Longitudinal Survey is not Relevant Basis for Berenson Study

Background

The Berenson Study states their findings are based primarily on the Community Tracking Study, which is conducted by the Center for Studying Health System Change and funded by the Robert Wood Johnson Foundation and National Institute for Health Care Reform. The Community Tracking System (CTS) is an ongoing longitudinal survey that was started in 1996 and probes metropolitan households and physicians, in an every-two-year alternating cycle (e.g. Household survey followed by Physician survey).

The Berenson study concluded hospital consolidation as the major contributor in perceived negotiating leverage over the private health care insurers on the cost of medical payments and network plans. Specifically, the researchers opined that as hospital market share increased over competing smaller hospitals and physician groups, these top-tier hospitals are able to demand higher payment rates on insurers.[1] The study claims that the insurers have no leverage due largely to the medical specialty coverage gained by the hospital as a result of their consolidation.

The Center for Regulatory Effectiveness (CRE) has conducted a review of the statistical methodologies used in the Berenson Study. The CRE assessment reviewed the availability and relevance of the Community Tracking System survey data as well as other factors that may have been overlooked with regards to causes for high medical payment rates.

Summary

The overall finding in the CRE assessment is that neither the Berenson Study nor the Community Tracking System Longitudinal Survey provides statistical evidence to support the claim that must-have hospital systems[2] and large physician groups have significant enough clout to secure steep payment increases from private insurers. Details are provided directly below to support this primary finding.

Assessment Details

1. *Regarding the referenced Community Tracking System (CTS) longitudinal survey study: does it provide an accurate basis for the conclusions reached in the Berenson study?*

[1] The researchers concluded that Medicare and Medicaid managed care plan payments were in line with the relatively low Medicare fee-for-service rates; therefore, this study thesis was not applied to Medicare.
[2] The Medicare Payment Advisory Commission report defines "must-have" hospitals as prestigious hospitals that consumers want included in plan networks.

Assessment: The CTS survey scope does not cover the issues addressed in the Berenson Study nor does it support the conclusions reached in the study.
The Berenson Study claims the CTS as the centerpiece study data for its conclusions. Berenson cites the seventh round of metropolitan site visits conducted in 2010, involving "539 interviews with local health care leaders in…twelve (metropolitan areas)." The Study goes on to state that site interviews were conducted with leaders of three to four major hospitals – typically the CEO, CFO, Chief Medical Officer, and Medical Staff President of each institution. The researchers also interviewed leaders of two to three physician groups and major health plans – typically the provider network manager, marketing head, and medical director; state policy makers and market observers.
A review of the CTS methodology revealed that the longitudinal survey only collects data on households and physicians. Thus there is no CTS trend data collected from the health insurer side.

According to the CTS description found at www.hschange.org, as of 2008, the CTS Physician Survey questions have changed. "In 2008, the CTS Physician Survey was replaced by the HSC Health Tracking Physician Survey, which included information from more than 4,700 physicians and was conducted by mail by Westat. The new survey name reflects the substitution of the clustered 60-site sample design with a more efficient national sample. Additional changes to the survey include using a mailed survey instrument instead of telephone interviews, information technology (IT) questions, and significant modifications to the survey instrument to better represent current issues in care delivery and to adapt to the new data collection mode. The sample and data collection mode changes were dictated by resource availability and because of rapidly declining response rates achieved using telephone surveys of physicians. **None of the Physician Survey questions asked about hospital leverage in securing high medical payments from insurers.**

The Center for Health System Change website states that "…the 2008 Health Tracking Physician Survey establishes a new baseline that will allow future tracking of how physicians organize and practice medicine." **Because of these aforementioned changes in survey administration, results from the 2008 physician survey cannot be compared to findings from earlier CTS Physician Surveys.**
Berenson's study only considers interviews in 2010; no evidence of a time-series. For example, on page 974, the report states, "…respondents thought that hospital negotiating strength was growing." However, **no trend data is provided to support this claim.**

2. Is the researcher's data transparent?

Assessment: The Berenson Study is not Data Quality Compliant and cannot be used to formulate national policy.

