

**2016 SYMPOSIUM ON RECONCILING COMPETITION AND CONSUMER
PROTECTION IN HEALTH CARE
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW**

September 20, 2016

**Keynote Address: How to Succeed in the American
Health Care System**

*Remarks of Dr. Ezekiel Emanuel**

To be here is an honor. Let me begin with a story, a friend of mine creates accountable care organizations (“ACOs”) of physicians and puts primary care doctors together to try to lead them from volume to value—the basis of all transformation in health care. He has tried to work with physicians to get them to work together to deliver high-value care. Along the way, they have done some remarkable things. They have improved the quality of care for a few of the ACOs. They decreased emergency room visits, decreased all-cause mortality by 5 percent, reduced acute hospitalization—but they unfortunately got a 7–13 percent increase in hospital outpatient facility costs. And that increase in outpatient hospital facility costs totally bit down on any savings they gained in reducing emergency room visits, hospitalizations, and readmissions. This is an incredibly important message for the future because, here, you have primary care doctors doing the right thing—improving quality of care and reducing things we know are expensive, like emergency room and hospital visits. Consolidation is going on all over the country, as you know—hospitals buy up specialists and buy up other hospitals—and it can counteract all the work done by ACOs in their pursuit of the right thing.

Now, I would like to distinguish consolidation from integration, and I think it is very important to do so and not mistake one for the other. Consolidation is clearly what a lot of people who are holding on to fee-for-service reimbursement would prefer. But unfortunately, this does not foster innovation.

* Vice Provost, University of Pennsylvania, Department of Medical Ethics and Health Policy.

So what do we think about integration, and how can we distinguish or identify places that are integrating? Well, first, are health systems using data in a performance-driven way? Are they collecting data and giving it back to their physicians and hospitals to improve performance? I think that is very important. Second, are they actually taking responsibility for the continuity of care for primary care, tertiary, and home care? Third, I think organizations looking to integrate care are first undertaking a series of transformational changes. They may not undertake all of them because, after all, if you actually integrate, it is a process and you cannot do everything all at once. But here are seven different indicators that need to be looked at when looking to integrate.

The first one is: Are health care organizations transforming their scheduling to be more patient centric? Are they actually centralizing their scheduling away from individual practices? Are they using open-access scheduling? These are strong indicators of transformation and of attempts to put the patient central and increase value.

Second, as I mentioned, are they using performance measurement and are they actually providing close to real-time feedback to their doctors to improve their performance on key quality indicators as well as cost indicators?

Third, are they introducing standardization across their care, their physicians, and their health care teams? Standardization is a good indication of attempts to get costs down and improve quality of care.

Fourth, have they actually integrated care management directly with the front-line physicians? Not using telephonic care management, but are they actually outing care managers in the front lines and collocating them with the doctors and nurses actually taking care of patients?

Fifth, do they use virtual medicine, like this?¹ Are they actually beginning to integrate it into their care?

Sixth, are they actually engaging with the community and trying to use community health care workers to address the psycho, social, and other problems of their community?

And finally, how have they changed physician payment? If they are continuing to pay fee-for-service, it seems somewhat of a contradiction. Maybe what they are doing is not really integration, but more consolidation. On the other hand, if they have changed how they are paying doctors—if they are thinking differently about how to pay doctors—then they will be changing off the fee-for-service model. Now, in 2017, we do not know the ideal way to pay physicians to increase their

1. Dr. Emanuel gave this Keynote Address through an electronic video conference call.

focus on value and to increase their focus on putting patients center, but we do know that fee-for-service reimbursement only incentivizes doing more services (e.g., ordering more tests, etc.). And it does seem to me that part of what we want to see physician practices doing is experimenting with alternative payment methods (e.g., payment that is tied to performance on value-based metrics), whether it is improving quality or saving on the total cost of care.

So, I would say one of the ways that we can look at and distinguish consolidation versus integration is on whether the health system has actually begun these kinds of changes—using data, taking responsibility for the continuity of care, and implementing these seven other changes (scheduling, performance measurement that feeds back to doctors, standardization in their care, having care managers at the front line, using virtual medicine, having community health care workers engaging to address the psycho-social conditions of their patients, and paying doctors and other front line staff differently, not based on a relative value units (“RVU”) system. I think those have to be assessed when we assess integration.

