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Testimony of Mental Health Legal Advisors Committee Regarding Potential Modification of the 2018 Health Care Cost Growth Benchmark

This testimony is submitted on behalf of Mental Health Legal Advisors Committee (MHLAC), an agency under the Massachusetts Supreme Judicial Court that provides representation to low-income persons with psychiatric challenges. MHLAC also provides information and advice to any Commonwealth resident, including the legislature, other agencies and commissions on mental health legal matters. MHLAC presented oral testimony at the March 8, 2017 benchmark modification hearing.

In considering an appropriate benchmark for growth in healthcare costs, the Health Policy Commission (HPC) looks at potential drivers of costs as well as practices that will reduce healthcare expenditures. MHLAC directs its comments to these factors rather than to the specific level at which HPC should set the benchmark. MHLAC recommendations also pertain to the imposition and enforcement of performance improvement plans for entities that exceed the benchmark. Key points addressed below are:

- Financial incentives to reduce costs often have unintended results and should not be pursued without careful scrutiny and transparency.
- Innovative approaches to health care that are not covered by insurance or included in traditional medical models of care are fundamental to reducing health care costs.
- Health care delivery systems, like integrated care, should not be assumed to be beneficial for all persons or to result in decreased health care expenditures.
- The administrative costs of private insurance should be included in the examination of health care cost drivers.

Financial Incentives

Health care costs obviously can be reduced through the denial by insurers of coverage for medically necessary services and by provider refusal to recommend necessary treatment. In the 1990's, health

maintenance organizations were faulted for doing just this.[1] Of course, the HPC has no interest in reducing costs by reducing quality of care. For this reason, financial incentives which place providers in the place of insurers by giving them financial incentives to cut care should be carefully scrutinized. Unfortunately, most measures of quality, such as hospital readmission rates, are crude.[2]
We cannot depend upon how come measurements to guarantee quality of care.

In addition, even quality-related financial incentives can have ironic results. For example, pay for performance usually results in some improvement, at least temporarily, in the practices for which payment is made. However, studies show that those items not measured or incentivized often experience a decrease in the quality of care, sometimes resulting in an overall reduction in care quality. FN: insert In addition, pay for performance is often instituted at a point in time where the practice being incentivized is being adopted without any bonus payment.

Shifting costs to consumers through mechanisms like tiering of providers are ineffective and counterproductive. People do not shop for healthcare like they shop for appliances; much more is at stake, the need for the service is often immediate. This precludes leisurely shopping. A patient in this position is not emotionally or physically able to undertake the research necessary. Considerations about choice of provider are complex. And fundamental information, like the financial incentives under which the healthcare provider operates, is not public information.

Similarly, increased co-pays or deductibles for certain medications and services have been found to result in avoidance of medically necessary care or "non-compliance" with physician recommendations.[3] For instance, the elderly cut their medications in half to make them last longer. The ultimate result is not higher quality care or even lower cost care, rather it is low-income people ending up in the hospital or with more serious illnesses that require treatment, thus *increasing* morbidity, mortality, and costs.

For a full discussion of the unintended results of alternative payment arrangements, please see the attached MHLAC white paper, "The Unintended Results of Payment Reform."

Innovative Services

Instead of relying upon alternative payment arrangements which are reminiscent of managed care of years gone by or shifting costs to consumers, innovate to approaches to healthcare must supplement

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[1] *See, e.g.,* Jacqueline Kosecoff et al., *Prospective Payment System and Impairment at Discharge: The "Quicker-and-Sicker" Story Revisited,* 264 J. AM. MED. ASS'N. 1980 (1990). In a study with a sample size of over 10,000 patients, in which the hospitals were paid a fixed amount per patient rather than being reimbursed based on the patient's actual cost of care, the patients were repeatedly discharged sooner and in less stable condition. *Id.* "[O]ne (17%) of six patients was discharged with at least one instability, two (39%) of five patients . . . [had] at least one measure of sickness, and one (24%) of four patients had an abnormal last laboratory [test result]." *Id.* at 1980-81.

[2] Hospital readmission rates can be kept low simply by denying readmission or coverage of readmission. Furthermore, certain mental health conditions do not necessarily result in admissions or readmission. An individual with such conditions may instead become homeless or incarcerated.

[3] *See*, J. Piette, et al., Cost-Related Medication Underuse Among Chronically Ill Adults, 94 Am. J. Pub. Health 1782 (2004); B. Briesacher, et al., *Patients at Risk for Cost-Related Medication Nonadherence*, 22 J. Gen. Intern. Med. 864 (2007) (Up to 32% of elderly take less medication than prescribed to avoid costs). Research has established consistent links between medication nonadherence due to costs and financial burden, and to symptoms of depression and heavy disease burden.)

and replace our limited medical model approach to illness and recovery. We cannot possibly save any substantial amounts on health care by doing the "same old, same old."

This is particularly true with our approach to behavioral health care. A good beginning point to reform health care practices would be to ask the recipients of behavioral health services what services they think are helpful. One example of such a service is peer respite. Peer respite is a safe haven for people experiencing psychiatric crises. It is run by persons who have had psychiatric challenges, i.e., peers. Many people with psychiatric challenges would prefer peer respite over an emergency room or a psychiatric inpatient facility. Although DMH Commissioner Joan Mikula has spoken favorably of peer respites' efficacy, only one peer respite exists in Massachusetts[4] and, as a rule, peer respite is not covered by insurance. This is absurd as peer respite is considerably less expensive than inpatient hospitalization.

Service animals are another tool that could be used to reduce healthcare expenditures, including medication expenditures which the HPC report on health care expenditures notes is a significant cost drive. The former Chief Medical Director of the District of Columbia's Department of Mental Health, Colonel (Ret.) Elspeth Cameron Ritchie, M.D., attests that when persons with posttraumatic stress disorder are given service dogs, they frequently are able to successfully discontinue medication.[5] Again, despite the abundance of evidence supporting the efficacy of pet therapy and service animals for mental health conditions (see list of studies accompanying this testimony), insurers generally refuse to cover their provision.

"Housing First" is another approach that is under-utilized because it does not fit into the traditional medical model of healthcare.[6] It is based on the premise that the physical and mental health care needs of the homeless cannot be addressed in till they are provided a home. Instead of requiring sobriety or compliance with medication to obtain an apartment, the homeless individual is provided a place to live and must only abide by the requirements of any tenant: do not disturb the neighbors and do not destroy the premises. Several cities that have instituted this program have realized significant reductions in overall expenditures, including the cost of housing.[7] Nevertheless, once again, health insurers and provider organizations do not regularly cover, contribute to the funding of, or offer these services.

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[4] "Afiya is located in a residential neighborhood in Northampton, Massachusetts and is central to a variety of community resources. It is available to anyone ages 18 and older who is experiencing distress and feels they would benefit from being in a short-term, 24-hour peer-supported environment with others who have 'been there.' Typical stays at Afiya range from one to seven days." http://www.westernmassrlc.org/afiya (last accessed 3/8/2017).

[5] Presentation of Col. (Ret.) Ritchie, M.D. at MHLAC training held Nov. 15, 2016, Massachusetts Continuing Legal Education, Boston, MA.

[6] Local pilots exist in Massachusetts. See, Boston Public Health Commission's description of their program at http://www.bphc.org/whatwedo/homelessness/homeless-services/Pages/Housing-First-Initiative.aspx , as well as http://www.fobh.org/what-we-support/housing-first/ .

[7] The costs of homelessness include hefty health care costs, leading Denver's Housing First Program, Road to Home, to link funding through government and private entities.

> Detox admissions for homeless substance abusers fall 84 percent when they are targeted for housing and services, said Jamie Van Leeuwen, a Denver Department of Human Services official who is manager of Denver's Road Home. Those homeless were each averaging 70 detox admissions a year, which means the savings are substantial.