A review of the CTS data posted at www.hschange.org reveals that the 2010 "seventh-round" interviews are not available. It appears that only the non-CTS interviews, conducted by Berenson's research were the actual basis for this study. The non-CTS interviews are not available to the public and therefore there is no way to independently

verify trend-increase statements such as the one found on page 976: "According to study respondents, multihospital systems with varying degrees of leverage now dominate health delivery in most of the twelve (metropolitan) markets."

3. Is quantitative data used to support the opinions gathered in the interviews?

Assessment: Quantitative data, in trend form, is not provided in the report.
The primary thesis of the Berenson Study is that hospitals are securing steep payment increases from insurers. However, the Berenson study does not include any numerical data to support statements such as the following: "Reported price increases for hospitals in recent years …have been in the high single digits – although sometimes substantially more – in most of the twelve markets, which exceeds increases in hospital costs of caring for privately insured patients in all markets." [p. 978] Berenson stated that his study "…**did not gather data on actual payment rates**…", but instead referenced two studies that found substantial variation within (metropolitan) markets and across hospital sizes. [p. 975]

CRE reviewed the two payment rate data studies cited by Berenson: Medicare Payment Advisory Commission (MPAC) report and a study by Ginsburg. These reports were published in 2011 and 2010, respectively and have the same thesis that must-have hospitals and physician specialty groups have significant leverage over insurance payers. The MPAC report cites the Ginsburg study, stating that the Health System Change publication shows wide variation in hospital and physician payments within and across markets. Specifically, the Ginsburg study examined eight health care markets, using data from four national insurers who reported their payment rates as a percentage of Medicare rates. The Ginsburg study results included:

- Average payment rates in relation to Medicare for outpatient hospital services were generally higher than those for inpatient services.
- Variation in physician payment rates was not as pronounced but was still notable across and within markets and by specialty.

The results, provided in tabular form are provided directly below for the reader's inspection. While the data does show across the board higher-than-Medicare payment rates, the reader should be cautioned on three primary points:

1) The Ginsburg study collected payment rates for "Private Insurers" but does not make any distinction between the predominant health plans such as HMOs and PPOs, and private medical insurance for individuals (e.g. "gap insurance"). Such a distinction would be important since private medical insurance payers (smaller network) have significantly higher payments which could have skewed the data in both tables below.
2) The Berenson study focused on interviews in twelve metropolitan communities, of which only four are included in the Ginsburg study (Cleveland, Indianapolis, Los Angeles, and Miami). Therefore the Ginsburg payment data does not fully support the interview information collected by Berenson.
3) Finally, the payment data was only collected in the year 2010 (no trend data).

Table 1 from the Ginsburg study is provided directly below. Ginsburg uses the term "variation" which is commonly described in statistical terms by calculating Range (maximum data point minus the minimum data point), variance, or standard deviation. However, none of these calculations can be done on the data in Table 1 due to insufficient data. Nevertheless, the reader can observe that every cell in Table 1 exceeds 100%, which means that in every case, payment rates exceeded Medicare rates. One measure of variation that is also used is called "Inter-Quartile Range (IQR)" and is defined as the difference between the 75th and 25th percentiles (e.g. 75th percentile – 25th percentile). When the IQR is calculated for each of the eight communities for inpatient care, the results are: Cleveland 47%, Indianapolis 61%, Los Angeles 84%, Miami 61%, Milwaukee 53%, Richmond 67%, San Francisco 116%, Wisconsin 65%. These calculations show that 5 of the 8 communities have relatively the same payment variance: Indianapolis, Miami, Milwaukee, Richmond, and Wisconsin. **The study of variation in payments would have been more meaningful if data were collected in a follow-on year (e.g. trend analysis).**

From "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Center for Studying Health System Change, Paul Ginsburg, Nov 2010, Table 1: Private Insurer Payment Rates to Hospitals as a Percentage of Medicare

Hospital Payment	Cleveland	Indianapolis	Los Angeles	Miami-South Florida	Milwaukee	Richmond, Va.	San Francisco	Rural Wisconsin
Inpatient Payment								
Inpatient Average Payment Rate	151%	198%	149%	147%	205%	192%	210%	169%
25th Percentile	102	168	84	113	167	171	136	144
50th Percentile	128	197	118	136	195	200	210	178
75th Percentile	149	229	168	174	220	238	252	209
Highest Payment Rate, with Volume	232	283	418	284	333	291	484	318
Outpatient Payment								
Outpatient Average Payment Rate	234	307	277	*	267	267	366	240
25th Percentile	158	259	179	*	238	231	268	167
50th Percentile	193	303	243	*	262	275	368	195
75th Percentile	234	336	307	*	304	347	456	291
Highest Payment Rate, with Volume	357	493	559	*	439	495	718	381

* Fewer than three insurers reported.