The third point is the issue of size. As I go around the country and look at a variety of places that have integrated and transformed their care, one of the important things I try to identify is: What is the minimum unit of doctors needed (or doctors and patients) that really can have the sufficient scale to transform the care, to actually do the things I mentioned—change their schedule, get performance measurement, and have care managers. I have asked a lot of experts—maybe it is 25,000 patients, which would be about fifteen to twenty doctors. I think we are much more solid and we probably get really to the top end of the curve—somewhere around 50–100 doctors responsible for about 100,000 patient lives. I think that gives you a sufficient scale so you can begin to work on your own data, transform pay, and take sufficient risk. And I think that element is important.

I think it is also important that at some point you get to a plateau. Maybe between fifty and 1,500 to 2,000 doctors, you can deliver very well-integrated care, standardize with good care management, and adequately engage with the community. Unfortunately, where there are bad bureaucracies, it is very difficult to coordinate care, and a lot of problems happen just because the organization is too big rather than nimble and responsive. And I think the key question is getting people to the sweet spot of between fifty and probably a maximum 2,000. I think beyond that, we really have to question whether we are seeing integration or whether integration is even possible. I think this is an important empirical question. What I am suggesting to you is anecdotal—I

recognize anecdotes are not data; I prefer data—but I do think that we need to see whether beyond somewhere in the 1,500–2,000 range you actually get what can be called “integration” or whether what you end up with is just big hulking bureaucracies. As we analyze across the spectrum in this country, I think we (and the regulators responsible for assessing this), need to look carefully at consolidation and integration. I would suggest five important things that we need to push the system on in terms of policy to move us forward.

First of all, I think when policymakers or antitrust people evaluate these ever-growing health systems, they need to evaluate and distinguish between horizontal consolidation and vertical integration or consolidation. Horizontal consolidation is when one system merges with another hospital (merges with doctors), and is responsible for the continuum of care. I am quite suspicious of that, especially as it gets big and tips over the 2,000-doctor mark. Mainly that kind of consolidation, or that bringing together of different groups—not to prejudice the issue—is mostly about leverage and negotiation. And I think that just bringing doctors and hospitals together is necessary, but insufficient, and I would be quite suspicious if that is all that is done.

On the other hand, I view vertical consolidation much more favorably, and I think regulators ought to take a much more favorable look. But this connection comes with a much greater assumption of financial risk either in contracts with payors, in contracts with Medicare, or directly. And again, many groups that look like they are consolidating are taking on their own financial risk whether they are developing Medicare Advantage plans, taking financial risk directly from payors and insurers, or contracting directly with employers. It seems to me that the worry we have about consolidation on the provider side is much less—and ought to be much less from a regulatory standpoint—when there is this vertical integration and these groups are taking a substantial portion of their payments in a risk-based manner. I think that suggests much more that they are going to be directed toward efficiency and toward controlling costs. So, I think when regulators look and assess the size of these mergers going forward, they really need to look at whether it is horizontal or vertical consolidation. My own view is if they are taking on a sizable amount of financial risk and pushing that up, then we should actually look on that as more favorable and be more willing to let those go forward.

Second, I think, and I have recommended to Washington, one of the most important things that can happen over the next few years—certainly for the government and then I would hope for the private payors—is a move toward site-neutral payments. I think this is one of the great hitherto unused policy levers that we have to reverse the consolidation in

the marketplace, certainly to reduce hospitals buying physician practices. As my initial vignette suggested, part of the reason there is a lot of consolidation here—not hospital-hospital consolidation, but hospitals buying physician practices—is really about increasing that hospital facility fee and increasing the costs that hospitals can get from doctors by billing them at the hospital rate. Now, we have some tentative moves in the site-neutral direction. I note just two of them. One is the provision that Congress passed to prevent any mergers or consolidations after 2017 from having to pay a hospital facility fee.² I think that is a very positive move, but obviously lots of consolidations will happen between now and January 1, 2017, and we need something that looks back retrospectively.

