Incentives 2.0: Is Paying for Performance Enough?
The Commonwealth Fund
Alliance for Health Reform
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ED HOWARD: Good afternoon. My name is Ed Howard, I am with the Alliance for Health Reform and I want to welcome you on behalf of Senator Blunt, Senator Rockefeller, our Board, to today's program on how to structure incentives in healthcare in a way that promotes the so-called "triple aim" that is better quality, easier access and lower costs than otherwise.

I am the husband of an economist. So I'm well aware of the general rule that if you are trying to induce a certain behavior, you reward it financially. Hence a whole range of programs in both public and private sectors in healthcare. You will hear a lot about pay for performance today, there are also bundled payments and accountable care organizations and God knows what other acronyms will pop up in the course of the discussion today. And they are all premised on this basic market principle of economics. So you have that at the base, but we also know that results from a lot of the plans that have been put in place over the last few years to reward value not volume, if you will, have not met with resounding success. Or if they have succeeded, its been relatively modest.

So today we are going to look at healthcare incentives more broadly. Yes, payment restructuring is essential, but what is the best way to do it? And are there other ways to incentivize the providers in healthcare to get the results that we are trying to induce? We are pleased to have in a partner in today's program, the Commonwealth Fund, which has supported a lot of research about incentives along with its other interests in maximizing access to care and promoting a high performance healthcare system and joining me in moderating today's program is the Fund's Vice President, Dr. Anne-Marie Audet, who runs both their delivery system reform program and the new breakthrough opportunities program. Anne-Marie is herself a respected researcher in this field and can not only welcome you on behalf of the Fund, but help frame the issue of incentives for us. Anne-Marie?

ANNE-MARIE AUDET: Thank you Ed and thank you, The Alliance for helping us put together this briefing and also one of my colleagues, Mark Sza from the Commonwealth Fund with whom I work closely on this new endeavor that we call Incentives to Point O.

So I am going to begin by saying that no doubt we are in the middle of an unprecedented change in how we deliver care, how we pay for care and how we finance healthcare in this country. And our goal is to control the total cost of care, but also striving for high quality and health outcomes. We are seeing shifts in the way we pay for healthcare and although the shift away from fee for service has been slow, it is really happening. Last week, the catalyst for payment reform issued a scorecard where they looked at the private sector and the commercial payers were seeing an increase in the payment that is made to both physicians and hospitals that is value based, about 40% of those is value based compared to 11% last year. So that is significant change in value base care. Some of this is – we are looking to encourage providers, it's a pay for performance type of payments and other ways to encourage quality and affordable care. Medicare is also of course doing

a lot in this area with – as Ed mentioned, with a spectrum of different payment reforms that range from shared savings programs to two sided risk contracts where providers will gain, if they save cost and they also will lose if they do not. And then, all the way to capitation and eventually global payment. We are also seeing in Medicare a number of different reward and penalty payment reforms in terms of pay for performance, value based purchasing program, the hospital reduction – hospital readmission reduction program, which is more of a penalty program. So there is a variety of ways by which payment reform is now starting to incentivize a practice.

So the question is, when you look at this, the biggest challenge that the system is facing today is how organizations and providers start to translate these macro level influences to the more micro level of providers, physicians, teams and at that micro level. When you think about it, it's may be cliché to say that the most expensive technology is the physician's pen, but in reality when you think about it, it's more or less true, fundamentally at the core of our national expenditure and outcomes, if you drill down, you get down to the individual decision making that happens at the level of provider and their patients and all of these billions of decisions that are made every day about which drug to choose, whether to have surgery or not, all of those rolled up add up to our national expenditure and health outcomes. So how do we incentivize and how do we drive those decisions to drive value based healthcare? That is the key. We know that multitude of factors influence clinical decision making and performance from financial incentives, policy and regulation, organizational influences, intrinsic motivation. And this is a slide that even goes in more depth to show you all the myriad of influences – in the middle you have physician practice patterns, decision making and there is all of these influences that drive that, including knowledge and skills, the patient preferences, external drivers, that is the payment and the regulatory environment. Internal drivers, issues of professionalism, ethics and also social norms. The peer norms, the organizational culture and all of these influences are really important. So why do we need to look at a way from incentives 1.0 to incentives 2.0? I think if we really want to drive value, we need to look at much more comprehensively at those influences, knowing that financial incentives are one part of that whole cadre of influences that drive this decision making.

So we want to encourage and support healthcare decisions that are consistent for value based healthcare and hence why we are looking at multiple drivers of those decisions. We need to look at the science of human motivation, organizational culture; the peer context and behavioral economics can also help us a lot in this area. There is a lot of research that has been done on using behavioral economics to drive the consumer choices and less has been done in the provider's sphere. The Commonwealth Fund has just started a new program that is looking particularly at how we can use principles and concepts of behavioral economics and apply them to design better provider incentives that will lead to high value healthcare.

So some of the examples – and you will hear from our panelists about some of them, but just to give you a few examples – in terms of behavioral economics and how we design financial incentives, there are principles of choice overload for instance. So here people get overloaded if you have too many choices. So one rule would be if you design incentives, look at simplicity as opposed to complexity. The principle of mental accounting provides your incentive in the form of a reward that is easy to track and that is visible. We also know that people are quite loss adverse, so that people, human beings, value loss at the much more than the gain for a similar amount of dollars. So that should be really important to think about when you are designing incentives that are either a balance of rewards and penalties. And in thinking about how to organize non-financial incentives, these other influences, what is really important here are the choice architecture decision supports, forcing functions, for example, that will drive people to make the right decision at the right time. Social ranking and transparency, a lot of organizations are experimenting and using public transparency in terms of provider performance and in terms of the social ranking and the peer pressure and also peer learning from that type of an approach. Finally, thinking about other rewards such as reduced administrative burden. So together, if we really think more comprehensively about all of these influences, I think we have a chance to end up in a situation where we really drive value healthcare and this is our window of opportunity.

So today we have assembled a panel that will provide a really broad perspective on the topic. So first Dr. Ashish Jha will provide and overview of incentives 1.0 where we are today and some perhaps recommendations and insights about where we could be going. Our second speaker will be Ateev Mehrotra who has done some work with behavioral economics and will provide much more details than I have done here on some of the behavioral economic principals that could apply here in how we design these incentives. Finally, Dr. Patrick Herson will provide the on-the-ground experience at Fairview as to how they have really gone from the macro level incentives that as an organization they face and translated that into the provider incentives for several years now and a lot of insight and learning's from that experience.