M. Booth, *Four years into a 10-year plan to end homelessness in Denver, the mayor cites the cost savings as 1,500 units have opened up*, Denver Post (May 15, 2009, updated May 6, 2016). The cost of homelessness bears directly

Another healthcare approach that reduces healthcare expenditures involves do use of either peer support or home companions to encourage persons to exercise. We have an obesity epidemic in this country, which results in numerous conditions like diabetes, heart disease, and joint issues. Exercise has been identified as a key component to improving health generally. In fact, exercise is sometimes identified as the most promising approach to dealing with a mental or medical condition. For example, the medication used to treat dementia is extremely expensive and has very modest, if any, success. Exercise, on the other hand, has been shown to reduce the likelihood of an progress of dementia. Yet, at most, most physicians will make a recommendation for exercise in passing. We know from our own experience or the experience of our loved ones and friends, that a physician recommendation to exercise, without more, will not inspire action. Home companions and peer support can result in this recommendation's effectuation. Home companions and peer support are far less expensive over time than hospitalization and treatment for cardiac conditions or problems due to dementia and are clearly less expensive than nursing homes.

When considering performance improvement plans, MHLAC suggests that whether or not innovative services such as those listed above and others are being provided or covered.

Health Care Delivery Systems

Some tout evidence-based services, resulting in the disregard of promising practice-based approaches which do not have behind them the same powerful financial interests that can undertake extensive studies. On the other hand, the structure of financial incentives and their efficacy in reducing cost AND improving care or not required to meet the same evidenced-based tests. In addition to the problems with pay-for-performance noted above, integration of physical and mental health services have been promoted without the attention to critical evidence.[8] The healthcare of persons with psychiatric diagnoses does not necessarily improve if a person's mental health and physical health providers share information. This is due to the stigma associated with psychiatric diagnoses and the problem of diagnostic overshadowing, where in a person's physical symptoms are attributed to mental health issues

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on health care costs and health care entities and insurers should participate monetarily as it is in their self interest to reduce health care expenditures.

> Living on the streets isn't cheap: Each chronically homeless person in Central Florida costs the community roughly $31,000 a year...The price tag covers the salaries of law-enforcement officers to arrest and transport homeless individuals —largely for nonviolent offenses ... —as well as the cost of jail stays, emergency-room visits and hospitalization for medical and psychiatric issues. In contrast, providing the chronically homeless with permanent housing and case managers ... about $10,000 per person per year, saving taxpayers millions of dollars during the next decade....The findings are part of an independent economic impact analysis....
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> "The numbers are stunning," said the [Florida] homeless commission's CEO, Andrae Bailey. "Our community will spend nearly half a billion dollars [on the chronically homeless], and at the end of the decade, these people will still be homeless. It doesn't make moral sense, and now we know it doesn't make financial sense."

K. Santich, *Cost of Homelessness in Central Florida? $31K Per Person,* Orlando Sentinel (May 21, 2014). In Denver, the estimate of savings ran about $23,000 per homeless person. M.Booth, *Ibid.*

[8] Studies show very variable results from the integration of mental and physical health care, both in terms of cost savings and quality. In those studies where improvements are seen, the improvements result from the addition of added resources or from other factors not related to integration per se. For more information, please contact Susan Fendell at Mental Health Legal Advisors Committee.

if the person has a history of mental illness or treatment. Attached is a white paper on this issue entitled "EHR: Healthy for Whom?," which details the impact sharing of physical and mental health information can have on the physical health care provided to persons with psychiatric diagnoses.

Administrative costs

The cost of payment systems should be included in evaluating cost drivers, as noted by Dr. Berwick at the March 8, 2017 HPC hearing. The cost of private insurance as compared to a public model is important to investigate,[9] as some estimates of the additional administrative costs of privatized health care run as high as 46%.[10] Other models of health care delivery permit costs reductions without directing these budget cutting efforts at denying care or shifting costs to patients:

> The lessons of Canadian national health insurance are as straightforward as they are neglected. Having a single government-operated insurance plan greatly reduces administrative costs and complexity. It concentrates purchasing power to reduce prices, enables budgetary control over health spending, and guarantees all legal residents, regardless of age, health status, income, or occupation, coverage for core medical services. Canadian Medicare charges patients no copayments or deductibles for hospital or physician services. Controlling medical spending does not, the Canadian experience demonstrates, require cost sharing that deters utilization.[11]

While such a single-payer solution may not be politically viable at this moment in time, it is important that *all* the drivers of health care costs be examined and on public display. This examination is within the purview of the HPC .

Conclusion

In performing its function to lower health care spending growth, HPC should always be cognizant utilization itself does not necessarily drive costs. Financial incentives that reduce medically necessary care in the short-term often result in higher medical expenses in the long-term or a reduction in the quality of care and quality of life for Massachusetts residents. Rather, HPC should encourage through performance improvement plans the use of innovative services and practices by expanding the overly-narrow definition of what constitutes medical care. Finally,we recommend that the HPC scrutinize claims made about the quality and costs of delivery systems and the contribution of administrative costs to overall healthcare expenditures.

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[9] See, e.g., M. Robinson, *Universal Healthcare Coverage Around the Globe: Time to Bring It to the United States?,* J. Health Care Finance at 1-10 (Winter 2016).

[10] S. Woolhandler and D. Himmelstein, *Single-Payer Reform*, Annals of Intern. Med. at 1 (Feb. 21, 2017).

[11] J. Oberlander, *The Virtues and Vices of Singer Payer Health Care*, 374 N. Engl. J. Med. 1401, 1402 (2016)(citations omitted).

MHLAC looks forward to working with the HPC in helping the Commonwealth reach the goal affordable high quality care .

Sincerely,

Susan Fendell, Esq

Susan Fendell
Senior Attorney

Attachments

The Unintended Results of Payment Reform

Susan Fendell, Esq.[*]

Reform of how healthcare is delivered, whether through state or federal initiatives, insurer protocols, or provider action, is proceeding rapidly and with insufficient attention to how it affects the recipients of health care. The motivation for health care reform is primarily to control health care costs, and secondarily to improve quality of care. Healthcare reform often relies heavily on financial incentives, and policy makers have repeatedly touted the efficacy of electronic health records. Financial incentives and electronic health records produce unintended results that may be detrimental to patients, and persons with psychiatric challenges in particular. This paper examines some of the pitfalls of payment reform and electronic health records.

Financial incentives

Healthcare is moving away from fee-for-service and towards a system of capitation and risk sharing.[1] Experiments with financial incentive systems, such as global capitation, bonus payments, and profit-sharing, are being promoted as a means to decrease the cost of healthcare while increasing the quality of healthcare.[2] Individual providers or provider groups receive financial incentives for: reduction of medication costs, sometimes through the use of formularies or protocols that favor lower cost drugs; reduction of imaging and laboratory services; reduction of frequency or length of services; reduction in the recommendation or authorization of certain other types of

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[*] Susan Fendell is Senior Attorney at Mental Health Legal Advisors Committee (MHLAC), a state agency within the Supreme Judicial Court. This article is an updated version of a portion of her article that appeared in the *Journal of Health & Biomedical Law*.

[1] *See* Robert A. Berenson et al, *US Approaches to Physician Payment: The Deconstruction of Primary Care*, 25 J. GEN. INTERN. MED. 613 (2010) (outlining why fee-for-service reform is needed to support primary care in the patient-centered medical home).

