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To the Honorable Chairs and Members
Health Care Finance Committee

Re: Recommendations of the Special Commission on the Health Care Payment System

My name is Alan Semine, M.D. I am a radiologist and the Chief of Breast Imaging at Newton Wellesley Hospital and Medical Director of the Manton Breast Imaging Center and of the Auerbach Breast Center. I am president of the Massachusetts Radiological Society (MRS), which represents over 800 radiologists and radiation oncologists practicing in the Commonwealth.

Radiologists and Radiation Oncologists

Radiologists are physicians who, after four years of college and four years of medical school, continue their studies by undergoing specialty training with one year of internship followed by four years of residency to become general diagnostic radiologists, followed by one or two additional years of fellowship to develop the special expertise required for subspecialties such as neuroradiology, nuclear medicine, breast imaging, musculoskeletal imaging and interventional radiology.

Radiologists care for their patients by examining images of anatomy and physiology generated with X-rays (including CT), nuclear isotopes (in nuclear medicine and PET), ultrasound, and MRI. Other physicians, including primary care physicians and specialists, refer their patients to radiologists who perform studies or procedures in order to evaluate symptoms and make diagnoses, as well as to monitor treatment. Radiologists also use imaging to guide their placement of needles or catheters for diagnostic purposes, to sample tissue, or to treat specific conditions while avoiding the need for open surgery.

The use of radiology services has increased significantly over the decades. This change reflects how the dramatic progress in the science and the practice of radiology has revolutionized the way we provide health care. From the use of screening mammography to detect early breast cancer, to the use of MRI to diagnose and map brain tumors, to examination with ultrasound to complement prenatal care, to the use of catheter embolization of uterine arteries to stop post partum hemorrhages, radiologists are providing essential high level care for patients.

At the same time, the field of radiation oncology has also advanced significantly with ever more exacting and complex options for administering radiation to treat patients.

Imaging and the Cost of Health Care

The Special Commission was convened in order to explore payment options with the express purpose of addressing the increasing cost of health care. The fact that health insurance costs increase year after year is indisputable. It represents a strain on the economy, especially for small businesses. In fact, most physician practices are small businesses and we too experience the escalating cost of health insurance.

The increased use of high cost imaging, specifically CT, PET and MRI, is commonly cited as an important contributor to cost. It is essential to understand and account for this specific aspect of health care cost escalation. The Special Commission began its analysis by concluding that the reason for increased utilization in medical care is the fee-for-service payment structure. However this generalization does not account for the increased use of high cost imaging. The vast majority of the time, when a physician orders a radiological study for his or her patient, the physician gains only information in return, and does not financially benefit from the additional procedure. It is only when the physician refers a patient for an imaging procedure to a facility in his own office or to a facility where he has any ownership interest that there is a financial incentive to increase volume. Such situations for high cost imaging may be common elsewhere in the country, but are not as common in Massachusetts, in part because of our Determination of Need (DON) regulations covering MRI, PET and radiation therapy services. Yet imaging utilization continues to rise in the Commonwealth. We need to understand what is really happening.

Radiologists are paid on a fee-for-service basis, but they do not control the number of examinations they perform. In fact, a radiologist, as a general rule, cannot order studies on any patient. The referring doctor must order the examination; otherwise the insurer will not pay for the service. Even when a radiologist believes that an examination is warranted, he can only recommend that it be performed. It is up to the referring doctor to act on the recommendation.

The contribution of imaging services to the quality of medical care is unquestioned. While improvements in technology are costly, when used appropriately, they add significant value. Appropriately used imaging allows significant savings by establishing diagnoses and focusing medical management, thus commonly avoiding still higher cost interventions such as unnecessary surgery or extended hospital admissions. We must make sure that any changes implemented do not undermine the benefits of medical progress. On the other hand, there are drivers that increase utilization beyond what is medically necessary, and we need to consider what these are.

Patients in Massachusetts are educated and savvy. When they need health care, they expect the best care available. In fact, patients often judge their physicians based on how proactive they are in making high level or complex services accessible. Physicians compete by helping their patients access such care. Physicians are also sensitive to patient expectations because of the concern that they will be held accountable if they omit or argue against an expensive service that ultimately proves to be of value, even if a lower cost alternative service would provide the same results. There is no support for the doctor when he or she tries to dissuade a patient from having an examination or a treatment. Concern about the potential for accusations of malpractice if patient expectations are not met commonly results in overuse of imaging studies.

Defensive medicine is a much-discussed phenomenon, but its reality is sometimes distorted. Although malpractice insurance rates and malpractice awards are substantial, these expenses constitute a minor proportion of health care expenditures. It is the health care provider’s behavior in the current climate of malpractice exposure that increases costs. For better or worse, physicians and other health care providers are fearful of getting sued. Lawsuits assault the very core of their professional identity and integrity. Whether we have global payment or fee for service, the impulse of every physician is to do whatever is necessary to avoid being second-guessed and challenged in a lawsuit, even when the measure taken is not medically warranted. It is not the financial cost of the lawsuit that guides the

decision; it is simply the prospect of being accused of being a poor doctor, however unfairly. The survey conducted by the Massachusetts Medical Society on the impact of defensive medicine determined that up to 25% of imaging studies were ordered for defensive purposes rather than for medical necessity.