ED HOWARD: Thanks, let's give Dr. Jha the clicker while I do a little housekeeping here, if I can. There are a lot more of items of biographical information on our very distinguished panelists in your packets. So we will eschew the time required to give them the introductions that they deserve. There is also a lot of background information in those packets, copies of those slides that the speakers will be using and those are also online at allhealth.org. There will be a video recording of this briefing perhaps as early as tomorrow, but within the next couple of days, followed a few days later by a transcript that you can take a look at, at that same website.

At the appropriate time, we ask you to get into the conversation either by coming to one of the microphones that you see in the audience, or by filling out a green question card that is in your packets.

Finally, the all important blue evaluation form, before you leave, please fill it out and I particularly ask those of you on congressional staffs to fill it out. Senator Rockefeller is pretty clear that you are our prime audience. Not that we don't love all of you, but we really want to get the feedback about topics and speakers and items that can be of use to you in your work.

So as Anne-Marie said, we have got a terrific panel for us today and we will turn to Dr. Jha.

ASHISH JHA: Great. So I am going to spend about six or seven minutes giving you kind of the state of play of where we are and I'm going to assume that most of you have not spent the last five years deep into the literature of the pay for performance stuff and so I'm going to spend basically a few minutes kind of bringing everybody up to speed about where we are. For those of you who have, it will feel a little redundant, but you will bear with us.

So why do we need pay for performance? Why is this a topic that we are discussing today? There are lots and lots of ways of showing the problem, here is one way that I like to do it. Let's look at heart attack deaths in America. So if you are a Medicare beneficiary, sitting here today, and you develop chest pain and you have a heart attack and you end up at an American hospital, which you will if you are here, what are your chances of surviving that? Right? So here is risk adjusted mortality on the X axis, number of hospitals on the Y – your chances of surviving depend a lot on which hospital you go to. There are hospitals where death rates are 5%, 10%, 15% at 30 days. That is pretty good. Right, that's pretty good? And if you are lucky enough to be at one of those hospitals, that is terrific. There are hospitals where it's more like 20% to 25%, not terrific, but okay. And then there are hospitals that do much worse. So here we are. Your chances of surviving your heart attack, somewhere in the 5%-10% range if you get the right ambulance taking you to the right hospital, your chances are three to four times worse. I don't know of any medical therapy that can reduce your chances of dying of a heart attack from 40% to 10%. Right? So picking the right hospital is the most important choice you make. The other point on that is if you are Medicare, you pay, until recently, the same amount to that 40% hospital as you do to that 10% hospital. That has never seemed quite right. And the notion has been, surely we can do something with incentives to make those 40% guys look more like the 10% guys. That has been – this is for hospitals, I could show you physicians and diabetes control, I could show you nursing homes and falls, it doesn't really matter, the story is basically the same. Lots of variation, some of it clearly inappropriate in the sense that we could all be doing better.

So what have we tried to fix this because this is not a new problem. People have been working on this for a while. So what we have tried, I would argue, is small dollars, but one percent of that payment at risk, maybe. Focus a lot on processes. Get doctors and hospitals to start doing stuff differently. Some of those processes were great, like getting heart attack patients aspirin and beta blockers, things that we know should be life saving.

Some of those processes were a little less than great, like getting hospitals to fill out a discharge instruction form. Sometimes hospitals would do a really good job and other times it was more of a tick the box. So those were mostly process measures and that is what I would say what we tried in the first half or much of the last decade. And if the question is, did it work? Well, you know the answer, because if it had, we wouldn't be here. So mostly it didn't really work very well and if you go to the headlines, you get headlines like *Health Affairs Article Finds Medicare Pay for Performance Did Not Spur Quality Improvement*. Here is one of my favorite lines from Politico [unintelligible] Report, *Pay for Performance A Bust, Paying Doctor for Quality Doesn't Work*. Another one on Medicare's policy change *Did Not Reduce Infection Rates*. And if you get away from the newspaper headlines and say, what does the evidence say? Here is a systematic review with slightly more academic language, the effect of pay for performance targeting individual practitioners on quality of care and outcomes remains largely uncertain. In other words, it isn't working very well. Right? And I would say the other way to think about it is, the evidence is variable. Sometimes it works, most of the times it doesn't and its pretty underwhelming.

Here is one more last visual description of whether this has worked. So this is the premium hospital incentive demonstration. This is really the model by which value based purchasing sort of was focused on, one to two percent payments for hospitals to focus on a series of mostly processed measures and this is a paper we had a few years ago where we looked at, did this big national program on pay for performance work in terms of improving patient outcomes? So I'm going to show you some data, I don't know how well the – but here we are. If you look at what we did, we took a group of the premier hospitals, these are the guys who are getting P for P, took a bunch of control hospitals, matched them up. You can see before on the onset of pay for performance, they are tracking together very nicely. What you want to see now is that pay for performance comes in and you want to see a separation. The pay for performance hospitals, you want to see them starting to do better. Right? They got incentives for doing better. So that is where they were when the stuff started and then if you follow them over the next six years, if this is not underwhelming to you, I don't know what to say. It really just didn't move the needle at all. Six years, pay for performance, patients were no better off in one set of institutions versus the other.

So that is where we came out and now we are in a different environment. We are trying a bunch of new things and if you look at the health policy situation right now, it's under the Affordable Care Act and what we see is a bunch of initiatives. I'm going to just list them and then go over them. So there a few more. You could put bundle payments in here as an experiment under CMMI, but the bottom line is, value based purchasing, about one to two percent of hospital payments for a mix of process measures, patient experience, mortality. The hospital readmission reduction program, one to three percent and now we are at three percent for lowering readmission rates. Accountable Care organizations, it's interesting because it's not primarily thought of as a quality improvement program. It is primarily thought of as a way to try to save money. But quality measures are very much

in there and if you don't hit your quality targets, you don't – I don't care how much money you save, you don't get to keep it. So quality is an important part of how we think ACO's ought to improve efficiency without hurting patient outcomes. And then the HAC reduction program, the Hospital Acquired Condition program is again, one to two percent and it's for hospitals that are in the worst quartile on these measures of patient safety.