[2] Harold D. Miller, *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform,* The Commonwealth Fund (Sept. 2007).

services; reduction of referrals to specialists; overall reduction in practice/entity costs; increases in the number of patients seen by each clinician (panel size); increase in favorable outcomes; execution of particular processes (pay for performance); and providing lower cost equipment.[3] Accountable Care Organizations (hereinafter "ACOs"), which have garnered much attention in recent years, use many of these financial incentives.[4]

ACOs and other risk-bearing organizations often trill about efficiency, quality and the freedom to innovate allegedly provided by the new payment arrangements.[5] These same proponents fail to address the practical implications of these measures for patients. These financial incentives are questionable with respect to their ability to control costs, allocation of resources, quality of care, adequacy of care, innovation in treatment, access to care, and cherry-picking of patients.[6]

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[3] *See* Lori Melichar, *The Effect of Reimbursement on Medical Decision Making: Do Physicians Alter Treatment in Response to Managed Care Incentive*, 28 J HEALTH ECON 902 (Mar. 28 2009) (stating MCO physicians reducing the number of procedures to patients increase income). Studies show physicians spend less time with their capitated patients than with their non-capitated patients. *See also Lower Costs, Better Care: Reforming Our Health Care Delivery System*, CENTERS FOR MEDICARE & MEDICAID SERVICE (January 30, 2014), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2014-Fact-sheets-items/2014-01-30-03.html. The Affordable Care Act also aims to end fraudulent attainment of coverage to limit costs of health care for all. *Id*. *See, e.g.*, Robert Seifert and Rachel Gershon, *Chapter 224 of the Acts of 2012: Implications for MassHealth*, MASS. MEDICAID POL. INST. (Sept 2012). Chapter 224 provides financial incentives for providers to accept MassHealth payment from alternative payment methodologies. *See also* Dennis Domrzalski, *UnitedHealthcare Steps Up its Move Away From Fee-For-Service Model*, BIZJOURNALS.COM (Jul. 10, 2013, 9:34 a.m.), http://www.bizjournals.com/albuquerque/news/2013/07/10/unitedhealthcare-less-fee-for-service.html. UnitedHealthcare announced an increase in bundled payments to providers from $20 billion to $50 billion. *Id.*

[4] Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 Health Affairs 32 (2011) (outlining ACOs and the financial incentives to reduce Medicare Costs).

[5] *More Partnerships between doctors and hospitals strengthen coordinated care for Medicare beneficiaries*, CENTERS FOR MEDICARE & MEDICAID SERVS. (2013), *available at* http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-12-23.html (touting ACO benefits of lower costs and increases in quality and efficiency).

[6] *See infra* note 7 and accompanying text. See L. Page, *Why 'Cherry-Picking' Patients Is Gaining Ground*, Medscape, Dec. 19, 2013.

The primary driver behind payment reform is to lower costs. Although in the short-term these incentives appear to cut costs, in reality unintended health related consequences result in higher expenditures.[7] For example, shorter hospital stays, while less costly up front, are more likely to result in complications, which ultimately are more expensive.[8]

Additionally, many existing health care costs are due to administrative expenses, which are unlikely to be reduced or impacted by these financial incentives.[9] Some provider groups relish the idea of eliminating the administrative cost of dealing with insurance companies. In reality though, many of these financial incentives, such as

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[7] Paul Glasziou, et. al. *When financial incentives do more good than harm: a checklis*t, BMJ (Aug. 14, 2012). The literature indicating the efficacy of financial incentives ignores alternative explanations for the positive results found. *See* Robert Coates, *The New Jersey Gainsharing Experience*, PHYSICIAN EXEC. J. (Jan./Feb. 2014), *available at* http://www.acpe.org/docs/default-source/pej-archives-2014/the-new-jersey-gainsharing-experience.pdf?sfvrsn=4. One article that reported cost savings from gainsharing incentives noted, "Many of the cost-saving measures that we used to succeed in gainsharing were expansions of programs that we had already instituted in an effort to save costs. Therefore it is hard to say to what extent the program, by itself, led to the cost savings." *Id.* Gainsharing programs give doctors a financial incentive to decrease the use of specific medical devices and supplies, switch to specific products that are less expensive, or adopt certain clinical practices or protocols that reduce costs by giving them a portion of any savings attributable to the doctors' activities. W.P. Carey Sch. of Bus., *Gainsharing in Health Care: Cost-Saving Kick Start...or Kickback?*, KNOWWPC (Nov. 23, 2005) *http://knowwpcarey.com/article.cfm?aid=864*.

[8] *See generally*, Sunil Eappen, et. al. *Relationship between occurrence of surgical complications and hospital finances*, 309 J. AM. MED. ASS'N. 1599 (2013).

[9] *See* Palmer Evans, M.D. and Steven Hester, M.D., *Addresses at the Massachusetts Health Care Forum: Accountable Health Care Delivery-Models and Policy Actions for Massachusetts* (Nov. 30, 2010) available at http://masshealthpolicyforum.brandeis.edu/forums/forum-pages/AccountableHealthCareDelivery.html. Such administrative costs included "huge executive salaries, fancy office buildings, and layers of bureaucracy to micro-manage doctors and argue with providers to deny or delay payments." *Id.* There is not much reason to believe that ACOs, run by corporate entities, will behave differently from HMOs. *Id.* Even not-for-profit HMOs exhibited the "arrogance and unaccountability, typical of large insurance companies, towards health care providers and enrollees" *Id.* Running an ACO requires formidable investment in technology and administration to ensure that the ACO remains financially viable. *Id*. *See also*, Robert Calandra, *The ACO Gamble*, Managed Care (June 2015) available at http://www.managedcaremag.com/archives/2015/6/aco-gamble (average start-up cost for an ACO is $2 million; average operating costs in subsequent years is $1.5 million).

global capitation, may actually increase a provider's administrative costs.[10] Recent evidence suggests that financial incentives are ineffective at limiting health care costs because physicians ignore those that do not provide a hefty enough financial incentive.[11] A survey of studies on doctors given financial incentives to increase preventive care yielded mixed results, leading to the conclusion that the incentives were not large enough to motivate the necessary provision of services.[12] The cost of "effective" financial incentives thus counterbalances any savings that might be achieved.

In addition to lowering costs, financial incentives are purported to increase the quality of care that patients receive, though few studies provide informative findings of explicit links between the quality of care and financial incentives for providers.[13] The

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[10] *See* Samuel H. Zuvekas & Joel W. Cohen, *Paying Physicians by Capitation: Is the Past Now Prologue?* 9 HEALTH AFFAIRS 1661, 1664 (2010) (discussing recent history of capitation and implementation on current payment reform measures). From 1980 to 2007, "[H]MOs may also have abandoned provider capitation because of the administrative complexity of calculating and negotiating capitation rates, and because capitation might not have delivered on its promise of cost containment." *Id. See also Capitation and Risk Contracting Survey*, AM. MED. GRP. ASS'N. 1, 11 (2008), http://amcp.org/WorkArea/DownloadAsset.aspx?id=11758 (last visited May 18, 2014). One survey of providers participating in capitated arrangements found that over half of those providers had a department dedicated to reconciling and administering risk pools and settlements. *Id.* The survey concluded that such risk contracts required "significant investment" in contract administration and oversight. *Id*. at 30.

[11] *See* Lauren A. Petersen et al., *Does Pay-for-Performance Improve the Quality of Health Care?* 145 ANNALS OF INTERNAL MED. 265, 269 (2006) (reviewing studies on outcomes of physician capitation plans). *See* Anthony Scott et al., *The effect of financial incentives on the quality of health care provided by primary care physicians*, 9 COCHRANE COLLECTION 1, 21 (2011) (noting physicians' contracting decisions with health plan may be dependent on existence of financial incentive). The survey review focused exclusively on primary care physicians. *Id.* at 2.

