

Tennessee's Episode-of-Care Payment Creates Conflict of Interest for Physicians

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Public and government concern about the relationship between pharmaceutical companies and physicians led to the Pharmaceutical Research and Manufacturers of America (PhRMA) code for interactions with medical professionals.¹ Those interactions are intended “to benefit patients and to enhance the practice of medicine.” Financial inducements “even if they are practice-related items of minimal value (such as pens, note pads, mugs etc)” are prohibited. This policy is clearly intended to remove any financial influence over physician decision-making—from pharmaceutical companies.

Tennessee's medical program for the indigent, known as TennCare, has now created a new payment system for physicians, creating “provider incentives” and penalties designed to “influence the practice patterns of physicians.”² That includes physician decision-making. One could question whether this payment system meets the ethical standards of the PhRMA guidelines.

Tennessee has formed a cartel with the insurance companies administering TennCare and the health insurance of state employees. To create cost savings, physician payment will be made for a 90-day episode of care (EOC) for a given treatment or procedure. This will replace traditional fee-for-service.

The State will analyze the EOC costs of all the patients undergoing a specific treatment each year. The physicians whose patients' EOC costs are in the bottom tenth percentile (below the “commendable threshold”) will receive a “gain sharing reward” calculated as 50 percent of the cost savings defined as the difference in the physician's actual costs and the “commendable threshold.” The state calls this “provider incentives.” The state defines the cutoff of the top tenth percentile of EOC costs as an “acceptable threshold.” Costs above this threshold are therefore unacceptable. The physicians whose costs are above this will be required to refund 50 percent of the extra costs. This includes the cost of the treatment the physician ordered—and also any unrelated medical costs, including medications, imaging, rehabilitation services and re-hospitalization *for any cause*. The treating physician may have no control over such additional medical costs ordered by other “providers,” or resulting from patient noncompliance and substance abuse.

To enable the State to succeed in “influencing the practice pattern of physicians,” treating physicians will now be at personal financial risk for the resources provided

to their patients. This part of the new payment system deliberately creates a conflict of interest.

Tennessee names the physician at risk the “gatekeeper.” A more appropriate term would be the “rationer.” The apparent goal of the state is to achieve rationing while avoiding responsibility for it.

Currently this payment system applies only to TennCare patients and Tennessee state employees. Medicare, however, has now provided Tennessee with a large grant to develop and implement this program, which could serve as a model for Medicare and commercial health insurance payment reform.

By incentivizing physicians to provide the cheapest care and penalizing more expensive and effective care, the state may actually increase its long-term costs. For instance, drug-eluting coronary stents are more expensive than bare metal stents. They improve event-free survival and reduce long-term costs by reducing re-stenosis and repeat procedures.³ The state will now discourage their use. A similar pattern has been documented in the care of peripheral vascular disease, in which more expensive technology improves outcomes at reduced long-term cost.⁴ Generic drugs will be incentivized over newer branded drugs that have improved efficacy and safety, whose long-term clinical benefits and cost savings accrue outside the 90-day EOC window. Curiously, TennCare requires an often denied preauthorization for the drug Chantix to help patients stop smoking and reduce the medical costs resulting from the cigarettes they buy at the governor's gas stations. The incentives are for physicians to avoid prescribing or appealing insurance denials for expensive drugs and diagnostic studies that they ordered in the patient's best interest.

Tennessee recently approved of a 30 percent rate increase for insurance policies under the Patient Protection and Affordable Care Act (ACA). This reflects the complex and high-cost medical problems of the previously uninsured. Physicians will easily identify those patients most likely to incur high costs of care due to co-morbidities, unhealthy lifestyles, and noncompliance. Physicians will now have a powerful incentive not to provide care to these patients. Tennessee physicians have provided free care to uninsured patients and discounted care to TennCare patients for years. Many of these civic-minded physicians may now decide not to participate in TennCare to eliminate the serious personal financial risk to themselves and their families that the new payment system inflicts on them. The Oath of Hippocrates

does not require physicians to subsidize hospitals and insurance companies.

Participation in this program may also increase physicians' liability. Plaintiffs' attorneys may now question whether every medical decision was made to reduce costs for the financial benefit of the physician, rather than for the patient's medical benefit. A recent study has shown that the physicians who spend the most on their patients have the lowest rate of malpractice suits.⁵

Imagine that Tennessee decided to require lawyers in the public defender's office, who provide legal services to the poor and whose court costs were in the top tenth percentile, to refund those excessive court costs to the state. This might encourage lawyers to call fewer witnesses, use fewer experts, introduce fewer exhibits, and spend less time picking jurors. It would also make a lawyer responsible for additional court costs of clients for the next 90 days. Lawyers and the trial Bar would undoubtedly oppose this scheme as unethical and unprofessional, especially as it targets services to the poor.

The organized medical community has expressed no opposition to the Insure Tennessee payment system. Worse than silence, the Tennessee Medical Association has encouraged physicians to donate their time and participate in the planning sessions to implement this program. In the absence of any organized opposition to this plan, Tennessee physicians' only recourse may be to stop participating in the program. They can provide out-of-network services to these patients so as not to compromise their care.

Physicians should reconsider their membership in those medical organizations that claim to represent the interests of physicians and patients yet do not oppose the EOC payment system. Physicians outside Tennessee should be vigilant for changes in their state or in the Medicare program. This would provide yet another incentive to opt out of Medicare.

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