So that is kind of where it is and if you look at these provisions, they are basically trying out a different version of the premium HQ ID with some important differences and I will mention them because I don't want to suggest that what we are doing now is exactly what we know hasn't worked. That evidence of what didn't work kind of emerged after this bill was crafted and put together, so there are attempts to tweak it, but if you think about where we are, the incentives are still relatively small. I suggest one or two percent, maybe three. The other people argue, look, it's one to two percent for each one of them, but overall it starts adding up. Two percent for this, two percent for that and pretty soon we are into bigger money. We have moved from just doing process to adding more outcomes – I think that is a good thing and you will hear me say more about that in a minute. And the effects to date are pretty modest as opposed to the early stuff, which seemed to have nothing at all, at least on a couple of measures we are starting to see some improvements and here is a slide from some data that Patrick Conway, who is a Chief Medical Officer of CMS, published in JAMA earlier this year. This is just looking at rates of readmissions. This is re-hospitalizations and re-hospitalizations plus observation status for all Medicare fee for service beneficiaries. We could draw that line much further back, it's been pretty flat for a long time and then you can see just in the last year, as these incentives kicked in, the numbers are starting to move, and to the extent that this represents better care, we think that is a good thing.

So I am going to take the question that we used to ask, which is, does pay for performance work? I think the question we need to ask slightly differently is, how do we get pay for performance to work? Because that slide I show you about heart attack mortality, I think we could all agree that is really not acceptable. That is what the world looks like if we don't do pay for performance. Right? So I don't think the most interesting question is, does pay for performance work, its' really about how do we get it to work and that is what the two other panelists who follow me will be talking about. If you think about what it might look like, I am going to throw out some ideas and I think our panelists can take them on and I'm happy to discuss them during questions. Do we need bigger incentives? My general inclination is, yes. Do we target a small number of outcomes? We have right now between re-admissions, all the VBP measures, the HAC measures; we have literally dozens and dozens of different measures. If you look at where people have made a big difference, where people have gotten real improvements, a lot of it is in context where you have a small number of high value measures. It's much easier to track and do something around all of them. And when I say across a broader set of measures, that might sound contradictory; I mean across a broader set of conditions. So right now, a lot of it is around a few conditions. We really have to target a broad set of clinical care, but a small number of high value measures. Structuring it right is really

important. Some of us have talked about things like if loss of version is really important, maybe one of the things we can do is instead of saying to hospitals, we are going to withhold money and give you some of it back, an alternative is, give hospitals the full amount of money and at the end of the year, ask the CEO to write a check to CMS for whatever they didn't get to keep because they didn't hit the quality target. Maybe that writing of that $50,000 check might be more painful than not seeing it show up at all.

And then playing into intrinsic motivations. One of the points that I want to make is you may hear a lot about intrinsic versus extrinsic motivation, it's really, really important for human beings, we all have a variety of motivations. It's a little less important for organizations. Organizations kind of intrinsic motivation, but organizations really are not people and so organizations respond much more to formal incentives than individuals do and so we have to think about, if we are targeting people, intrinsic motivation is really important. If we are targeting organizations, maybe it's a little bit less so.

Then the last point I want to make is I have written a bunch about this, is we have to a nuance approach to a safety net. One of the things that I think we have seen in a lot of incentive programs is that they are well intentioned, they are well structured, but the bottom line is they have a disproportionate negative effect on safety net and if its because safety net hospitals are providing lousy care to everybody, I can live with that. But if its because safety net hospitals just happen to have more poor patients, that is probably not a good enough reason to penalize them and that is – and differentiating between those two notions and doing something about that is worth doing.

Those are my thoughts; I'm going to hand this over to Ateev Mehrotra.

ATEEV MEHROTRA: So I agree with everything that he said, I don't know if the Supreme Court agrees with you that organizations are not people.

So I think my comments really build upon what Ashish said, which is – and the theme of what I'm going to be discussing with you is, how do we structure pay for performance better? While I think having more money on the table is a key thing, my title says it all in terms of what I'm going to talk about. It's pay for performance how we structure those incentives, it may be just as important as how much money is at the table. Its not all about the money. Just to highlight, why are we doing this? What are we hoping for from pay for performance? We are hoping that putting this money on the table will drive providers in the US Healthcare system from hospitals, to physicians, to nursing homes, to devote more resources and time, behavioral responses; they will focus their energies on quality. Decrease immortality rate for AMI or any of the other plethora of things where we find inappropriate variation in the healthcare system.

So the overly simplistic model is, we will give about this much money and providers will jump and if we give twice as much money, providers will jump twice as high. What I'm going to review with you is, a couple of the examples of how we structure the pay for

performance [inaudible] incentives and how we can structure those a little bit better and drive a better response.

So some of this was raised before, which is that, say you have a certain pool of money - $100 or a million dollars, ten million dollars and you want to use that money in the most wise manner in terms of driving that greatest behavior response. There are different ways you can actually allocate those dollars. I'm always struck by that example that I think many of you have heard of, Richard Thaylor who gives the example of the clock radio. Richard Thaylor is an economist who speaks about behavior economics and he talks about how you are in a store, you have a clock radio in front of you that costs ten dollars, half way across town there is a clock radio that costs five dollars. A lot of people jump in the car and go to that store across town and save the five dollars because it just doesn't seem right to spend twice as much money on your clock radio. Then he gives the example, you are in a store and you have a big screen TV in front of you and it costs a thousand dollars, across town there is a $995 TV, people are like, it's not worth it. I think it's a nice illustration of the example that five dollars is not five dollars and that those different ways of – you are not going to get the same behavioral response.

So I think a theme of his work as well as some of this prospect theory is that smaller and frequent incentives are powerful. It can really drive change. So as we think about that in terms of value based purchasing or pay for performance, one idea that we can start to explore if we are going to go to incentives 2.0 is can we start allocating those dollars in small increments of ten payments of ten dollars as opposed to one single payment at the end of the year? Again, the goal is to get a behavior response, you might get a stronger behavior response if you structure it in that way.

Also, one of the things we do often with these pay for performance programs is we provide the incentive as a percentage on reimbursement. We will pay you $100 regularly, but if you do well, we will give you $110 next year for every visit. That isn't as strong a motivation as actually separating the incentive dollars from the reimbursement itself.

