement and Reporting
  - <http://www.healthinfolaw.org/topics/65>