[12] *See* Robert Towns, et al., *Economic Incentives and Physicians' Delivery of Preventive Care: A Systematic Review*, 28 AM. J. OF PREVENTATIVE MED. 234, 234 (2005). Six studies that met the inclusion criteria were identified, which generated eight different findings. *Id.* The literature is sparse. *Id.* Of the eight financial interventions reviewed, only one led to a significantly greater provision of preventive services. *Id.* The lack of a significant relationship does not necessarily imply that financial incentives cannot motivate physicians to provide more preventive care. *Id.*

[13] Petersen, *supra* note 11, at 270. Financial incentives may over or under reward providers. *See Id.* at 269-70. Additionally, the design of the incentive can sometimes cause ambiguity in that the measures do not take into account factors outside the control of the incentivized party. *See, e.g.*, Molly Doyle and Elyse Pegler, *Medicare Advantage Star Ratings: Where Do We Go From Here?*, HEALTH DIALOG (Sept 2010), *available at* http://www.healthdialog.com/Libraries/Research_Documents/Medicare_Advantage_Star_Ratings.sflb.ashx (illustrating that location of the provider as a factor outside the control of the incentivized party). "Success with a measure such as 'Ease of Getting Needed Care and Seeing Specialists' is more challenging for plans

studies that found financial incentives improve quality often ignore data manipulation by providers, who seemingly demonstrate high levels of success through selection bias and choosing participants who best fit the study.[14] Additionally, patients requiring services that fall outside the clinical targets could be adversely affected if practices devote all of their efforts to meeting the goals for the target population.[15]

While the efficacy of many of these financial incentives has been called into question generally, incentives tend to have a greater negative effect on vulnerable populations, and especially on persons with mental illness. The following sections will discuss several financial incentives often implemented to reduce costs and improve

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serving rural and poorer areas with fewer primary care physicians and specialists." *Id.* at *5. G. Flodgren, et al. *An overview of reviews evaluating the effectiveness of financial incentives in changing healthcare professional behaviours and patient outcomes,* THE COCHRANE LIBRARY 2011, Issue 7. Art. No.: CD009255. (July 2011) (noting "[w]e found no evidence from reviews that examined the effect of financial incentives on patient outcomes"). For example, quality improvement initiatives were instituted prior to the adoption of the incentive scheme being studied. "Evidence suggests that quality for some aspects of care was already improving before 2004, and could have been approaching its achievable limit in affluent areas, which would mean that the incentive scheme was introduced at a time when inequalities had already peaked." *See* T. Doran, et al., *Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework*, 372 LANCET 728-736 (2008). The evidence regarding quality improvements is mixed, with some studies showing financial incentives neither lower nor improve quality of care. *See id.*

[14] Doran, *supra* note 13, at 728-736. Providers reporting high levels of achievement create a façade of improvement. *Id.*

> [T]he results assume consistent and accurate recording of activity by practices, which were given a financial incentive to report high levels of achievement. Improvements might have been stimulated by over-reporting numerators –e.g. by claiming a missed target had been achieved – or by under-reporting denominators – e.g. by inappropriately excluding difficult patients or excluding them from disease registers.

Id. At the same time, the performance based contracting system might cause some unintended provider behavior such as misreporting, which could make performance look better without actually improving the treatment quality. Y. Shen, *Selection Incentives in a Performance□Based Contracting System*, 38 HEALTH SERV'S RESEARCH 535, 536 (2003). A different study noted that there can be a substantial risk of bias in most studies, because many do not address the issues of selection bias as a result of the ability of primary care physicians to select into or out of the incentive scheme or health plan. S. Sivey, et. al, *The effect of financial incentives on the quality of health care provided by primary care physicians*, THE COCHRANE LIBRARY 2011, Issue 9; 12 (2011).

[15] Doran, *supra* note 13, at 735. "[T]he activities we assessed were mainly concerned with secondary prevention in people with existing chronic disease, and inequalities could have widened for activities that were not subject to an incentive, especially in practices that were devoting all their efforts to meeting the targets." *Id*.

quality of care and examine the disparately negative impacts of these measures on individuals with psychiatric challenges.

Capitation

Though capitation payment systems have existed since the 1930s, the movement to shift the financial risk to health care clinicians is relatively new.[16] Under traditional fee-for-service, payments are made to providers for each service provided. However, under global capitation, ACOs are paid a flat fee per patient, thus placing financial risk on ACOs and their providers to control costs.[17] The shifting of financial risk of providing care to clinicians is allegedly moderated where the clinician or ACO is responsible for the full range of outpatient and inpatient services.[18] The incentive, however, is to provide just enough care to obviate the need for more costly interventions.[19] Capitation "essentially turns the doctor into an insurance company, often without adequate actuarial spreading of the risk."[20] Therefore, the more treatment the doctor withholds, the more money he or she earns.[21] In terms of the ethical implications

[16] *See* Mark Hagland, *How Does Your Doctor Get Paid? The Controversy Over Capitation*, PBS FRONTLINE (May 11, 2014), *available at* http://www.pbs.org/wgbh/pages/frontline/shows/doctor/care/capitation.html (discussing the differences and controversies between fee-for-service and capitation payment systems).

[17] *Id*. Bundled payments and global capitation shift the financial risk of providing care to the providers because the providers' income is dependent upon reducing their cost to provide health care below the capitated payment amount. Even ACOs that reimburse some of their providers on a fee-for-service basis are able to limit care with methods formerly used by managed organizations: financial incentives to "gatekeepers," cash bonuses, threat of expulsion from the network, fee "withholds," contract limitations, the delay of authorization for treatment, and utilization review. Russ Herman, et. al., Westlaw Database: 5 Litigating Tort Cases § 62:2, HMO Litigation (last updated August 2013). The author has represented clients whose mental health care providers were subjected to onerous utilization reviews, including requests for records dating back for years, because these providers actively participated in the appeal of denial of service authorization.

[18] *See* Herman, *supra* note 17.

[19] *Id*.

[20] MYRNA C. GOLDSTEIN AND MARK A. GOLDSTEIN, CONTROVERSIES IN THE PRACTICE OF MEDICINE, 125, 2001.

[21] *Id*. Because under a capitation system a doctor is paid a flat monthly payment for each patient they see, that doctor is paid the same for a patient who requires four visits a month and a patient who hasn't been to

of capitation, "large [financial] incentives may create conflicts of interest that can in turn compromise clinical objectivity. It is unethical to do unnecessary procedures to reap financial gain and unethical to limit medical care for financial gain."[22] Financial incentives related directly to performance of processes and outcomes do not effectively address this conflict.[23] Ultimately, the conflict between the provider's and the patient's interests could negatively affect the creation and maintenance of therapeutic alliances and the efficacy of care.[24]

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the doctor in years. *Id.* Thus, there is a positive relationship between the treatment the doctor withholds and the money that doctor makes. *Id.* While stop-loss protection or reinsurance may mitigate some of the danger to providers, including small providers, of assuming financial risk, many may not have it. *Id. See* Peter S. Wehrwein, *Reinsurance and Stop-Loss Coverage: Are You on a Firm Footing?*, MANAGEDCAREMAG.COM, http://www.managedcaremag.com/archives/9802/9802.reinsurance.html (last visited May 18, 2014). "A 1995 [American Medical Association survey] . . . [found] that 86 percent of primary care physicians had no reinsurance on any capitated contract" to limit the physician's financial exposure. *Id.*

[22] Robert Kuttner, *Must Good HMOs Go Bad? – The Search for Checks and Balances*, 338 NEW ENG. J. MED. 1635, 1637-38 (1998).

[23] *See* Carine Chaix-Couturier et al., *Effects of Financial Incentives on Medical Practice: Results from a Systematic Review of the Literature and Methodological Issues*, 12 INT'L J. FOR QUALITY IN HEALTH CARE 133, 136-39 (2000). Studies show that any form of capitation decreases the use of services. *Id.* at 139. For instance, total volume of prescriptions decreased by 0-24% and hospital days decreased by up to 80% under a capitation system compared with fee-for-service. *Id.* at 136-37. Little difference could be found in the outcomes of care, except with respect to elderly and poor patients, whose outcomes were better under fee-for-service. *Id. at 137.* Because financial incentives create a conflict of interest between providers seeking revenue and their patients, quality, productivity, and severity of patient adjustments must be made to financial incentives. However, such adjustments can be difficult to make "and have been shown to result in increased inequities between patients." *Id.* at 139.