So that is an example and there is many others we can discuss about how we can deliver or structure the incentives. We also have to talk a little bit about how we structure the quality measures and the quality thresholds we think about. There is this theory of – gold gradient theory which is relatively intuitive. It is the idea that if you have a goal that is really hard to get to, you don't put much energy or effort into it. You are pretty close, you put a lot of energy and then after you have met that threshold or that goal, then you actually don't put energy or effort into trying to improve any further. That actually has a lot of application to pay for performance because often how we structure the incentives, we will put a single tier – if you reach this threshold, you will get the money and if you do not meet that threshold, you are not going to get any money. You can see how that could, actually for a large subset of the providers, have little motivation. Those who are far away are not going to both; those that have met the threshold aren't going to really put money and resources into terms of improving quality. So we can start thinking about -

how do we structure the quality metrics or the quality thresholds in a way that we think is going to drive the greatest response across the full spectrum of providers out there? Can we use tiered thresholds? So as you go up the rankings you get more and more money? Or actually instead of pay for performance, should we pay for improvement?

So that is an idea on the quality side, how we measure the quality measures. I also wanted to focus on some other things that are going to really drive whether providers respond to the pay for performance incentives and I think a key one is this whole idea of uncertainty. Let's be clear that – again, going to some of the literature on behavioral economics, there is this idea that contrary to what we might expect from a rational person and I put that in quotes, most of us in the room, if we had a choice between choosing a guaranteed one week vacation over a 50% chance of getting a three week vacation, we are going to choose the guaranteed vacation. It just makes sense. That is how we are, we are risk adverse in general – a bird in hand is worth more than two in the bush.

Why is this important for pay for performance? Well, we have a lot of uncertainty in pay for performance incentives as they are currently structured. You have this idea that an organization like Fairview and others, that are facing these incentives, doesn't really know what the threshold that they are going to have to meet is at the beginning of the year. Because you have to be in the top ten percent or the top 20% or the top 30% - but we don't know what that distribution is going to look like. So what you have is that uncertainty of what you need to reach is going to decrease the amount of resources and time that organizations are going to be devoted to pay for performance or to quality of improvement. You also have programs that Ashish mentioned such as accountable care organizations, shared savings program, pioneer program, where you have a lot of uncertainty. First you don't know if you are going to meet the quality thresholds because those are based on a percentile and you also don't know if you are going to save money. So therefore, it may not be surprising that organizations are going to be reluctant to again, do what we hope pay for performance does, devote time and resources to improving quality.

I also wanted to highlight that so much of the focus is on the money and we have to recognize that other kinds of incentives may be just as powerful. Gifts or other items – again, I will give you another example of – a Thaylor example of the NFL and they had this big problem that their pro bowl players, at the end of a long season, they try to get the best players to go to the pro bowl, they gave a $10,000 incentive – go to the pro bowl and most of the players were like, eh, long season, I'm making millions, it's not worth it to me. What they then did, the NFL said, okay, what I will do is I will give you first class ticket for you and your loved one, a hotel stay in Hawaii and a lot more players took them up on the offer. The same amount of money, but now the gift was a much stronger motivator in terms of that response.

So when we think about pay for performance, we have to think back to what Anne-Marie was showing in one of her slides, which was that physicians, other providers are in a

complex environment with lots and lots of things that are driving their behavior. And money is not the only motivation and ideas may be motivators that – incentives that may be a stronger motivator are for example a decrease in time burden, decrease in the need for prior approval for example or for hospitals, for example, can we remove requirements such as accreditation if certain hospitals reach a quality threshold? This might drive a greater response than just putting money on the table.

Another thing I wanted to discuss here is that when we think about pay for performance, we have to recognize that a key component of pay for performance is the feedback loop. We are giving providers out there information on how well they are doing on AMI mortality and we want them to drive a response. We do this in a lot of industries. We give people feedback and what we know from that other literature, both theoretical and empirical is that not all feedback is the same. If we give frequent feedback, if we tell you the provider how they are doing, how their organization is doing, if we just don't tell them how they are doing, but we have to tell them where they should be headed, a nice study in JAMA from about a decade ago showed that just giving the physician the achievable benchmark of care drove a greater response than just telling them how they were doing. We also tell them not only how you are doing, but here are some ideas on how you can improve. All of those were critical components of driving a great response among providers and how does that apply to pay for performance? It's not what we do right now. If you hear the providers out there, they are frustrated, they don't get good feedback in terms of – they find out way beyond the fact, a year and a half down the road, how well they actually did and they don't have that constant feedback that is really necessary to drive improvement. So again, it may not be surprising; we are not seeing the response we would like from the pay for performance incentives.

I will end with the point that, again, I talked about the money on the table, I talked about the quality thresholds, we also have to be very thoughtful about both who we are profiling and what do we give the incentive dollars – what are they based on? We have a choice of individual providers, large groups of physicians, large integrated healthcare systems. When we are thinking about pay for performance, we need to think about where is the decision making going to happen? What do we want these organizations to do in terms of improving quality? Going back to Ashish's example of AMI mortality, it may not make sense for us to profile individual physicians in the hospital about AMI mortality because it's not quite clear to me that the locus of control is that individual physician has the ability to make the decisions that are going to improve mortality rate. Maybe it makes more sense to profile at the organizational level. So thinking about, what are we trying to drive? Not just choosing the easily measured organization is critical. And also, we also have to be conscious that individual providers, rewarding them on incentives can be also a bit dangerous. Some work we have done and others have done have documented that if Dr. Jones did well this year, he might do really poorly next year. Not because something happened in terms of his care, but just because of measurement error. Random variation. If we are going to put money on the table and we are going to be rewarding noise, that is going to be a great way to de-motivate providers to make a behavioral response.

Lastly, we have to remind ourselves that all of the money on the table is not going to drive a response if the providers do not think that that quality measure is important. And I recognize its not all about what the providers want, it's also about what we want as a society in terms of quality. We need to be thoughtful of the choice of the quality measures is critical and what do the providers think is important?

So I will end with the idea that the theme of this talk is about incentives 2.0, what do we do? What I have been trying to emphasize in my presentation is that how the incentive is structured is maybe more important than the actual dollar amount on the table and we have to be very thoughtful about where the incentives are applied, how we give that feedback to providers and what quality measures we have chosen and that might drive whether pay for performance is going to have an impact on our healthcare system.

ED HOWARD: If you want to give the clicker to the Dr. Herson and I should point out that we will have a chance to test one of your premises because I understand the NFL is going to play the pro bowl in Arizona next year.