Recommendations of the Special Commission

The solution proposed by the Special Commission to reduce health care costs is to mandate global payments. Global payments are expected to provide financial incentives to limit use of health care resources in order to decrease overall costs. Today, 20% of health insurance in MA is already provided using such principles and health care providers have good experience administering such plans. However, to mandate that all plans should be converted to global payments would ignore consumer choice. There are consumers who object to capitation because they perceive a conflict of interest and a perverse incentive for providers to withhold services. If we want to expand the use of risk-based contracts, we should explore strategies to accomplish that. However, the premise that global payments represent the complete solution to rein in costs may be missing important opportunities to identify specific issues that should be addressed in this effort regardless of the payment structure.

There is a serious risk that newly formed "accountable care organizations" (ACOs) would struggle to adapt and would fail to be effective providers of coordinated health care. Currently, there are a significant number of medical organizations that accept and manage patients insured through risk-based contracts. These organizations function as ACOs, though they may be identified with different terminology. Their use of RBRVS based fee structures to guide the distribution and sharing of the global payments is pivotal to their success. To the extent that there are geographic locations in Massachusetts where such organizations do not exist and there is a market for risk-based insurance products, these organizations can serve as a model for others. However, given the need for provider cooperation, infrastructure and support services for the mechanism of global payment to develop effectively it may be important for state government to provide support and resources to help form them. It is absolutely essential that new "accountable care organizations" be given guidance and structure to allow effective collaboration among PCPs, specialists and hospitals. There need to be clear guidelines establishing the framework for the formation of ACOs in order to diminish the prospect of internal strife and fractious competition for the global payments, as occurred in the 1990s during the previous attempt to implement capitation.

Electronic Health Records and Appropriateness Criteria

The success of ACOs is predicated on collaboration among PCP's, specialists and hospitals to manage patient care efficiently. To succeed, they need to analyze valid data on their patients, and to compare that data to valid benchmarks and standards. The use of Electronic Health Records is an essential measure to support such collaboration, and should include order entry and decision support. Only with such resources do physicians have the necessary tools to order appropriately. In radiology, evidence-based appropriateness criteria have been developed and refined over many years. These criteria are available but not necessarily readily accessible, and can be applied to any system of payment, whether fee for service or global payment. The government could be helpful by encouraging their use and dedicating resources for wider availability and affordability of EHR with decision support. The need for such resources applies to all payment structures. Physicians who do not have financial incentives to order unnecessary tests want to order the right tests. If given the tools to do that effectively and efficiently, they will choose the right options. When patients request and even demand unnecessary or inappropriate testing, the ordering doctor can share with them the decision process and the reason why they do not require the examination. With the use of EHR with decision support, it should be possible to decrease the ambiguity that sometimes accompanies medical decision-making, and hence to defend a decision made according to appropriateness criteria, and consequently also to discourage lawsuits and defensive medicine.

Proposal for formation of an oversight agency

The proposal for the formation of a state government agency to oversee the transition to global payments is not reassuring. An agency consisting of experts representing the perspectives of different stakeholders with different agendas would have serious difficulty gaining the trust required and accomplishing the tasks assigned. There is no such agency overseeing current risk contracts. The alleged need for such an agency is based on the expectation that the mandate to implement global payments will encounter serious obstacles and complexities, which would be true of any governmental mandate imposed on a complex economic and social system like health care. But such an agency would likely lack the wisdom and the experiential basis to implement needed corrections on a health care delivery system which is not uniform, and risks causing unintended damage trying to balance the interests of consumers, providers and public and private payers. We should build on the successful experience we have with voluntary risk contracts rather than force a change that generates doubts and requires a panel of alleged experts to implement and oversee.

Conclusion

The recommendations of the Special Commission for transition to global payments as the sole methodology for providing health insurance in the Commonwealth is based on the observation that risk based contracting can be accomplished effectively. However, the Commission fails to recognize that mandating such a change ignores consumers who do not want their doctors' decisions to be clouded by a financial conflict of interest. In addition, the Commission neglects to emphasize the critical importance of organizational structure and collaborative balance characteristic of successful accountable care organizations currently providing care with risk-based contracts. Instead, it proposes the formation of an oversight agency to oversee the transition as though such an agency could be effective gaining the trust of the stakeholders and could avoid being arbitrary and heavy-handed.

While total health care expenditures and the cost of health care insurance have been increasing steeply, the unit cost of health care services has not been outpacing the consumer price index. Reference to "health care inflation" is misleading. The alleged inflation mostly represents expansion of services including technological advances and new medical treatments. Patients in the Commonwealth have access to many of the most advanced medical treatments available and they recognize and value this advantage. Physicians in Massachusetts are proud of their ability to provide such services. Most doctors do not have a financial interest in the tests and imaging examinations they recommend to their patients. They want to be thorough but also cost effective. Electronic Health Records with decision support to access appropriateness criteria are valuable tools to achieve such goals. We need to invest in the resources that allow physicians, hospitals and other health care providers to do the best they can with the assurance that they will not risk being accused of malpractice for patient outcomes they cannot control.