[24] *See* LAURA THOMPSON & ROSE MCCABE, BMC PSYCHIATRY, THE EFFECT OF CLINICIAN-PATIENT ALLIANCE AND COMMUNICATION ON TREATMENT ADHERENCE IN MENTAL HEALTH CARE: A SYSTEMATIC REVIEW 5-7 (2012). The therapeutic alliance, a strong clinician-patient relationship, is the best predictor of adherence in mental health treatment and good mental health outcomes. *Id.* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. HEALTH POL. POL'Y & L. 661, 680 (1998).

> [While] [m]any . . . regard transfer of financial risk to clinicians as a necessary condition for resource conservation . . . it is hardly clear that the physician's personal remunerative interests should be the main mechanism by which this is achieved. . . . [I]t is equally prudent to avoid incentives that place clinicians at such high personal risk that they must weigh their clinical decisions in terms of their own interests and needs.

Id.

Although capitated payment systems were discredited in the 1980s and 1990s due to their propensity to encourage the denial of medically necessary care, today's ACOs essentially use the same payment methodology.[25] Even with consumer protections, this model has proven problematic as exhibited by similar systems in Europe.[26] The European experiences illustrate the underlying issue with capitation, namely that providers have responded by cutting or reallocating care rather than by controlling care for the purpose of better outcomes.[27]

Specialist services, which are generally more expensive than primary care, are also negatively affected by capitation because doctors in capitated systems feel more pressure to limit referrals, sometimes even compromising patient care.[28] One study that

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[25] Austin Frakt, *Health Care Cost Control is Hard, And Humbling*, KAISER HEALTH NEWS (Nov. 3, 2010), http://www.kaiserhealthnews.org/Columns/2010/November/110310frakt.aspx. *See also* James Roosevelt, Jr., President and Chief Executive Officer, Tufts Health Plan, *Address at Health Law Advocates Law and Policy Forum: The Health Care Cost Containment Law: A first step in controlling costs* (October 18, 2012). As Jim Roosevelt commented, the capitation of today and the capitation of the 1980s and 1990s is the "same thing in essence, hopefully done better." *Id.*

[26] *See* David Mechanic, *The Functions and Limitations of Trust in the Provision of Medical Care*, 23 J. OF HEALTH POL., POL'Y & L. 661, 681 (Aug. 1998). In the United Kingdom, for example, capitation has led to "perverse effects" such as "underprovision of many types of valuable services" and the inappropriate shifting of work (and costs) to entities that were not part of the capitated system. *Id.* The author of the article states, "Money is a significant motivator in most realms of activity and we would do well to link financial incentives more directly to our aspirations for quality improvements." *Id*. However, there is no solid research that shows that paying for quality improvements controls the deleterious effects of capitation. Experience with pay for performance is checkered at best. *See* Jeroen N. Struijs & Caroline A. Baan, *Integrating Care through Bundled Payments – Lessons Learned from the Netherlands*, 364 N. ENGL. J. MED. 990, 990-991 (2011) *available at* http://www.nejm.org/doi/pdf/10.1056/NEJMp1011849. Additionally, from 2007 to 2010, the Dutch system experienced extreme price variations in the amount that capitated care groups were reimbursed for diabetes care bundles. *Id.* This persistence in price variations indicated that insurers were interpreting the Dutch Diabetes Federation Health Care Standard guidelines in ways "to stint in order to contain costs." *Id.*

[27] *See supra* note 26.

[28] *See generally* D. Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 155-197 (1996). A Canadian study of fee-for-service and capitated primary care physicians found fewer referrals to specialists and imaging by the fee-for-service PCPs. Clare Liddy et al., *What is the Impact of Primary Care Model Type On Specialist Referral Rates? A Cross-Sectional Study*,15:22 BMC FAMILY PRACTICE 1, 1-8 (2014), *available at* http://www.biomedcentral.com/1471-2296/15/22. As a result, physicians will keep the patient within their limited knowledge of care and delay the patient from receiving necessary and specialized treatment. *See* E. Pelligrino, *Rationing Health Care: The Ethics of Medical Gatekeeping* 2 J. CONTEMP. H. L. & POL'Y 23, 31 (1986), *available at* http://heinonline.org/HOL/Page?handle=hein.journals/jchlp2&div=6&g_sent=1&collection=journals#37.

examined the practice behavior of primary care physicians indicates that the number of referrals to specialists decreased by eight percent in a physician group under a capitated payment system.[29] Another experiment concluded that physicians choose significantly fewer services under capitation than under fee-for-service.[30] Generally, under capitation systems, doctors discharge patients from the hospital post-surgery "quicker and sicker."[31]

In the case of persons with mental illness, the goal is to prevent hospitalization or acute residential care.[32] However, for this population in particular, avoiding hospitalization, while an admirable goal if appropriately pursued, does not necessarily equate to total wellness. Delayed or denied services or tests may simply result in a longer period of physical or emotional pain and discomfort, but not a worsening of the medical condition itself. A study of six Ohio mental health centers shows a negative correlation between capitation, or capitation-like financing mechanisms, and outcomes for severely mentally ill patients.[33] Outcomes for patients under the capitated system were worse than

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For example, an internist might not consult a cardiologist about a patient with coronary artery disease quickly enough, resulting in exacerbation of the coronary artery disease because of the delay in consultation. *See id.*

[29] T. Godsen, et al., *Capitation, Salary, Fee-For-Service and Mixed Systems of Payment: Effects on the Behavior of Primary Care Physicians (Review)*, COCHRANE DATABASE SYST. REV. (2006). "To date, capitated systems [principally capitated primary care practices] have achieved savings largely by blocking specialist referrals and hospital admissions altogether." Kuttner, *supra* note 22 at 1559.

[30] H. Hennig-Schmidt, R. Selton, & D. Wieson, *How Payment Systems Affect Physicians' Provision Behaviour--An Experimental Investigation,* 30 J. HEALTH ECON. 637 (2011).

[31] *See* Jacqueline Kosecoff et al., *Prospective Payment System and Impairment at Discharge: The "Quicker-and-Sicker" Story Revisited,* 264 J. AM. MED. ASS'N. 1980, 1980 (1990). In a study with a sample size of over 10,000 patients, in which the hospitals were paid a fixed amount per patient rather than being reimbursed based on the patient's actual cost of care, the patients were repeatedly discharged sooner and in less stable condition. *Id.* "[O]ne (17%) of six patients was discharged with at least one instability, two (39%) of five patients . . . [had] at least one measure of sickness, and one (24%) of four patients had an abnormal last laboratory [test result]." *Id.* at 1980-81.

[32] Charles A. Kiesler, *Noninstitutionalization as Potential Public Policy for Mental Patients*, 37 AM. PSYCHOLOGIST 349, 349 (1982).