ATEEV MEHROTRA: No one is going. [laughs]

PATRICK HERSON: Well, good afternoon and thank you for coming. I'm Patrick Herson, I'm the President of the Fairview Medical Group located in the broader Minneapolis/St. Paul Twin Cities area of Central Minnesota. My medical group, we have about 580 providers, we call them. That is a mix of physicians, osteopaths, as well as nurse practitioners, physician's assistants. Two thirds of our providers are primary care and about one third are specialists ranging from neurosurgery through a variety of surgical medical sub specialties. Orthopedic muscular skeletal care and women's health providers. We are also part of a large integrated delivery network with five plus community hospitals and an academic health center at the University of Minnesota Medical Center, that is kind of the milieu that I practice in. I presented the slide to you that this was something that drew up in 2009 actually and you can see in the middle there, the physician compensation is in red and my point of bringing this is that we have thought that we would be on a journey over many, many years about getting our physician compensation right, if you were to support a variety of work that we are doing. And you can see our very optimistic thoughts that we would be going from fee for service there in the 2009 market to somehow being in global payments to some degree in 2012. That hasn't happened in our market. But 85% of our payment arrangements have some portion of shared savings or equality improvement bonuses built into them. We have very little that is strictly considered global payment or capitation per se. But I just want to set the context that this has been a long iterative process that we have been involved with.

As we really went from in the medical group from a volume to value mindset in 2010, we restructured how we were delivering care, focusing on team based care, really heightening the aphorism of people working at the top where their license is. People

really engaging the RN's, the medical assistants, the other stuff available within the practices to help them care for their patients. We also restructured our compensation to try to account for that. You can see that we started by – instead of being on RVU's relative value units – a formalized way of assigning a certain value to every clinical, procedural or cognitive activity that a provider might do. We instead said that four deeper set would be based on quality. We live in a state that has a statewide reporting mechanism for quality called Minnesota Community Measurement, which we had been a part of – its been around for almost a decade, so we had some good external benchmarks to see how we did, not just with our metro competitors but also across the rest of the state. Patient experience using external bench marks on the CG cap survey that we use [unintelligible] as our vendor for that. Citizenship, which was decided by the local leader in the practice, whether someone was being a net contributor or a net taker from the vitality of the practice. Sometimes we call that – are you being glue or are you being solvent? How the practice is a cohesive group of providers and then productivity, but we didn't base that, at that point, on relative value units. Instead, it was based on acuity adjusted panel size as well as clinical activities. You can see from this quick table that the notion was, if you look at the percent payout, that equals 100%, but if your clinic, your team, is blowing away quality, you could actually get 60% of the median for your specialty as part of your salary. So it's a real chance for people to earn considerably above median for their specialty with this kind of an arrangement.

This is a pretty fun graph, actually. This is sort of norm – the 100% of the light barely visible line, is median, which has been going up and up and up year over year for specialties but we normally use data for that. The red line shows the productivity based on RVUs that our providers had provided. You can see that as we started this work in 2009 as a baseline, we were about 94% median, 94% of average for our typical provider compared to their peers in terms of being productive. The number of RVU's or visits that they would generate. You can see we took a dip and that was intentional as we instituted those team based care protocols and practices and began to see an up tick, which had us all thinking we were on the absolute right path and then you can see sort of where we got to. Above that, the blue line is the amount of salary based on median that we are providing to our providers. You can see where that blue line crosses the green line, that was when we started paying on that 40% quality, 10% satisfaction rubric in the previous slide. A considerable jump occurred in people's salaries. The period prior to that, we froze people's salaries because people said, why would I want to contribute to the vitality of the redesigning the work if I'm being paid on visits, if I can't see patients or be in a meeting or a huddle with my team to go through a QI process and such. So we froze salaries, you can see the jump that they took. We did a couple of correctives along the way. The one on the far right I think is most important is we put a cap on the gap. We said essentially, there is a maximum amount you can earn above what you would have earned in an RVU production world. And it was a sliding scale, way too complicated to try to explain here and violates all the rules we are told about keeping things simple, avoiding loss aversion, etcetera.

I will just tell you a quick little story about that, which illustrates most of these. A colleague who I love dearly had seen her salary go from about 80% in median to 140%. She was in a phenomenally high quality, really committed practice. When the first cap on the gap was instituted, her comp fell down to 119% of her specialty. She was still producing at 80% of median, so she had gone across town to our competitors, she had been making 80% of average, I was paying her almost 50% more than she would be making even after the drop in her salary and she requested a one on one meeting to complain about the fact that her salary was going down by 21%. So you can see that we regrettably built in some loss aversion into this and some uncertainty because the cap on the gap had some tiers to it and people would be right on the bubble and their comp could go down an extra 5% depending on which side of a tier they were. And that uncertainty caused some people a lot of distress. We did though, with the help of Jessica Green and Judith Hibbard and support from the Commonwealth Fund, evaluated the impact that [unintelligible] had for us. You can see that the quality metrics did improve and but it was not related to the size of the financial incentive. So diabetes for example got more of a percent of that 40 than asthma did, if my memory is correct. So we are able to kind of control for that to see if it would really make a difference, if you got a lot more money for focusing on diabetes than asthma, that didn't really seem to make much of a difference. The biggest difference was when people went from a low baseline clinic, often in our rural areas and a couple of inner-city clinics akin to the safety net providers, if you will. They saw some of the bigger jumps. Also people reported that they were using a number of different ways to impact how patients improve the quality of care. The biggest being a variety of mechanisms we developed for the system to assist between visits. So it was reliant on the provider at the point of care. The teams were looking at those sort of pieces. We also got out of this that people thought some of the team based models seemed to go against the natural American incentive for individualism. They felt that there was a lot – they weren't sure that they could necessarily stimulate their fellow providers to do better care. So we asked people, our leaders, should we change our compensation model in a group of 580, you rarely get something as significant and directional as this, overwhelmingly people thought we needed to make some changes. We then asked the front lines, well what would you change if we were going to change some things and add some things in? You can see a lot of people rated putting RVU's back in the model as highly important. And what we heard from people was, I want to know what I can do today that might impact my compensation in the future. I don't know if I take time now to contact two diabetics and get them in to get them under better control, if I can make more money doing that, or squeezing in two more people onto my schedule today. Also, interestingly, you can see people wanted individual quality added in, but maintaining some team quality and they wanted panel size included as well. Really interesting, but total cost of care got a really low response from people and we can talk about that during the Q&A if people have questions about that. But I think many of my providers feel as though they have such little control over how their patients spend money, necessarily. And I think we may have insulated them from quite a bit of that because we have systems developed that we have invested in that help do a lot of that care management work, so it doesn't – that burden doesn't fall necessarily onto the frontline provider. So we talked

about incentives 2.0, but we did change this model. We found in the end, based on those results, that input, that we changed the model just this month, we started paying our primary care doctors differently. It's now 90% individual productivity measured by RVU's and 10% acuity adjusted panel size. I don't think we are circling back and I come from a land of hockey and I think in many ways – and I know you have a good team here in Washington, but I think in many ways we are kind of circling back into the neutral zone, that we are at risk for being off sides and so we are cycling back to take another run at this, but keep ourselves on the offensive and in the game.