Second, as many of you may have noticed in the new oncology-bundled payment model that Medicare released, there has been a move in the fourth and fifth years toward regional pricing. I think this is a very good move; although it does not begin to exactly counter the facility fee, I think it moves away from individual hospital differences and more toward uniform payment in big places that have premiums that I think will decrease. I have urged Washington—and I think this is one of the most important things that we can do over the next few years to really move toward site-neutral payment for everything—to get rid of the facility fee, for say, giving chemotherapy in a hospital versus a physician’s office; get rid of the differential of doing a hip or knee replacement in a hospital versus doing it in an ambulatory care center; and, similarly, to discard the facility fee related to doing a colonoscopy in a hospital versus a physician’s office. If we implement site-neutral payment, with a one- or two-year glide path into it, I think you would see a very rapid disgorgement by a lot of hospitals and I think a rapid reversal of the move toward hospitals buying up physicians. I also think you would have a different outcome in the story I have just mentioned and a different outcome in terms of not seeing this big increase in hospital facility outpatient costs, despite a reduction in the emergency room and hospitalization. So, I think that is a very important change that should come about and would make a big difference.

The third policy I would recommend—and one that I have already hinted at—is moving more toward regional pricing to even out the pricing across the country; I think this is a very important item. As I mentioned, Medicare has begun that process with its bundled payment—I would like it to go a little faster—and I think there are some very important implications of moving toward regional pricing.

2. Bipartisan Budget Act of 2015, Pub. L. No. 114-74, § 603, 129 Stat. 597, 597–598 (2015) (amending 42 U.S.C. § 1395l(t)).

And the last thing I think is important is something that I want to come back to, which is physician payment and moving toward different kinds of physician payment. I just think that we need to move off a RVU system of paying physicians; it is a terribly anachronistic system. And even health care systems that are taking risks at the *system* level, but not moving risk down to the physician or physician-group level, are not actually doing a good job of transforming.

We, right now, are in the midst of working with a variety of groups to try to change how they pay doctors. We are working with Hawaii Medical Service Association (“HMSA”), trying to change their fee-for-service system to a capitated system. Our main suggestion is to keep physicians whole. Systems should give them, at least initially, a 25 percent bonus for meeting quality metrics based not on 64–66 quality metrics in the Healthcare Effectiveness Data and Information Set (“HEDIS”) scorecard, but on a much smaller amount of leading indicators. And then also incentivize them for keeping the total cost of care down by sharing about a quarter of the savings from any reduction in total cost of care with the physicians. I would say first that it is a process, in part because you have to keep people whole initially and then you have to slowly move them to a uniform per-member, per-month capitated model. Second, it is very hard—this is our experience in Hawaii—to get front-line physicians to understand the difference and to change their practice from RVU toward more capitated payment. It is hard to change physicians’ thinking about how they practice and to get them to understand that the money does not come by just doing things, but that the money comes from keeping people healthy, and that their big chance of scoring is by reducing the total cost of care. That is not easy for doctors to learn and understand, and it is very important that we try that process and begin changing that process over time. But that has to come with rewards. And unless we change the hospital facility fees and that added element, we will get this kind of contradiction—that I think is unsustainable even in the short time—of doctors doing better, reducing emergency room visits, reducing unnecessary tests, reducing hospitalization, and yet, not seeing any savings because the hospital costs have gone up because of the hospital facility fees and outpatient costs.

And so, I think, all of these changes—site-neutral payment, regional pricing, trying to assess integration at the hospital-system level, vertical integration by having them take risk—are all important and they all really end up feeding each other. They all need to occur together so we can see some change. I am hopeful, and I will just leave you with the following thought. We have seen over the last few years a dramatic decline in the rate of per-capitated payments on Medicaid (that has actually been

negative), Medicare, and even commercial payment. That decline has been consistent after the end of the recession, which suggests there is something else happening inside the health care system to actually keep costs down. And yet, what is interesting is that if you look, it is hard to point to any one thing that has been a sort of “big home-run success.” The ACOs, you can say are at best: “Eh.” Some are succeeding; typically, the successful ones are serving Medicaid populations or are in low-price areas. Bundled payments have some successes, but they are just not big enough to make that big of a difference. So, when you see this dramatic decline in the growth rate of per-person cost, but you find it hard to pinpoint something that is really “it,” and you can no longer attribute it to the recession (that is now six or seven years old), it seems to me that the decline is a good indication that lots of changes are happening in the health care system. But we are still not feeling that happen or congeal into a dramatic change in how we deliver care. But they are out there and they are haphazard, in a fragmented way, affecting care and keeping costs under control. That, I think, is a good thing.