Source: Author's analysis of hospital payment rates of four large national insurers, Aetna, Anthem Blue Cross Blue Shield, CIGNA and UnitedHealth Group

Table 3 (provided directly below) from the Ginsburg study describes the variation in physician payment rates across the same eight areas. Ginsburg opines that larger practices negotiate higher rates with insurers based on the perceived importance of their presence in plans' networks. "Standard—not negotiated—rates tend to be based on a common fee schedule for most specialties, but there are important exceptions, such as hospital-based specialties, particularly anesthesiology. Average standard physician rates across the eight markets were within 20 percent of Medicare rates in most of the geographic areas. Miami had the lowest rates, while Milwaukee and rural Wisconsin stood out at the high end."

"Standard rates tend not to apply to hospital-based specialists. Although reporting of rates for anesthesiologists for this study was limited, rates were substantially higher than for other specialties."

Ginsburg reported that insurance executives explained the high rates for anesthesiologists are a consequence of patients' inability to choose an anesthesiologist. "Since hospitals tend to contract with one or more anesthesiology groups to provide all services, insurers perceive that it would be inappropriate to penalize enrollees using an in-network hospital for using an out-of-network anesthesiologist. This leads to insurers seeking to obtain a much higher percentage of anesthesiologists in their networks than for other specialties."

From "Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power," Center for Studying Health System Change, Paul Ginsburg, Nov 2010, Table 3 Private Insurer Physician Payment Rates as a Percentage of Medicare

Physician Payment	Cleveland	Indianapolis	Los Angeles	Miami-South Florida	Milwaukee	Richmond, Va.	San Francisco	Rural Wisconsin
Standard Rates	101%	110%	92%	82%	166%	112%	108%	176%
Rates for Practice, 75th Percentile								
Internal Medicine/Family Medicine	112	117	*	89	175	128	*	169
Cardiology	155	156	*	110	223	145	*	234
Orthopedics	124	140	*	101	212	144	*	195
Anesthesiology	251	217	177	*	*	*	177	*
Radiology	166	147	*	134	238	153	*	240
Oncology - Physician Services Component	138	138	*	116	204	132	*	195

* Fewer than three insurers reported.

Source: Author's analysis of hospital payment rates of four large national insurers, Aetna, Anthem Blue Cross Blue Shield, CIGNA and UnitedHealth Group

CRE analysis of Anesthesiology fee-for-service rates during the 2010-2011 timeframe confirmed an upward trend. However, the reader should be cautioned that Table 3, from the Ginsburg study elected to only show the 75th percentile for the specialty practices perhaps as a means to over-emphasize the anesthesiology rates. In other words, the reader is looking at the top 25% percent of payment rates for the listed specialty practices. **It would have been more meaningful and transparent if Ginsburg were to include the 50th percentile (the median, the middle) of payment rates for the listed specialty practices.**

4. Are there others factors that may impact payment rates?

CRE investigated two other factors that should be further investigated and considered in the outlook for medical payments:

- Alternatives to fee-for-service payments
- Information Technology capital investments

Coincidental with the release of the Berenson Study, the Washington Post printed the results of their study investigating the American Medical Association (AMA) Committee's establishment of procedure points which impact overall fee-for-service payment rates submitted to the insurers. The study featured endoscopic procedures to illustrate that AMA-established time measurements do not reflect the actual procedure completion times, often resulting in inflated specialty practice payments. Strangely, the Washington Post article featured comments from Robert Berenson who reportedly timed his own colonoscopy as a means of supporting his skeptic view of time-measurements.

The Washington Post article points out that AMA procedure points are just one factor in an otherwise complex Medicare formula for determining payments. Likewise, private insurers are not bound to the AMA procedure points and indeed make separate network factor adjustments. So, are there any alternatives to AMA's procedure point system and fee-for-service model? The answer is yes.