My time is running out here, but still baked in this is the opportunity to earn 15% above what you could and strictly fee for service world based on quality, patient satisfaction, a lot of that much more individual based now than team based, based on the input, the feedback that we got from our frontline providers. So in our planning meeting, Anne-Marie had asked, could we bring a few policy ideas, so I thought of a couple. One was, why don't we think about taxing our primary care providers like we do hedge fund owners. This is an idea that I'm stealing from Uwe Reinhardt who suggests if we use tax policy to encourage things that we think are net social benefits, why wouldn't we potentially want to use this to stimulate more people's interest in primary care? I think my panelists up here probably agree with that? Don't you? As primary care docs. Also, I do think we need bigger incentives, to some degree, to really get people's attention. I have proposed at some point, going to a mix where we take whatever it is, whether its RVU's or panel size and we multiply it by a value factor that could be less than one or greater than one with a slightly bigger upside like I have listed here. We all know or many of us know you can create value in a medical encounter, a medical office and you can destroy it by offering poor quality care or churning people through, etcetera. If we really want to be effective at getting a set of outcomes in healthcare that we think benefit patients, then all of us as a whole ought to be prepared to pay for it. Thank you.

ED HOWARD: Thanks very much, Patrick. Can I just ask you, actually I had asked you before but I didn't give you time to answer. You were describing RVU's as being the highest rated factor that your providers wanted to build back into the compensation plan. How do RVU's work? Relative value units? Is that right?

PATRICK HERSON: Yes. Well, I bet there are a lot of people in this room who know a lot better than I do, but every clinical activity that a provider can do, whether it's a craniotomy for brain surgery to a simple checking someone who has sunburn in the office, has been assigned an amount of value for that effort and that activity. They add up and they become normed I guess. So a typical family doctor would generate about 4800 RVU's a year in my market. A typical, simple outpatient visit for a known patient kind of following up is worth about one RVU. So you can figure out that that would be about 4800 office visits like that, that someone may have to generate throughout a year to kind of earn a typical median salary in the Minneapolis/St. Paul area, if that helps. There are some specialists who can generate 12000 RVU's because often procedural activities,

surgeries, colonoscopies, things like that, have many more RVU's assigned to them than more cognitive things like consultations or outpatient primary care work.

ATEEV MEHROTRA: So for those of you that are not familiar, so then an RVU is converted into a dollar amount by the conversion factor. I think Medicare is last. If I have it right, it's around $32 per RVU. So if that helps translate.

ED HOWARD: So RVU's reflect both volume and complexity, right? Is that fair?

PATRICK HERSON: That is very fair, Ed.

ED HOWARD: Well, we have come to the point where if you have questions, you get a chance to ask them. As I said, you can either go to one of the microphones or fill out a question on a green card and hold it up and it will be brought forward. Meanwhile, Anne-Marie and I might have a few to get us to your part of the program. I was remiss in not mentioning that you can Tweet #payforperformance and the instructions for how to get onto WiFi, which it is probably too late for you to do, is also on the screen and on your table. So go to it social media wise. Anne-Marie, do you have something you would like to throw into the pot at the beginning?

ANNE-MARIE AUDET: Yes, I actually have a question for everyone on the panel and that is, we have done a lot of experiments in the past, we have evidences that the results are mixed. If you look at the way we have gone at this kind of research agenda, it was really piece meal. Let's try to incentivize a process. Hemoglobin, a IC for diabetes. Well, then let's try another one, hypertension. What about blood pressure? So we have gone at this with a very small steps. The size of the incentive and ten years after that whole experiments we still have inconclusive results. We are now in 2014 and we are starting to realize that a lot more can be done if we bring in other signs of motivation, behavior economics. What would be – and then we hear from Patrick, who is doing experiment in the field, trying this on an ongoing basis, revising and getting feedback from the providers themselves. So what would you recommend we – how do we go about starting to test and to design how we are going to structure these incentives in a way that will inform us not in 20 years with inconclusive results, but something that we could really benefit from?

ASHISH JHA: So maybe I will start by thinking about the fact that if you take a website like Amazon.com, they run hundreds of experiments every day. Depending on what time of the day you show up, who you are, your buying history, they are making little changes to that front page, they are making changes – because they have a very simple goal, right? They want you to buy more stuff. And if you buy more stuff, they win. So their incentives are very clearly aligned and since they don't know the right answers to how to get you to buy more stuff, they are experimenting all the time. In some ways, that is what we need healthcare to do a lot more of. A lot more of the iterative experimentation. So you don't have a group of experts saying, here is the right way to do pay for performance.

There is no one right way. It is going to vary tremendously based on local culture, it's going to vary tremendously based on what you are trying to do. Are you an organization, are you an individual practice? But what I think we need more than anything else is from policy makers, is getting the incentives aligned in a way that gets organizations to start experimenting. So Patrick can figure out what is going to work for his organization, Ateev can figure out what would work at his. That is the notion. And we just have far too few of those in healthcare and that to me is the big problem and that is why it takes ten years to figure out that these six different ways of doing it didn't quite work. I would love to figure that out in 30 days so that we can then try the next six.

ATEEV MEHROTRA: Just to echo what Ashish said, we really – I gave some ideas, others have some ideas, but in terms of – the evidence base, the different kinds of incentives and the way they are structured, I think there is almost no evidence. Almost all the work that has been done has been a binary yes, no, does pay for performance work as opposed to what kind of pay for performance. We really lack data and there needs to be this general – both at the providers as well as the larger policy arena about experimentation because we need to know.

ED HOWARD: Now we will go to the microphones and we will ask you to identify yourself and your affiliation if you have one and keep your question as brief as you can.

