Analysis of the Health Care Financing Task Force Final Report

Introduction and overview

On January 15, 2016 the Health Care Financing Task Force approved a report to the Legislature ordered by the Legislature last year. The Legislature instructed the Task Force to make recommendations that will lower health care costs and improve quality.

The report contains 33 recommendations. The Minnesota chapter of Physicians for a National Health Program (PNHP) supports the recommendations that call for expanding coverage as well as two recommendations that call for research (recommendations 21 and 23). We oppose those recommendations which call for the expansion of, or support for, "accountable care organizations" (ACOs). Those recommendations, which appear *inter alia* in recommendations 18 through 33, are not based on evidence. The available evidence indicates ACOs have not lowered costs and may create several destructive side effects. We support the Task Force's recommendation 21 which calls for more research on ACOs before they are given any additional resources or support.

The ACO recommendations continue an effort by the Department of Human Services (DHS) to push Minnesota clinics and hospitals into privately sponsored ACOs without public debate. DHS is using federal and state tax dollars to mold not just the health care system that serves public programs, but the entire Minnesota health care system.

DHS applied to the federal Department of Health and Human Services (HHS) for a State Innovation Model (SIM) grant in September of 2012. In that application, DHS promised HHS Minnesota would use the grant money to push more doctors, hospitals and patients into ACOs – both ACOs that DHS would contract with and those which insurance companies and hospital-clinic chains would establish. Since DHS received the SIM grant in February 2013, it has done exactly what it promised HHS it would do – accelerate the formation of private- and public-sector ACOs.

DHS's ACO campaign is overseen by a task force called the Multi-payer Alignment Task Force, chaired by a vice president of Blue Cross Blue Shield.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=sim_task_forces_multi_payer
In a presentation DHS made to this task force on September 16, 2015, DHS stated its goal was to push 60 percent of "fully insured people" into ACOs (slide 5 http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_197075)
.

In short, two government agencies, DHS and HHS, are attempting to transform Minnesota's entire health care system (not just the publicly financed portion) into one dominated by ACOs without any public debate about the system they are creating and, moreover, on the basis of virtually no rigorous evidence that ACOs can lower costs without causing more harm than good. We strongly urge the legislature to endorse the evaluation called for in recommendation 21 and to take no further action to support ACOs until that report has been completed.

The remainder of this report is divided into three parts. In Part I we endorse those recommendations which expand coverage. In Part II we summarize the evidence indicating that ACOs have not cut costs but will have destructive side effects. In Part III we explain why we support recommendations 21 and 23.

Part I. We endorse the recommendations which expand coverage

Like many other participants in the health care reform debate, PNHP believes Minnesota and the nation will never achieve and maintain universal coverage without addressing the enormous waste in our health care system. Our principle criticism of the Task Force report is that it failed to identify and address the fundamental causes of high health care costs. The primary drivers of high health care costs are high prices, the enormous expenditures required to administer our multiple-payer system, and the never-ending consolidation of our health care system into fewer and fewer sellers of health insurance and medical care. Until Minnesota and the country address these fundamental problems, we will be unable to cut costs, and until we cut costs, we will never achieve and maintain universal coverage.

But until we find the will to address the fundamental causes of high health care costs, we should resist calls to cut existing public insurance programs and we should expand them where possible. We support those Task Force recommendations which would expand coverage, including these recommendations listed in Recommendations 2, 5 and 9:

- Add coverage for non-emergency medical transportation to MinnesotaCare;
- Require that insurance companies selling "qualified health plans" (QHPs) make available dental benefits on par with the coverage available in Medical Assistance and MinnesotaCare;
- Provide access to coverage for uninsured, low-income individuals ineligible for Medical Assistance, MinnesotaCare and QHPs through MNsure due to immigration status ; and
- Expand MinnesotaCare up to 275 percent of the federal poverty level.

Part II: Why we oppose the DHS-HHS campaign to promote ACOs

PNHP sent three letters to the Task Force urging the task force not to endorse ACOs. Those letters laid out our rationale for that request. It said ACOs have destructive side effects, including worsening disparities and physician morale, accelerating the consolidation of our health care system, and raising costs. If ACOs had been shown to lower costs or improve quality of care, then the question of whether to endorse ACOs might be difficult. But the evidence does not support the claim that ACOs lower costs or improve quality (for all patients, not just the small fraction subjected to quality measurement). Therefore, the decision about whether to endorse

ACOs is not a close call: ACOs should not be endorsed until they have been subjected to rigorous testing and the results demonstrate that ACO benefits outweigh their costs.

Rigorous testing of ACOs will require that the proponents of ACOs define that term far more precisely than it has been defined to date. ACOs are so vaguely defined it is impossible to say what methods DHS and other ACO proponents expect ACOs will use to cut costs or improve quality. An ACO is typically defined as an entity made up of clinics, hospitals and other providers of health care goods and services that "takes responsibility" for the cost and quality of health care for a defined population that is "attributed" to the ACO by a third party.

