The Unintended Results of Payment Reform
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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

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).
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. Accountable Care Organizations (hereinafter “ACOs”), which have garnered much attention in recent years, use many of these financial incentives.

ACOs and other risk-bearing organizations often trill about efficiency, quality and the freedom to innovate allegedly provided by the new payment arrangements. 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.

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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).


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 checklist*, 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.*

8 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.

global capitation, may actually increase a provider’s administrative costs. 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. 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. 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. 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.


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/Library/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. 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.

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 serving rural and poorer areas with fewer primary care physicians and specialists.”  

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

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.”
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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{18} The incentive,
however, is to provide just enough care to obviate the need for more costly
interventions.\textsuperscript{19} Capitation “essentially turns the doctor into an insurance company, often
without adequate actuarial spreading of the risk.”\textsuperscript{20} Therefore, the more treatment the
doctor withholds, the more money he or she earns.\textsuperscript{21} In terms of the ethical implications

\textsuperscript{16} See Mark Hagland, \textit{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).
\textsuperscript{17} \textit{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.
\textsuperscript{18} See Herman, \textit{supra} note 17.
\textsuperscript{19} \textit{Id.}
\textsuperscript{20} MYRNA C. GOLDSTEIN AND MARK A. GOLDSTEIN, \textit{CONTROVERSIES IN THE PRACTICE OF MEDICINE}, 125,
\textsuperscript{21} \textit{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.”

Financial incentives related directly to performance of processes and outcomes do not effectively address this conflict. 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.

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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.


[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.\textsuperscript{25} Even with consumer protections, this model has proven problematic as exhibited by similar systems in Europe.\textsuperscript{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.\textsuperscript{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.\textsuperscript{28} One study that


\textsuperscript{26} \textit{See} David Mechanic, \textit{The Functions and Limitations of Trust in the Provision of Medical Care}, 23 J. OF HEALTH POL’Y, 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. \textit{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.” \textit{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. \textit{See} Jeroen N. Struijs & Caroline A. Baan, \textit{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/NEJMtp1011849. 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. \textit{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.” \textit{Id.}

\textsuperscript{27} \textit{See supra} note 26.

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.\textsuperscript{29} Another experiment concluded that physicians choose significantly fewer services under capitation than under fee-for-service.\textsuperscript{30} Generally, under capitation systems, doctors discharge patients from the hospital post-surgery “quicker and sicker.”\textsuperscript{31}

In the case of persons with mental illness, the goal is to prevent hospitalization or acute residential care.\textsuperscript{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.\textsuperscript{33} Outcomes for patients under the capitated system were worse than

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\textsuperscript{29} T. Godsen, et al., \textit{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.


\textsuperscript{31} See Jacqueline Kosecoff et al., \textit{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. \textit{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].” \textit{Id.} at 1980-81.


\textsuperscript{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., \textit{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.\textsuperscript{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.\textsuperscript{35} These discrepancies are likely attributable to the financial risk capitation imposes on providers, which eliminates incentives for providers to promote preventive services.\textsuperscript{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.\textsuperscript{37} Some criticize ACOs generally for restricting innovation in medicine by limiting entrepreneurial ventures.\textsuperscript{38}

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

\textsuperscript{34} Id.
\textsuperscript{35} J.P. Morrissey et al., \textit{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).
\textsuperscript{38} Id.
\textsuperscript{39} See AM. MED. ASS’N supra note 36 (defining capitation). Under global capitation, physicians are paid on a per patient basis. See Hagland, \textit{supra} note 16 (defining and comparing global capitation with other
prepaid plans undoubtedly result in a reduction of time spent with the patient.\textsuperscript{40}

Additionally, providers are encouraged to schedule patients for returning appointments at extensive intervals, which further delays the patient’s care.\textsuperscript{41}

The caseload and time impact of incentives is particularly severe for persons with behavioral health issues.\textsuperscript{42} For example, under revisions imposed by Massachusetts Medicaid’s capitated mental health manager, the time allotted for a standard medical 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. \textit{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., \textit{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., \textit{Capitation Payment, Length of Visit, and Preventive Services}, 8 AM. J. OF MANAGED CARE 332-40 (2002). \textit{See also}, Estella M. Geraghty et al., \textit{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. \textit{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. \textit{See Gottlieb, supra} note 37 (discussing ACOs in the context of the Patient Protection and Affordable Care Act).

\textsuperscript{40} K.B. Wells et al., \textit{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].”). \textit{See also} Lori Melichar, \textit{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).


\textsuperscript{42} Shorter visits with doctors directly affects patients’ health. Davidoff, \textit{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, \textit{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., \textit{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, \textit{supra} note 40.
management visit was reduced from 30 minutes to 15 minutes. 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. They also must receive information about new medication, how to administer it and potential side effects. 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.

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. 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. 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

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44 Id.
45 Id.
46 MWJ. 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. 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. 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. 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.

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

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. It was not until October of 2012, six years after


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.


56 See In re 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.\textsuperscript{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.\textsuperscript{58}

\textsuperscript{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).


[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.\(^\text{59}\)

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.\(^\text{60}\) 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.”\(^\text{61}\)


\(^{60}\) 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.\textsuperscript{62} As a result, doctors screen and select less severely ill patients, which adversely affects patients with more serious diagnoses.\textsuperscript{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.\textsuperscript{64} Because persons with psychiatric challenges are more likely to be poor, cherry-picking further affects this patient population.\textsuperscript{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

\textsuperscript{62} Jeffrey S. Berns, M.D., \textit{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, \textit{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. \textit{Id.}

\textsuperscript{63} Berns, supra note 62 citing N. Tangri et al., \textit{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. \textit{Id.} Outcomes are therefore highly dependent upon patient mix. \textit{Id.} For example, Ninety percent of the variability in hemodialysis units’ ability to meet quality goals could be explained by patient mix. \textit{Id.} If quality goals are tied to patient mix, providers will avoid those patients who would diminish their ability to enhance the providers’ finances. \textit{Id.}

\textsuperscript{64} Berenson, supra note 58 (discussing readmission related to socio-economic status).

issues with their employer, spouse/significant other, and family members. 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. 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.

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 and Open

67 Id.
68 Id.
Dialogue, which emphasize social connection rather than medication and institutionalization.\textsuperscript{71}


\textsuperscript{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., \textit{et al.}, A Behavioral Weight-Loss Intervention in Persons with Serious Mental Illness, 368 New Eng. J. Med. 1594-602 (2013).