The Center for American Progress published a comprehensive study titled, Alternatives to Fee-for-Service Payments in Health Care in September 2012. The study highlights numerous ongoing pilot studies in which providers and payers are in partnership with the Centers for Medicare and Medicaid Services (CMS) to implement a variety of payment and delivery system reforms designed to control costs and improve care, especially in the Medicare program. The Center for American Progress examined three alternatives to fee-for-service payments:

1) Bundled Payments: fixed amounts paid to health care providers for a bundle of services or all the care a patient is expected to need during a period of time;
2) Patient-Centered Medical Homes: redesigned primary care practices that focus more on preventive care, patient education, and care coordination between different health care providers; and
3) Accountable Care Organizations (ACOs): groups of heath care providers who agree to share responsibility for coordinating lower-cost, higher quality care for a group of patients.

Even though the pilot alternative programs are primarily focused on the public sector, the American Progress study included successful private sector initiatives as well as factors for success. CRE contrasts these pilot results against shortfalls identified in the Berenson study.

The following pilot illustrates the successful deployment of "episode bundled" payments, in which the provider and payer collaborate to define the medical services and conditions (the episode) that will comprise the bundled (fixed) payments for specialized services.

The Geisinger Health System's Proven Care pilot was selected for this CRE analysis since it demonstrated reduced costs for private insured patients (the focus of Berenson) as well as Medicare beneficiaries. The reader should note that the eligible episodes include cardiology. Hence, cost reductions such as in this Geisinger pilot may contribute to reduced variation in cardiology practice payments – thereby countering the claims made by the Ginsburg study (see Table 3 above).

From Center for American Progress, Alternatives to Fee-for-Service Payments in Health Care, Sep 2012, Appendix A: Select Bundle Episode Payments, Quality and Cost Results, p. 42.			
	Eligible episodes and definition	**Payment model**	**Quality and cost outcomes**
Geisinger Health System's ProvenCare 2006–present Geisinger, or GHS, a private health system in Pennsylvania, first piloted global episode payments for elective cardiac bypass surgery. They later expanded the program to include a total of eight episodes based on best practices. This fee includes 50 percent share of historical readmission rate. Geisinger is an integrated delivery network.	**Eligible episodes:** Coronary Artery Bypass Graft (CABG), hip replacement, cataract surgery, angioplasty, perinatal care, bariatric surgery, low back pain, and erythropoietin management. **Episode definition:** For each eligible episode, ProvenCare requires its physicians to follow 40 essential best practice steps. For example, for CABGs, bundles include all non-emergency procedures including preoperative evaluation, and all hospital and professional fees. Geisinger also offers a surgical "warranty," covering the entire cost of any follow-up care needed by patients experiencing an avoidable complication within 90 days of the procedure. **Eligible patients:** Geisinger health plan patients.	ProvenCare uses a pay-for-performance model and charges a fixed price for the eligible procedure, which includes a percentage of the historical costs of complications.	**Cost:** Hospitals reduced costs 5 percent.6 **Quality:** Requires adherence to evidence-based clinical measures (40 best practice steps). CABG guidelines were developed based on American Heart Association and American College of Cardiology guidelines. For CABGs, the average total length of stay fell half a day and the 30-day readmission rate fell 44 percent over 18 months. Also, 59 percent of patients received all 40 best practices; six months later, 100 percent of patients received all best practices.7 ProvenCare is also estimated to have reduced all complications by 21 percent. 8

The next set of pilots illustrates the quality and cost results of select Accountable Care Organizations (ACOs). Some noteworthy items for these pilots: First, Monarch Health Care partnered with insurance payer Anthem, which is one of the commercial insurance payers discussed in the Berenson study. Secondly, it is interesting to note that several of these ACO initiatives include increased risk-bearing taken on by the provider (see the fourth column in the table). This is in stark contrast to Berenson's thesis that top-tier hospitals and large physician groups consolidate in order to gain negotiating strength. [p. 976] Thirdly, HealthCare Partners formed-ACO is based in the Los Angeles area, which is one of the metropolitan areas visited in the Berenson study.