ACO proponents, including DHS, use numerous vaguely defined phrases to communicate what they mean by "take responsibility." A common phrase used throughout the Task Force report is "value-based purchasing" (VBP). It appears that the Task Force would like readers to understand that an ACO is somehow synonymous with VBP, or is an example of a "purchase" based on "value." Value is, of course, something that can be determined only if both cost and quality have been measured, and measured accurately.

ACOs have not lowered costs

The evidence indicates ACOs have not lowered costs. The only reliable data we have on ACOs is data reported by the Centers for Medicare and Medicaid Services (CMS) on the two Medicare ACO programs that began in 2012. That data indicates ACOs have slightly raised Medicare's costs. Here is how *Kaiser Health News* summarized the data: "After paying bonuses to the strong performers, the ACO program resulted in a net loss of nearly $3 million to the Medicare trust fund, government records show." http://www.npr.org/sections/health-shots/2015/09/14/440240225/medicare-fails-to-save-money-so-far-on-cooperative-care-experiment

If the cost to the hospitals and clinics that are part of the ACOs is included in the definition of "total cost," then ACOs have probably raised the total cost of caring for Medicare beneficiaries. Based on anecdotal evidence, the Medicare Payment Advisory Commission estimates ACOs spend at least 1 to 2 percent of their Medicare payments on information technology and more staff. The cost may be higher. We simply don't have good data. We have no data at all on what it costs insurers, public or private, to establish and monitor ACOs.

In addition to saving little or no money for insurance companies but driving up provider costs, ACOs are contributing to rising health care costs by encouraging consolidation among providers. It is well established that when hospitals and clinics merge or join together by contract, prices go up. Here is how the Robert Wood Johnson Foundation described this problem:

> The Patient Protection and Affordable Care Act (ACA) promotes Accountable Care Organizations (ACOs) and the bundling of payments across providers for an episode of care ("bundled payments"), both of which encourage consolidation between hospitals and physician practices. …
>
> Hospital consolidation generally results in higher prices. This is true across geographic

> markets and different data sources. When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent. http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.html

Evidence demonstrates the same effect when physicians consolidate with each other or with hospitals.

ACOs will aggravate disparities

ACOs, and the third parties who seek to "purchase based on value" from ACOs, use payment schemes that punish and reward providers for their performance on so-called quality and cost measures. This is true of any method of payment that is alleged to be "value based." Commonsense suggests that if these cost and quality measures are not adjusted accurately to reflect the effect of patient health and income, attaching financial rewards and penalties to these measures punishes clinics and hospitals that serve a disproportionate number of sick and poor people. In other words, they worsen disparities.

Research supports what commonsense suggests. Much of this research was summarized in a report commissioned by the Obama administration. Here is an excerpt from an article in the *New York Times* about that report:

> Federal policies to reward high-quality health care are unfairly penalizing doctors and hospitals that treat large numbers of poor people, according to a new report commissioned by the Obama administration….
>
> Medicare and private insurers are increasingly paying health care providers according to their performance as measured by the quality of the care they provide. But, the draft report by an expert panel says, the measures of quality are fundamentally flawed because they do not recognize that it is often harder to achieve success when treating people who do not have much income or education.
>
> Low-income people may be unable to afford needed medications or transportation to doctor's offices and clinics, the panel said. If they have low levels of formal education or literacy, they may have difficulty understanding or following written instructions for home care and the use of medications. In addition, the clinics and hospitals they use may lack the resources and high tech equipment needed to diagnose and treat illnesses. [Robert Pear, "Health law's pay policies are skewed, panel finds" April 27, 2014 http://www.nytimes.com/2014/04/28/us/politics/health-laws-pay-policy-is-skewed-panel-finds.html?_r=0]

It is extremely unlikely that the cost and quality of health care will ever be adjusted accurately for factors outside clinic or hospital control such as patient health and income. It is extremely likely, however, that efforts to improve the accuracy of cost and quality measures will be costly.

ACOs will further damage physician morale

Over the last decade researchers have begun to pay attention to the damage that the rise of managed care has inflicted on doctors. The research indicates that burnout among doctors has become very serious. Loss of autonomy and more paperwork are the primary causes of the problem.

Last May the *Star Tribune* published a front-page story on the "epidemic" of physician burnout. http://www.startribune.com/doctor-burnout-is-a-rising-problem-in-minnesota-medicine/304822101 The article identified paperwork and micromanagement via computers as the main causes. "[C]omputerized records and payment reforms that judge doctors by their patients' health," is how the paper put it.

The latest data on physician burnout appears in the December 2015 edition of *Mayo Clinic Proceedings.* The authors, affiliated with the Mayo Clinic, report that physician burnout has grown by about 20 percent since 2011 and now afflicts more than half of all doctors.