[33] The study compared a Case Rate Pilot (CRP) group financed by capitation, with a fee-for-service (FFS) group. *See* Mina Chang, et. al., *The Impact of Managed Care: Comparison of Case Rate and Fee-for-Service Financing for Persons With Severe Mental Illness,* MEDSCAPE (2003), *available at* http://www.medscape.com/viewarticle/466934_2.

those within the fee-for-service group. Any improvements observed were only significant for patients in the FFS group. Once the capitated group was discontinued, treatment outcomes for severely mentally ill patients showed improvement.[34] Another study had similar results when the health status outcomes of persons with severe mental illness in managed care organizations financed through capitation and no-risk fee-for-service were compared.[35] These discrepancies are likely attributable to the financial risk capitation imposes on providers, which eliminates incentives for providers to promote preventive services.[36]

In addition, capitation and similar financial incentives can also actually impede the adoption of quality improvements. For example, increasing the use of peer-run mental health alternatives/services or expanding the definition of medically necessary services to include work and supportive services will improve the quality of care. ACOs may be fearful of adopting innovative peer services until they are the routine standard of care and definitively proven to reduce cost.[37] Some criticize ACOs generally for restricting innovation in medicine by limiting entrepreneurial ventures.[38]

Global capitation incentivizes higher patient caseloads, and as caseloads increase, the time that clinicians spend with their patients is reduced.[39] The incentives inherent in

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[34] *Id.*
[35] J.P. Morrissey et al., *Service Use and Health Status of Persons with Severe Mental Illness in Full-Risk and No-Risk Medicaid Programs*, 53 PSYCHIATRIC SERVICES 293, 293-98 (2002).
[36] *See Capitation*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/capitation.page (last visited May 18, 2014) (explaining physicians' assumption of risk in using capitation versus fee-for-service).
[37] Scott Gottlieb, *Accountable Care Organizations: The End of Innovation in Medicine?* AM. ENTER. INST. FOR PUB. POLICY RESEARCH, Health Policy Outlook No. 3 (Feb. 2011), *available at* http://www.aei.org/files/2011/02/16/HPO-2011-03-g.pdf.
[38] *Id*.
[39] *See* AM. MED. ASS'N *supra* note 36 (defining capitation). Under global capitation, physicians are paid on a per patient basis. *See* Hagland, *supra* note 16 (defining and comparing global capitation with other

prepaid plans undoubtedly result in a reduction of time spent with the patient.[40] Additionally, providers are encouraged to schedule patients for returning appointments at extensive intervals, which further delays the patient's care.[41]

The caseload and time impact of incentives is particularly severe for persons with behavioral health issues.[42] For example, under revisions imposed by Massachusetts Medicaid's capitated mental health manager, the time allotted for a standard medical

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physician payment methods). One of the key factors in misdiagnosis and hence malpractice claims is a failure of communication. Hardeep Singh & Saul N. Weingart, *Diagnostic Errors In Ambulatory Care: dimensions and preventive strategies*, 14 ADVANCES IN HEALTH SCI. EDUC. 57–61 (2009) (listing "provider-patient encounter" as first "dimension[] of ambulatory care from which errors may arise"). The time pressures under which clinicians operate in ambulatory settings contribute to this communication issue because of the brevity of a physician-patient encounter in an ambulatory setting. *Id*. In a study that compared high-volume and low-volume physicians, "high-volume physicians had visits that were 30% shorter." S.J. Zyzanski et al., *Trade-offs in High Volume Primary Care Practice*, 46 J. FAM. PRAC. 397-02 (1998). In another study, researchers who analyzed 46,320 doctor-patient visits found that shorter visits are associated with capitation, even after controlling for HMO enrollment status, race, and location. H. Balkrishnan et al., *Capitation Payment, Length of Visit, and Preventive Services*, 8 AM. J. OF MANAGED CARE 332-40 (2002). *See also,* Estella M. Geraghty et al., *Primary Care Visit Length, Quality, and Satisfaction for Standardized Patients with Depression*, 22(12) J. GEN. INTERNAL MED.1641–47 (2007), (practicing in an HMO was one key factor in shorter visits). If high caseloads are the norm, there is a potential for delays in care. *See* Zyznski, *supra* (highlighting relationship between high caseloads and accompanying risk of lower-quality care). If a person must go out-of-network, that diminishes an ACO's controls over cost, which is its primary function. *See* Gottlieb, *supra* note 37 (discussing ACOs in the context of the Patient Protection and Affordable Care Act).

[40] K.B. Wells et al., *Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-For-Service Care*, 262 J. AM. MED. ASS'N 3298 (1989) (explaining that "[prepayment] care [patients] . . . were . . . less likely to have depression detected . . . than . . . fee-for-service [patients]."). *See also* Lori Melichar, *The Effect of Reimbursement on Medical Decision Making: Do Physicians Alter Treatment In Response to a Managed Care Incentive*, 28 J. HEATH ECON. 902 (2009).

[41] D. Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155 (1996). Doctors "may schedule return appointments at intervals between appointments that are too long." *Id*. at 161. Edmund D. Pellegrino, *Rationing Health Care: The Ethics of Medical Gatekeeping*, 2 J. CONTEMP. HEALTH L. & POL'Y 23, 30 (1986) (noting "negative and positive financial incentives" force a physician to "conserve . . . referrals for consultation"). Not surprisingly, high caseloads and the concomitant lack of time to adequately provide services affects quality of care and outcomes. Frank Davidoff, *Time*, 127 ANNALS INTERNAL MED. 483, 483 (1997). Davidoff reports "41% of physicians . . . reported that the amount of time they spent with their patients . . . decreased." *Id*.

[42] Shorter visits with doctors directly affects patients' health. Davidoff, *supra* note 41 at 483. In one study, high-volume doctors had lower up-to-date rates of preventive services, and scheduled one third fewer patients for well care. Zyzanski, *supra* note 39. One study found that drug treatment programs with a lower ratio of counselors to clients are associated with better drug use and crime outcomes. Michael L. Prendergast et al., *Program Factors and Treatment Outcomes in Drug Dependence Treatment*, 35 SUBSTANCE USE & MISUSE, 1931, 1958 (2000). In yet another study, researchers linked shorter visits to lower rates of detection of depressive disorders. Wells, *supra* note 40.

management visit was reduced from 30 minutes to 15 minutes.[43] In this quarter hour, Medicaid recipients must report their current mental health status, including reactions to current medications and personal factors that might be affecting their health.[44] They also must receive information about new medication, how to administer it and potential side effects.[45] This obviously leaves little time for questions or for the patient and provider to develop the sort of relationship that is so important for the successful treatment of persons with psychiatric challenges.[46]

In a capitated system, where prices for an episode of care are fixed or where a provider group is responsible the individual's total care, providers can hold down expenses by "creaming" or "cherry-picking" patients with less severe diseases that require low-cost treatment over "high-cost" patients, in order to contain treatment costs and increase profits.[47] Not only does capitation run the risk of compromising patient care, but it can lead to a denial of access to care because of provider incentive for pre-selection.[48] The impact of this "cherry-picking" can be especially severe for persons with long-standing, severe mental illness whose treatment requirements are often complicated and long-term.

Shared Savings

[43] Mental Health Legal Advisors Comm., *Consumer Control of Mental Health Information*, 6 (Feb. 4, 2013), *available at* http://www.power2u.org/downloads/EHR-Privacy-White-Paper-2.4.13.pdf.
[44] *Id*.
[45] *Id.*
[46] MW.J. Doherty et al., *Levels of Physician Involvement Psychosocial Concerns of Individual Patients: A Developmental Model*, 25 FAM. MED. 337, 337-42 (1993)(explaining practitioners' involvement with patients' psychosocial concerns increased with length of visit).
[47] Chang, *supra* note 33.
[48] *Id.*

Shared savings, an example of an incentive used to cut health care costs, is meant to ensure greater accountability by providers in the delivery of care.[49] With this type of incentive, providers receive a percentage of the costs saved by reducing services, labs, and referrals, utilizing cheaper medical devices, and limiting the doctor's choices for certain clinical products.[50] This type of arrangement most commonly occurs when a target is set for spending and cost savings or overruns relative to the target are shared between the parties, e.g., physician groups and ACOs or managed care organizations and physicians.[51] Shared savings, however, inadvertently threaten a patient's quality of care. In passing the civil monetary penalties statute for health care fraud and abuse, Congress recognized that providing incentives to reduce care was unethical and could lead to reduced quality of care.[52]

Shared-savings incentives may have a plethora of other unintended results, such as encouraging providers to refer patients to low-cost hospitals to receive a percent of the savings or bonuses.[53] These hospitals may or may not be proficient in the care the individual needs. Similarly, less expensive medical devices and services, which frequently are less effective or appropriate for the individual, are used in place of more

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[49] Gail R. Wilensky et al., *Gain Sharing: A Good Concept Getting a Bad Name?*, 26 HEALTH AFFAIRS 58, 58-67 (Dec. 5, 2006), *available at* http://content.healthaffairs.org/content/26/1/w58.full. *But see,* W.P. Carey Sch. of Bus., *supra* note 7.