From Center for American Progress, Alternatives to Fee-for-Service Payments in Health Care, Sep 2012, Appendix C: Select Accountable Care Organizations, Quality and Cost Results, pp. 48-49.				
Program	**Scope**	**Key Organizational Features**	**Payment Model**	**Key Outcomes**
Monarch HealthCare[4] *Brookings-Dartmouth pilot member* Monarch is a large independent physician association in Orange County, California, partnering with Anthem.	**Providers:** 500 of Monarch's 760 primary care physicians will participate (not currently assigning patients to specialists) **Payer:** Anthem **Patients:** 25,000 PPO members *Note: Anthem plans to introduce an ACO product in 2012.	**Quality measures:** Quality measures based primarily on Healthcare Effectiveness Data and Information Set, or HEDIS, performance measures and additional efficiency measures **Population health management:** • Case management • Disease management • "Touch Teams" • Personal health records and advance directives • Use of urgent care and hospitalists	Shared savings with no risk in year 1, transition to risk bearing. Providers are eligible for up to a 20 percent shared-savings bonus based on performance. Providers receive a care management fee from Anthem.	There are no results yet but Anthem projects a potential 3 percent to 7 percent reduction in trend of total cost of care in 2012.
HealthCare Partners[6] *Brookings-Dartmouth pilot member* HealthCare Partners is a medical group and independent physician association in Los Angeles, California. The accountable care organization is being integrated into HealthCare Partners' existing coordinated care model. HealthCare Partners is also a Pioneer ACO.	**Providers:** 1,000 primary care physicians, 1,700 specialists **Payers:** Anthem **Patients:** 50,000 Anthem PPO members	**Quality measures:** Still in development but will be aligned with Brookings-Dartmouth starter set. **Organizational capacity:** HealthCare Partners uses regional business units to ensure that services are delivered based on local needs. Each regional team is accountable for the collective performance of doctors in their unit. Team performance determines compensation. The organization also has a strong system for managing population health, quality and costs, which includes a robust HIT infrastructure, care management tools, and use of hospitalists.	Shared savings with no risk in year 1, transition to risk bearing. Providers will receive a medical management fee. Percentage of savings providers are eligible for is not determined yet, but will only be available if providers meet quality thresholds.	There are no results yet, but Anthem projects a potential 3 percent to 7 percent reduction in trend of total cost of care in 2012.
Tucson Medical Center[7] *Brookings-Dartmouth pilot member* Tucson Medical center is a non-profit community hospital. A new legal entity, the Southern Arizona Accountable Care Organization was created to virtually integrate the hospital and physician groups.	**Providers:** 55 primary care physicians, 35 specialists **Payer:** United Healthcare **Patients:** 8,000 Medicare Advantage beneficiaries and 23,000 commercial PPO members	**Quality measures:** Still in development, but will be aligned with Brookings-Dartmouth starter set. **Organizational capacity:** Tucson has several programs aimed at care management, including Hospitals- to-Home post-acute care coordination, seven PCMHs and care coordination teams.	Shared savings with no risk in year 1, transition to risk-bearing, likely by year 3. Any savings will be distributed as follows: 65 percent to physicians, 20 percent to the hospital, 15 percent to meet internal efficiency goals. Physicians will not be eligible for any upside savings unless they meet quality thresholds.	No results yet.

Finally, the American Progress study includes "keys to success" for these alternative payment measures. One lesson learned with regard to the Bundled Payment methodology is that both the provider and payer must collaborate to determine the performance measures. Another challenge is front-end investment in organizational capacity. In particular, provider organizations (whether hospitals or physician groups) need to make investments in necessary technology platforms in order to integrate new payment models more readily as well as share medical information within the Accountable Care Organization in order to eliminate redundant procedures and share best practices in real-time. **Coincidently, the 2008 new baseline Health Tracking Physician Survey now includes information technology (IT) survey questions. Data from these questions should be investigated for possible correlation with the ongoing alternative payment model pilots.**

The Affordable Care Act requires the Department of Health and Human Resources to explore alternative payment models. The National Pilot Program began on January 1, 2013 and is scheduled to run for five years. The American Progress report highlighted several predecessor demonstrations that will undoubtedly continue into this phase. Stakeholders will certainly receive trend data on these alternative payment methodologies.