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Maryland's Maverick Health Care Overhaul: A Physician Perspective

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Beginning last year, the state of Maryland embarked on an extraordinary new experiment — one that could be a model for the nation. In partnership with the Centers for Medicare and Medicaid Services (CMS), Governor Martin O'Malley's statewide hospital commission announced in January 2014 that it would address escalating health care costs by tackling the arms race of medical care. The Commission unveiled the framework for a new plan that will pay hospitals for quality over quantity, enabling them to profit from providing more appropriate—rather than simply more—care.

The proposed change of incentives has the potential to positively alter hospital workplace culture by halting the current revenue-based push to do more — an effort that invariably trickles down to doctors. The government pays more for more medical care, CEOs in turn tell their department leaders to increase volumes, and department leaders tell their doctors to do more. The push sometimes gets magnified along the way, and it is met with frustration among doctors because it values how much a physician does over how well they do it.

Maryland's framework has the potential to break these vicious cycles and replace them with virtuous ones leading to greater quality and health. However, the plan is still in its early stages and its impacts are still developing; it also contains the seeds of potential conflict between hospitals and physicians, and there are other issues that must be addressed if the plan is to achieve its potential. These concerns and some potential solutions are discussed below.

The context for Maryland's new plan is a health care system in which a record 40 percent of physicians report feeling burnt out. Many physicians cite increased pressure to see more patients and do more procedures with limited resources; doctors are often evaluated by monthly volume quotas that do not measure appropriateness or outcomes. Some doctors regularly receive coaxing emails from their higher-ups reminding them how "critical" it is to meet their monthly relative value units (RVU) targets, clinic targets, or target number of operations in a month, if they are projected to have a slow month, in the same way a car dealer is evaluated by monthly car sales. Physician burnout has negative implications for patient safety, quality, and access, imposing costs that can ironically offset the added revenue from increased volume.

Increasingly aggressive compensation structures promoting the arms race of doing more are now being recognized as a driver of the massive waste in American medicine. While doctors will generally do the right thing most of the time, there are myriad examples where decisions were driven by profit over quality care, fueled by the fee-for-service system. The problem has reached endemic proportions. Calling out the trend, the Institute of Medicine now reports that up to one-third of health care dollars in the U.S. are spent on care that does not make us any healthier. One great strength of Maryland's new health reform is its long-term plan to address this dangerous and costly trend.

A Radical Overhaul

In the new plan, a hospital can now profit from fewer hospitalizations and office visits by offering durable health to its patients in any form, opening the door for new ideas ranging from creative health apps to home and workplace visits to promote prevention, wellness, and follow-up care. As physicians, our clinical experiences often remind us how such patient-centered care and community engagement can decrease hospital utilization.

We embrace the concept of rewarding quality and curtailing manufactured incentives for overtesting, overdiagnosing, and overtreating. Under the new plan, a Maryland hospital is no longer paid on a per-admission basis but instead receives a global payment based on the number of Maryland beneficiaries cared for by the hospital. Patients and payers are still charged on the basis of services provided, but overall growth of per capita hospital payments by all payers is limited to 3.58 percent by diagnosis related groups, and the Medicare-specific growth rate will be held to 0.5 percent less than the annual national average.

To reward prevention and good patient outcomes, hospitals will be permitted to retain a portion of lost revenue if volumes decrease. Within five years, the commission hopes to take a subsequent step away from fee-for-service and introduce a true population-based system that rewards quality of care as a function of both outcomes and cost, which is already being piloted in some rural areas of the state.

Unanswered Questions And Recommendations

The new plan is as refreshing as it is radical, but, there are some important limitations that could impact doctors.

A Potential Hospital-Physician Conflict

First, the new payment plan is only for hospital costs. We doctors will still be paid by professional fees (pro fees) in the old fee-for-service system that rewards high-volume medicine. This clash of incentives within a hospital, where hospitals profit from less care and doctors profit from more care, is a divergence that could create new friction between doctors and their hospitals; this could endanger the success of Maryland's reforms and compound problems of burnout, quality, and cost if not managed properly.

One solution is for hospitals to share their profits with their doctors. The profit-sharing model has been shown to be effective in other industries; however, it has rarely been applied to health care. The new plan underscores the potential benefit of this model in health care. We recommend early engagement with physicians.