AUDIENCE MEMBER: Steve Redhead with Congressional Research Service, CRS. I have a different kind of question or pair of questions. If you approach a physician or a practice or a facility for which you have evidence that it is not performing very well and you bring this to their attention, what do they say? Do they think they are doing a good job? If they agree with you – if they happen to agree with you that they are not doing a good job, then you ask them the question, what kinds of things will help you do a better job? What do they say?

ASHISH JHA: Let me take a shot at that. As you might imagine, it varies by the organization, but the first response – if I came to any one of you and said, you know, you are not doing a very good job. Whatever you do, you are not doing it very well. It would depend a little bit on who was giving that message. The second question you would ask is – the first question you would ask is, who are you? Right? Second question is, what are your metrics? Or do I buy them? Then all the sort of defensiveness comes up, this is where having really good clinical metrics matters a lot. And what we have seen is there are a lot of organizations. If you come with clinically meaningful metrics that people care about and you are a credible source and you show up with that data, a lot of organizations actually respond quite well because then you are sort of tapping into the intrinsic motivation. None of us want to be lousy. None of us want to be below average. So you can actually motivate people to improve a lot if you get those first few things right. A lot of times we show up with measures that are not all that good and then we say, you are not doing a very good job and then we are surprised that people don't respond effectively and spend most of the time going after how lousy the measures are.

PATRICK HERSON: And a couple of thoughts. So my medical group, we are about 120 miles – if you think of us as a big square, so we have quite a bit of area. I have been in most rural practices were we have got good data. We have a very transparent tool. Anyone can go in there at any time and look at any individual providers or group clinic's results and how they are performing, with the thought being that they should be able to say, I wonder why the Rosemont Clinic is at 70% optimal diabetes control, let's call them and find out. That doesn't happen as much as it should. But when I travel around in my practices and present data, I have heard things like, well we are a rural site, everyone knows, look at the atlas, people in rural areas smoke more, they have poor health habits, they are poorer in general, what do you expect? I have had my doctors in our wealthiest inner ring suburb say, we take care of a bunch of rich people here, everyone knows you can't tell rich people what to do, what do you expect? I have had people in the inner city say, well we are full of all these Somali immigrants and Mung immigrants, we don't even speak their language, what do you expect? I have had people say, look at our depression burden in our practice, what do you expect? No one wakes up to do a bad job, but we all psychologically defend ourselves for the job that we do. I think if we can come with solutions and I think Dr. Jha kind of talked about that. If we can come and say, in my case, the Rosemont clinic does have 70 plus percent diabetes control, which is remarkable. I remember eight years ago when they were in single – all of our state was in single digits and as a health plan executive, I said, can you get to double digits? And people would have thought I was asking for their first born child. As a state, we are now at about 45% in Minnesota, which is pretty remarkable. In many ways we are still the fastest horse at the glue factory. If you think about it, if you are a diabetic. But I have a practice that is at 70% and it's reproducible. They are capable of telling you why that happens. It's not just good luck and its not just passion from a couple of providers. They have a program and a process that has lead to those results, which is available for others to copy in their system if they want to.

ATEEV MEHROTRA: The only last thing I would add is, we talked about other ways that motivate people and how we can drive incentives and Judy Hibbard has done some nice work with hospitals in Wisconsin, just documenting in a nice trial that professional reputation was an important driver of whether hospitals were devoting resources to improving quality. So I think that is something else for us to think about. It is a key driver and maybe a more important driver than I think sometimes money is.

AUDIENCE MEMBER: I'm Kyle Fisher; I'm an Emergency Physician in town at Prince George's Hospital and a Health Policy Fellow at University of Maryland. One thing that is really important to me is that we know that end of life care is a huge issue now and that we spend a tremendous amount of money on patients in their last year of life and many patients end up getting care that they never wanted in the first place. But I haven't heard much discussion or seen any metrics regarding this issue. So what can we do to A, promote palliative care and comfort care in appropriate situations and B, to

perhaps have opt out measures for some of these aggressive quality metrics when patients decide that they no longer want aggressive care? Thank you.

ASHISH JHA: I don't really – that is a really great question to which I think the answer is, we don't really have very many good answers. You know, so first of all, there are ways in which people try to deal with Hospice and palliative care in some of these mortality measures. I will tell you, we don't do a very good job of it because we can't figure out who is somebody who died because they got poor quality care and then at the last minute got switched to Hospice, versus somebody who really did not want aggressive care at the end of life. They may have had a terminal illness or otherwise. So there is a technical issue of how do we do this better? But I think your question is much more philosophical than technical around this stuff and I agree with you that there is hopefully a renewed discussion about how do we manage people's health and healthcare at the end of life? The challenge of developing metrics around it or even understanding how to measure that is difficult because I don't think we figured out what good care looks like at the end of life. First of all, it's very variable by patient preference and second, we have not done a good job of measuring that in any systematic way. So I think as an academic, it's easy enough for me to say, its an area for important research, but as an area for research, we really have to understand it a lot better before we go off measuring it or starting to reward people on it.

PATRICK HERSON: I agree with all of your comments, Dr. Jha, it's a very complicated issue. We are working on a Honoring Choice as a statewide effort to get people to have advanced directives be available and accessible in ER's where you practice and other sites of care. And it is a very, very challenging clinical topic and the patient and family preference is the key part. I would love someone, some great policy person in this room to figure out a way to really assess satisfaction against need or desire in that part of someone's life, because it is a tricky thing to really know what value you are bringing to someone sometimes.

ED HOWARD: Very good. Yes, Joyce?

AUDIENCE MEMBER: Joyce Freedon, *Med Page Today*. This is for Mr. Herson. I just wanted you to kind of do apples to apples. You said you have changed your payment system and you went now to I think 90% productivity. At the beginning was it 60%? Can you?

PATRICK HERSON: So before we changed the compensation model in 2010, back with the slides that I showed, it was 100% RVU production and then we had no RVUs in the model we have used for the last three and a half years. We have the quality, experience, citizenship and then productivity measured by clinical activities and acuity adjusted panel size. Now it's 90% with RVU and 10% with the panel size and my goal is as our pair mix changes or our reimbursement mechanisms change, we can adjust that

ratio to maybe 80/20 RVU's or maybe someday even 20% RVU's and 80% panel depending on further evolving of the payer mechanisms. Is that clear?

AUDIENCE MEMBER: Yes, thank you.

ATEEV MEHROTRA: I'm not sure if this is allowed, but one of the things we talked about before the panel started, can you talk about how that compensation model impacted Fairview's bottom line? Because I think that is a part that is missing in the conversation.