So, what I actually think we will identify over the next few years (and this is my congenital optimism about the health care system) is what has been driving this control and keeping the cost growth rate down. I do think it will be an important transformation in the way we deliver care in some of these larger groups and I do think we will figure out what is working and what is not working. So, we need better indications for what to regulate, what not to regulate, and which changes are essential for cost control.

SELECTED ANSWERS TO SYMPOSIUM ATTENDEES’ QUESTIONS

Pursuant to a question regarding patient incentives, I would say that patient incentives work on two levels. The first level is high-deductible plans making people pay a lot before they access their insurance. I think we clearly see that these plans have some effect. We—meaning the people working on the Affordable Care Act—tried to mitigate the negative effects on preventive services and primary care by putting in free visits and trying to exempt the deductible on preventative care. I think that was one of the best things we did. It may not have gone far enough, but it was important in mitigating what we know to be negative effects of high deductibles on people using prevention and primary care services.

The flip side, or the second place that we are just in the baby steps of is: How can we use patient incentives to try to actually improve quality of care and get them to do better things? One of my colleagues at the University of Pennsylvania, you all will know, is Kevin Volpp, the king of behavioral economics and using incentives with patients. Kevin,

myself, and Amol Navathe are trying to combine both physician incentives and patient incentives to try to get end points that really require both parties collaborating. So, we are trying now, including in Hawaii as I mentioned, to not only change how we are paying physicians, but also to try to bring in patient incentives. For example, with diabetic patients, we want to give them some financial reward for measuring their hemoglobin A1C, measuring their glucose, and keeping their hemoglobin A1C low, so we want to test that combined incentive out. And I think the short answer is that we just do not know in the second mechanism how important getting patients engaged in their own health through financial incentives is going to work. I will say that we do have some pretty good experience indicating that places that have care managers in the physician office and really surround the patient are in constant contact with that patient either weekly or bi-weekly. Those places do seem to achieve much better quality and much more consistent quality on things like congestive heart failure, diabetes control, etc., even without patient financial incentives. Whether they can succeed even better with the patient financial incentives, again, is an empirical question that can only be answered by running randomized trials. We are trying to do that. It is hard, but I think we will learn over the next 3–5 years whether it really does work.

In response to a question discussing how health care price transparency could limit price competition among providers, I am not sure why you think price transparency should limit price competition. But let me suggest why I think it might at least enhance—not in the Medicare section because obviously, in Medicare, there would not be a price competition—the commercial market, if you have site-neutral payments and no added facility fees and you provided cost information to physicians. It should make a big difference. But I would say two things about being both in Medicare and commercial contract. If you are a doctor participating in Medicare, you get regional pricing and you get site-neutral payments; so, as a doctor, what is your primary motivation in referral? Your primary motivations in referral, it seems to me, are twofold: first, the physician will be concerned with which physicians are delivering high-quality care, in terms of getting outcomes. And second, a physician will be motivated by who is not using excessive, unnecessary services, and is therefore decreasing utilization. So, if you take the unit cost out in the Medicare case, you get an emphasis on quality and an emphasis on utilization. And these are good things it seems to me. On the commercial side, you still get price competition between places that have negotiated different prices, and so you have the incentive to have the low per-unit cost, at least on the commercial side. And let me say, we have evidence that if you

give doctors information about the price of services, they actually respond. And one place where we know that is true appears by looking at the alternative quality contract model in Massachusetts where they gave doctors the pricing and the charge where doctors were responsible for total cost of care. And they began shifting their patients to lower costing places—initially, to lower cost hospitals, and then to lower cost labs and other things. And, so, you get both the advantages of focusing on quality, decreasing utilization, and decreasing cost per-unit of delivering services. Maybe I am just the wild optimist on that, but I think here is one of the strengths of multiple payors each doing something slightly different—where there are advantages to Medicare and advantages to the commercial side.