The Task Force's ACO recommendations, including the recommendation that the state set up a health information exchange, mean Minnesota doctors will get no relief from paperwork, and may in fact have to endure more paperwork and a further erosion of autonomy.

Part III: We endorse Recommendations 21 and 23

Recommendation 21 calls for evaluation of the ACO experiment (presumably in both Minnesota and the nation) and related experiments that shift insurance risk from insurance companies and public programs onto doctors and hospitals. This recommendation states there should be no "significant expansion" of these experiments until this study has been conducted. As the September 15, 2015 *Kaiser Daily News* report we cited above put it, "ACOs are still in their infancy." A health policy notion that is "still in its infancy" should be studied further before it is expanded.

We are particularly supportive of the requirement that the evaluation report on all costs associated with ACOs and similar experiments. As we have already noted, reliable data on the cost to providers and insurers of participating in ACOs and kindred experiments is non-existent. The additional costs providers incur include extra staff and new or additional information technology hardware and software. It is not possible to determine whether ACOs raise or lower total health care spending with no data on the costs providers and insurers incur.

We also strongly support the requirement that the evaluation determine the impact of ACOs on health disparities.

We would amend recommendation 21 to make it clear that the study must also examine the costs and benefits of the "health information exchange" (HIE) promoted by recommendations 18-20. The costs studied should include the threat to patient privacy posed by the spread of electronic health records, and the costs to all payers (including clinics and hospitals) of electronic medical records. The evidence does not support the Task Force's claim that HIE will improve quality or

lower costs. The title of a recent paper in *Health Affairs* summarizes the state of the evidence on HIE as follows: "Despite The Spread Of Health Information Exchange, There Is Little Evidence Of Its Impact On Cost, Use, And Quality Of Care" http://content.healthaffairs.org/content/34/3/477.abstract.

We endorse recommendation 23 as well for reasons similar to our support of recommendation 21. This recommendation calls for a study of value-based purchasing and ACOs, as well as a system of universal coverage that does not rely on the undocumented assumptions that have to be true for value-based purchasing and ACOs to work.

Recommendations 21 and 23 are reprinted in their entirety in the appendix below.

A plea for evidence-based health policy

We conclude this critique of the Task Force's report with a recommendation of our own. We recommend that the Legislature and all future task forces or commissions adopt the principles of evidence-based health policy. Over the last quarter-century the principles of evidence-based *medicine* have been widely adopted within the medical and academic communities and by policy-makers. But policy-makers, including Congress, the Minnesota Legislature, and the numerous Minnesota commissions and task forces that have issued reports over the last quarter-century, have refused to adopt the principles of evidence-based health policy.

Like evidence-based medicine, evidence-based health policy would require that lawmakers and task force members refrain from proposing any "treatment" for a problem unless and until research demonstrates that the proposed treatment is safe and effective. In cases in which research is non-existent, lawmakers and task force members should (a) recommend pilot projects testing the proposal and (b) rigorous evaluation of those pilots by independent researchers. Policy makers should not recommend exposing all or a substantial portion of the population to the effects of the proposal until the pilot project is completed and evaluated.

If evidence-based health policy were the norm in Minnesota, ACOs would be limited to a few pilot projects. They would not be the centerpiece of a campaign by DHS, HHS and the Multi-payer Alignment Task Force to push most Minnesotans into ACOs. And they would not be endorsed by the Health Care Financing Task Force without reference to a single peer-reviewed paper, which is what this task force did.

Appendix: Recommendations 21 and 23

Recommendation 21: Evaluate, on an ongoing basis, current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Programs and pilots should not be significantly expanded until an evaluation of cost/benefits is conducted. At a minimum, the evaluation should address the following domains:

· Health disparities - Does the model worsen or improve health disparities? If so, by what mechanism or mechanisms? Does the model sufficiently account for variation in the complexity of patients across providers?

· Financial stability and cost of health care system – What is the impact of the model on costs across the system, including all payers? What costs are associated with the model at the provider level? What is the ROI of the program?
· Patient choice and provider attachment - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate patient choice of provider?
· Multi-payer alignment – What are the areas of alignment across payers under the model? What additional areas could be aligned?
· Quality of patient care – How has the model impacted the quality of patient care?
· Population health – How does the model address population health?
· Social determinants of health – How does the model address the determinants of health beyond medical care (e.g. flexible payment options that enable payment for non-medical services)?
· Impact on provider work force - What impact has the model had on the provider work force? If it has an impact, what mechanism caused the impact?

Recommendation 23: Conduct a study that examines various long-term payment options for health care delivery. Study will do a comparative cost/benefit analysis of the health care system under the following approaches:

· Maintenance of current financing mechanism, without expansion of value-based purchasing beyond existing levels;
· Expansion of value-based purchasing within current system;
· Publicly-financed, privately-delivered universal health care system.

The study would additionally examine the stability and sustainability of health care system under the approach and identify any data or information needed to design and implement the system.