Out-Of-State Patients And Gaming The System

Second, the new Maryland health plan does not apply to out-of-state patients. Maryland hospitals will be heavily incentivized to attract out-of-state patients. This incentive could have a positive effect by promoting competition to innovate and develop nationally-recognized centers of excellence, but it could also result in gaming of the system. For example, doctors with privileges at Maryland and non-Maryland hospitals could send certain patients to out-of-state hospitals, especially if the case is complicated. Hospital systems with out-of-state hospitals could be rewarded for playing a similar shell game.

State-level experiment in health care is much needed, but it will be important to monitor its implementation to ensure that the playing field of measurement is fair for all Maryland hospitals. Early in New York State's cardiac surgery program, some hospitals were discovered to be manipulating the system, yielding performance metrics which were not fully valid. Excluding ER to ER transfers covered by the Emergency Medical Treatment and Labor Act (EMTALA), how much will a hospital promote inpatient transfers of in-state and out-of-state patients in need of tertiary care? Will marketing campaigns only take place out-of-state to encourage out-of-state business? These are important issues to follow since any incentive can turn perverse if not re-evaluated against real-world trends.

Inadequate Quality Measures

Third, the quality metrics that will affect payment are limited, while the field of quality continues to develop physician-endorsed metrics that are valid and comprehensive. For example, patient satisfaction accounts for 30 percent of the formula to adjust payment based on quality, yet this metric may be more meaningful to assess office-based specialties than procedure based specialties — you can have an unnecessary operation and be totally satisfied with it.

Central line infections account for 10 percent of the adjustment formula but represent a much smaller fraction of the avoidable harm in medicine today. Given the past achievements in reducing central line infections due to improved technology and increased awareness, preventable Central Line-Associate Bloodstream Infections (CLABSI) are rare today. In fact, in our personal clinical experience performing complex operations and caring for the patients through their intensive care unit (ICU) stay and subsequent hospitalization, we have not observed a single preventable central line associated infection in years.

The Maryland quality measures represent the problem of metrics that capture what's easy to measure rather than what matters most to patients. A national survey of physicians confirms the estimates by the Institute of Medicine and our own clinical observations that up to a third of procedures are unnecessary, yet this form of preventable harm is unmeasured in the Maryland framework because it is more difficult to measure. Quality metrics need to mature to include appropriateness of care and unsupported pathology for surgical cases; they need to measure complication rates beyond the Agency for Health and Research Quality (AHRQ) patient safety indicators, which have little credibility among surgeons because of their inadequate risk-adjustment. We applaud the use of patient satisfaction, central line associated blood stream infection rates, and patient safety indicators but they are only a preview of more comprehensive metrics which are needed.

National registries of patient outcomes are vastly underfunded and underdeveloped, but these efforts, in conjunction with new quality metrics under development by physician groups, are needed for Maryland's plan to better measure quality. More robust quality measures under development include hospital outlier status of risk-adjusted blood utilization rates; risk-adjusted complication rates; risk-adjusted C-section rates; and the hospital-level risk-adjusted proportion of operations performed laparoscopically when that is indicated by Cochrane reviews.

A Crucial Payment Formula Question

Finally, will the state ultimately incentivize hospitals to do more care by calculating a hospital's financial allotment based heavily on procedure volumes from the past year? If so, it could result in business as usual, sending a between-the-lines message to hospitals that the more they do, the more favorable their allotment for the subsequent year will be. If this untended consequence is realized, it will render impotent Maryland's efforts to address the epidemic of too much medicine.

A Change In The Culture Of Medicine

Waste is prevalent in medicine, with America's businesses and families footing the bill. In light of the growing problem of physician burnout, wide variations in workplace cultures, and the epidemic of overtreatment in the United States, the current path has been recognized as unsustainable. This reform seeks to reverse incentives that promote overtreatment while rewarding quality. Built into the forecast is a global cost savings, but more importantly, a reform could change the culture of medicine. If successful, it could represent a landmark change of course for health care.

The best hospital is not just a brick-and-mortar building for people when they get sick; it may be an occupational therapist teaching business how to minimize workplace injuries, or a partnership with schools to serve low-sugar fresh meals. If the Maryland plan delivers what it promises, it will remind us that the best neonatal intensive care unit (NICU) is one that is scarcely used because of good prenatal care, and the best type II diabetes management is not a gastric bypass surgery but prevention. With this new plan, appropriate care can be rewarded as a means to achieve better health. And ultimately, the best means to address rising health care costs is good health.