[50] See *Gainsharing*, MED. DEVICE MANUFACTURERS ASS'N., ,www.medicaldevices.org/?page=gainsharing&terms="gainsharing" (last visited May 18, 2014).

[51] *See* David Muhlestein, *Continued Growth of Private and Public Accountable Care Organizations*, HEALTH AFFAIRS (Feb. 19, 2013), http://healthaffairs.org/blog/2013/02/19/continued-growth-of-public-and-private-accountable-care-organizations/.

[52] *See The Ethics of Health Care Reform: Issues in Emergency-Medicine-An Information Paper*, AM. COLL. OF EMERGENCY PHYSICIANS, http://www.acep.org/Content.aspx?id=80871 (Last visited May 15, 2014) (explaining ethical implications of several provisions of the Patient Protection and Affordable Care Act).

[53] Katherine Ho and Ariel Pakes, *Do Physician Incentives Affect Hospital Choice? A Progress Report*, (Nov. 2010), *available at* http://kebijakankesehatanindonesia.net/sites/default/files/Makalah%20Katherine%20Ho.pdf.

expensive medical devices.[54] Doctors have also often reported feeling that quality of care is comprised due to these incentive systems.[55]

The problem of ineffective low-cost substitutes is especially notable for persons with psychiatric challenges, whose complaints of inefficacy and pain are frequently attributed to their diagnoses. The generic drug Budeprion XL, prescribed in place of the anti-depressant Wellbutrin, provides an apt example of the disparate effect low-cost substitutes can have on individuals with mental illness. The generic, approved by the FDA in 2006, was plagued by complaints. Patients stated that it was not as effective as the name brand, but the FDA ignored those complaints, likely attributing them to the normal ups and downs of depression.[56] It was not until October of 2012, six years after

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[54] *Hearing on Gainsharing*, Subcommittee on Health, Committee on Ways and Means, U.S. House of Rep. at 66-68, (Oct. 7, 2005), *available a*t www.gpo.gov/fdsys/pkg/CHRG-109hhrg26377/html/CHRG-109hhg26377.htm (hereinafter "*Hearing on Gainsharing*"). The Medical Device Manufacturers Association testified that gain sharing promotes higher incidents of medical complications, re-admittance into the hospital, follow-up surgeries, and malpractice liability. *Id*. Thirteen other groups, including the National Mental Health Association and the American Association of People with Disabilities also announced their opposition to gain sharing. *Device Industry Opposes Medical Gainsharing at Hearing*, HCPRO (Oct. 10, 2005), *available at* http://www.hcpro.com/HOM-52204-3587/Device-industry-opposes-medical-gainsharing-at-hearing.html. At the hearing, Congressman Pete Stark commented as follows:

> I recall 20 years ago in this Subcommittee we examined this gain sharing. We called it "kickbacks" in those days. We decided that wasn't such a good idea, to encourage profit sharing at the expense of beneficiaries, taxpayers, because they suffered. When the hospital prospective payment system was implemented, hospitals began enlisting physicians through incentive plans to help contain costs. But this created inducements for the docs to withhold care or create early discharge. We enacted new penalties in Title 9 of the Social Security Act. Bluntly stated, what we are going to talk about today is whether to turn back time [and] allow kickbacks, which will benefit nobody but either the doctor or the hospital, but saves money. The taxpayers, the beneficiaries will suffer.

Hearing on Gainsharing, *supra* at 5.

[55] Kevin Grumbach, et al., *Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems*, 339 NEW ENG. J. MED. 1516, 1516 (1998) (finding 17 percent of doctors believed the pressure of incentive systems compromised patient care).

[56] *See In r*e Budeprion XL Mktg. & Sales Litig., E.D. Pa., No. MDL 2107, 2010 WL 2135625. In 2009 and 2010 a series of class action complaints were brought regarding the efficacy and side effects of Budeprion XL. These cases were consolidated and heard in the Eastern District of Pennsylvania. *Id*. *See also* Meghan M. Grady & Stephen M. Stahl, *A Horse of a Different Color: How Formulation Influences Medication Effects*, 17 CNS SPECTRUMS 63 (2012), *available at*

the introduction of this generic on the market, that the FDA conceded the drug was not the bioequivalent of its name brand.[57]

Performance Incentives (Pay-for-Performance)

Performance incentives, or "Pay-for-Performance," provides higher payments for the execution of certain procedures or achievement of certain outcomes, but are often problematic because of their effect on outcomes or processes that are not incentivized.[58]

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http://onlinedigeditions.com/article/A+Horse+Of+A+Different+Color%3A+How+Formulation+Infl+Uences+Medication+Effects/1120847/119216/article.html. Generic drugs do not always have the same properties as the name brand. *Id*.

[57] *Questions and Answers Regarding Market Withdrawal of Budeprion XL 300 mg Manufactured by Impax and Marketed by Teva*; U.S. FOOD & DRUG ADMIN., http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm322160.htm#q1 (last visited May 18, 2014). The FDA acknowledged that two of the generic substitutions for brand-name extended release methylphenidate (Concerta), used to treat attention deficit disorder, were not necessarily bio-equivalents and could not be automatically substituted for the brand name drug be pharmacies. These generics had been approved 2012 and 2013 as automatic substitutes for Concerta. The FDA altered its position in November 2014. (http://www.fda.gov/Drugs/DrugSafety/ucm422569.htm , last accessed March 24, 2016); Katie Thomas, *Generic Drug, Found Flaw, Still in Use*, NYT (June 17, 2015), at B1. The plaintiffs in a class action lawsuit against a pharmacy that distributed the generics alleges that consumer complaints to the FDA about the effectiveness of the generics began shortly after they were approved by the FDA. http://cookcountyrecord.com/stories/510649346-class-action-alleges-osco-drug-knew-generic-adhd-drugs-they-were-distributing-were-less-effective-than-brand-name-version (last visited March 24, 2016).

[58] *See* Stephen J. Gillam, et al., *Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework: A Systematic Review*, 10 ANN FAM MED. 461, 463 (2012). A recent study found that achievement for conditions outside the incentive worsened relative to those within, and that the person-centered nature of the care and continuity of care generally suffered. *Id.* For example, under the PPACA, Medicare pays Medicare Advantage plans differentially based on performance measures derived from CMS administrative data, HEDIS measured data provided by plans, and beneficiary surveys. *See* Robert A. Berenson, et al., *Achieving the Potential of Health Care Performance Measures*, TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES at 6, (May 2012) *available at* http://www.urban.org/UploadedPDF/412823-Achieving-the-Potential-of-Health-Care-Performance-Measures.pdf.

> [While the measures are broad] there are gaps in important areas of health plan performance, such as the health plan's performance related to patients with acute, serious health care problems (which are obviously common in the Medicare population). For example, none of the measures relate to whether patients are informed about the advisability of referral outside of the MA plan's provider network for patients with unique clinical circumstances, such as particular cancers best cared for in a specialized cancer center.

When reimbursement requires identification of specific diagnoses, providers become too focused on identifying these conditions and ignore other disease areas for which quality is not measured. This process could result in a delayed or missed diagnosis of a disease that could have been prevented or treated earlier.[59]

In the short-run, targeted outcomes like prescribing aspirin for cardiac patients may superficially improve care, but long-term overall quality of care may be negatively affected.[60] One frightening study demonstrated that pay for performance "could end up widening medical disparities experienced by poorer people and those belonging to racial and ethnic minorities" because physicians under pay for performance programs that serve "vulnerable populations would likely receive lower payments than other practices."[61]

Id. *See also Health Policy Brief: Pay-for-Performance*, HEALTH AFFAIRS (Oct. 11, 2012), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78 (describing limited effect of pay-for-performance on quality improvements and concerns about its use).

[59] Sivey, *supra* note 14.

[60] Pay for performance systems are flawed because there is "no consensus about the best way to design a pay for performance program." Melony E. Sorbero, et al., *Assessment of Pay for Performance Options for Medicare Physician Services: Final Report*, RAND CORPORATION, xiv (May 2006), *available at* http://www.rand.org/content/dam/rand/pubs/working_papers/2010/RAND_WR391.pdf. *See also* R.W. Bremer et al., *Pay for Performance in Behavioral Health*, 59 PSYCHIATRIC SERV. 1419, 1427 (December 2008). One study of pay for performance with primary care providers in England found that while the payments accelerated improvements in quality for two of the three chronic conditions targeted, the rate of improvement slowed and the quality of those aspects of care not associated with the incentive actually declined. Campbell et al., *Effects of Pay for Performance on the Quality of Primary Care in England*, 361 New Eng. J. Med. 368 (2009). A RAND corporation literature review found that no literature on pay for performance programs provide a "reliable basis for anticipating [its] effects . . . in Medicare [on] . . . directing financial incentives for health care quality at physicians, physician groups, and/or physician practice sites." Sorbero et al., *supra*. Few studies provide informative findings of explicit links between the quality of care and financial incentives for providers. Petersen, supra note 11, at 270. Some studies were not rigorous enough to draw definitive conclusions from because they were not generalizable, too short in duration, lacked control groups, or had too small of a sample size. R. Adams Dudley, *Pay for Performance Research: How to Learn What Clinicians and Policy Makers Need to Know*, 294 J. AM. MED. ASS'N. 1821-23 (2005).

[61] *Pay-For-Performance Programs May Worsen Medical Disparities in Medical Care*, RAND CORPORATION (May 4, 2010), http://www.rand.org/news/press/2010/05/04.html (News Release). Researchers found that when simulating a pay for performance program on primary care physicians in Massachusetts, the "average-sized physician practices serving the highest proportion of vulnerable populations would receive about $7,100 less annually than other practices." *Id.* "That difference could be even larger if greater amounts of money are put at stake in future pay-for-performance programs." *Id.*

As with capitation, pay-for-performance creates an incentive to cherry-pick patients. In a performance-based system, funding is dependent on the overall performance of the provider or provider group for the year, and a set of clear indicators are used to measure the performance of the providers.[62] As a result, doctors screen and select less severely ill patients, which adversely affects patients with more serious diagnoses.[63] This "cherry-picking" obviously hurts the elderly and the chronically ill, but it also hurts the poor because certain cost drivers like readmission rates are related to socio-economic status.[64] Because persons with psychiatric challenges are more likely to be poor, cherry-picking further affects this patient population.[65]

Based on "effectiveness," "efficiency," and "special population standards," providers in one study measured their overall performance with outcome measures such as clients remaining drug free thirty days prior to termination, remaining free from arrest, maintaining employment, reducing absenteeism on the job and reducing the number of

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[62] Jeffrey S. Berns, M.D., *P-4-P and Dialysis Centers: A Look Beyond URR*, (Jan. 30, 2012), *available at* http://www.medscape.com/viewarticle/757433. Harvard public health professor Ashish Jha thinks too much time is spent on quality measures "just because they can be measured, not because they're necessarily the right metrics." Dan Gorenstein, *Paying doctors for value instead of volume*, MARKETPLACE HEALTH CARE (Feb. 25, 2014), http://www.marketplace.org/topics/health-care/paying-doctors-value-instead-volume. "If you have a patient who comes in with pneumonia, yes, you want to make sure that patient doesn't die, but one of the most important things is that patient can go back to work, play with their families and lead a meaningful life. Well, how do you measure all of that? That takes work," Jha says. *Id.*

[63] Berns, *supra* note 62 *citing* N. Tangri et al., *Both Patient and Facility Contribute to Achieving the Centers for Medicare and Medicaid Services' Pay-for-Performance Target for Dialysis Adequacy*, 22 J. AM. SOC. NEPHROL. 2296-2302 (2011). Performance-based funding can either be renewed or increased if levels of performance increase, however funding can be decreased or terminated as a result of lower levels of performance. *Id.* Outcomes are therefore highly dependent upon patient mix. *Id.* For example, Ninety percent of the variability in hemodialysis units' ability to meet quality goals could be explained by patient mix. *Id.* If quality goals are tied to patient mix, providers will avoid those patients who would diminish their ability to enhance the providers' finances. *Id.*

[64] Berenson, *supra* note 58 (discussing readmission related to socio-economic status).

[65] G. Sullivan, et al., *Pathways to Homelessness Among the Mentally Ill*, 35 SOC. PSYCHIARTY PSYCHIATRIC EPIDEMIOLOGY, 444, 444-45 (2000), *available at* http://www.brown.uk.com/homeless/sullivan.pdf (stating homeless individuals with mental illness have a "'double dose' of disadvantage").

issues with their employer, spouse/significant other, and family members.[66] This study utilized the "special population standard" in order to control for the possibility that the clinic would specifically target clients who were easier to treat.[67] However, even with the control, the providers engaged in activities aimed at attracting less severe clients and selected less severe clients in order to improve their performance ratings for optimization of funding.[68]

Alternatives to Capitation and Other Financial Incentives

Capitation and other financial incentives that encourage denial of care are hard to control through alternative incentives, like pay for performance, as these alternative incentives also have unforeseen consequences. Rather than focus on incentives that limit necessary medical care and the tools used for accurate diagnosis like MRIs, attention might be paid to alternative avenues for controlling costs, such as public health initiatives like reintroducing physical education as a daily part of school and soda/sugar taxes to discourage consumption of unhealthy foods, as well as exploration of alternative and up and coming modes of mental health care like meditation, peer services[69] and Open

[66] Yujing Shen, *Selection Incentives in a Performance-Based Contracting System*, 38 HEALTH SERVICES RESEARCH 535, (2003), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1360913/ (stating objective as "whether a performance-based contracting provides incentives . . . to select less severe clients").
[67] *Id.*
[68] *Id.*
[69] See, e.g., J. Repper and T. Carter, *A review of the literature on peer support in mental health services*, 4 J. MENTAL HEALTH 392-411 (2011); SAMHSA, Peer Support and Peer Providers: Redefining Mental Health Recovery (Sept. 21, 2010); N. Pistranq, *et al.*, *Mutual Help Groups for Mental Health Problems: a review of effectiveness studies*, 42 AM. J. COMMUNITY PSYCHOL. 110-21 (2008).

Dialogue,[70] which emphasize social connection rather than medication and institutionalization.[71]

[70] J. Seikula and M. Olson, *The Open Dialogue Approach to Acute Psychosis: Its Poetics and Micropolitics*, 42 FAM. PROC. 415, 403- 418 (2003)(use of Open Dialogue resulted in fewer hospitalizations, less medication use, better employment status, and fewer symptoms at two-year follow-up).

[71] Cost-saving targeted interventions are also possible for chronic issues like obesity that cause multiple physical ailments. See, e.g., G. Daumit, M.D., *et al*., *A Behavioral Weight-Loss Intervention in Persons with Serious Mental Illness*, 368 NEW ENG. J. MED. 1594-602 (2013).