PATRICK HERSON: Well, as you saw from the slide earlier, the two timelines, that whole delta between the top line, what we were paid, what we paid out to doctors and I think the bottom line, which was in red, what we kind of took in, based on our outpatient primary care doctors clinical activity, that whole delta was eaten by Fairview. By being an integrated delivery system and such and it was several million dollars a year. The way we are structured is we will lose money – that is just the way we have our accounting set up and we are very comfortable with that. It does not mean that my doctors are laggards are they are lazy or anything like that, but we had a bigger delta then we have and the company floated us through that as it were, but its clear that you can't pay for that much value without generating in our outpatient's practice, more income as well to support that.

ED HOWARD: Okay, yes Paul?

AUDIENCE MEMBER: Paul Cotton with the National Committee for Quality Assurance, thank you for an excellent presentation, this is fascinating, the things you are presenting. I wanted to ask about the distinction between p for p at the individual provider level, which is most of what which we talked about and p for p at the health plan level where we have seen more progress. CMS just reported earlier this month that they have seen some real improvements in the Medicare Advantage Star Ratings and then most of the states are now using Medicaid p for p in one way or another. Why do think there is this difference between the way p for p is playing out at the plan level versus at the provider level?

ATEEV MEHROTRA: Maybe I will start and then turn it over to Ashish because he has done more of these evaluations, but I think the key thing that is important to think about when we evaluate – did p for p work, what is the comparison group? And so I don't know why I'm talking about Ashish's work, but the work on the hospital mortality measures, there was I think rapid and significant improvement in all of the organizations in terms of their mortality and in other pay for performance programs we have looked at. It is the issue that, is there additional gains in the pay for performance program above and beyond what we would have seen otherwise? So to maybe re-phrase my response to your question, which is that yes, there have been improvements in the star ratings, but are those driven by pay for performance or were those driven just based on the general trend towards quality improvement in our healthcare system? That is the thing we struggle with

as researchers in terms of trying to discern whether there is an additional benefit of p for p.

ED HOWARD: Ashish, do you want to talk about your work?

ASHISH JHA: Only to say that control groups really are important, it's not some sort of boneheaded academic like, why do we need control groups, hey, people are getting better. Because you actually need to understand what is going on and what is making things better, right? And without control groups, your ability to understand what is happening underneath the surface is basically non-existent. So I have not done a whole lot of work with health plans and I can't comment on what is happening there, but we have seen over and over and over again – somebody puts in an incentive program, they come out six months a year, three years later, and say, look at all of this improvement. Then you go back and put a control group that looks just like that, except didn't get the incentives, the improvement was just about the same. That just means that the incentives had very little to do with it and that is an important thing to understand, because why waste our time with incentives if they are not adding anything? That is they key point. So control groups are really important, not just for academic publication, but to figure out what is going on.

ATEEV MEHROTRA: Just one last point on that, which is that when we think about pay for performance programs, we often think just about the dollars that are being allocated and whether it made a difference. I think the key thing we also have to be conscious of is, when we think about pay for performance, there is a lot of administrative burden that comes both on the payer's side and the provider side. The hospitals across the country are devoting tens and millions of dollars to generating and measuring these process measures that are being rewarded as well as CMS and other payers are putting a lot of resources in terms of trying to figure out how well the providers do, allocate those resources, etcetera. So we do have to be thoughtful of, that p for p programs do have a cost and we have to be conscious of that cost when we think about the best way to structure those programs.

AUDIENCE MEMBER: I'm Stu Gutterman with The Commonwealth Fund. On that issue of control groups, one of the things that has always struck me is that when you are doing something big and changing incentives, that there could be spillover effects that could actually affect the control groups that you are comparing it to. So I mean, you see that with Medicare spending, its going to become really hard for individual initiatives in that CMMI is doing to look like they save money because Medicare as a whole is growing so much more slowly on a per capita basis. How can you take into account the broader implications of doing a whole lot of stuff to change the incentives that folks face while trying to sort out what the individual effects of individual initiatives?

ASHISH JHA: That is a really hard question Stu, and you know it. The answer is, with really careful, meticulous work. So there are spillovers and we have to think about that

and that is why you have to think about who your controls are. When you have broad, national policy interventions, its really hard to find control groups because we don't have control countries, we don't – so you are stuck looking at things like, as things get implemented at different times, maybe your controls are coming from different places. You look at where the intervention was strongest versus weakest. There is a whole bunch of stuff, which you know very well in a lot of the work that you have done, that begins to try to tease that apart. Again, the reason it's important is because we are doing a lot of experiments, we do need to know which ones work and don't, so we can generalize the right ones and if you don't do that meticulous work of sorting it out, your ability to really know which one you are going to push out to a much broader audience is limited and then you will push out the wrong ones and it won't make as much of a difference and we will all be disappointed. So that is why its worth doing that meticulous work. I did not mean to suggest that controls are easy, you just find them and do them. It is hard stuff.

ED HOWARD: I think you were first.

AUDIENCE MEMBER: Okay, thank you. Allison Brennan with the Medical Group Management Association and as we are having this conversation, a lot of times we are often talking specifically about Medicare payment for obvious reasons, but I think its important to also keep in mind the fact that providers deal with so many payers and they have so much complexity. So when we talk about pay for performance, a lot of times group practices are dealing with different p for p criteria and feedback and evaluations from a multitude of different payers. A lot of times those are all very different. So how do we kind of deal with the complexity in our system when we are talking about pay for performance? Because if its one tenth of your payment, you know, one percent of one tenth of your overall payment probably isn't going to move the needle. So how would you address that challenge?

ED HOWARD: And if I can add to that, we have several questions from folks in the audience on cards talking about the validity of various metrics and how developed that area is, how valid is it to use the metrics that different payers are deciding to use and how is it decided and who is trying to get them all together? We ought to get Paul Cotton back up here.

PATRICK HERSON: So where I am in Minnesota, we have it kind of easy. We have a statewide collaborative, the Minnesota Community Measurement, which the payers and its supported by the payers in the large delivery systems, but all of the – all providers contribute into it. We have got reasonably well agreed to operational definitions for what quality is for many primary care things. We are working on specialty areas, which is a real need at this time. So that is a nice benefit. I would say though when you begin to later on like the Pioneer ACO 33 quality measures, it begins to add burden to my team. I supervise our quality team in the medical group and that was two extra FTE that I had to add into an RV type budget a couple of years ago and some of those overlap and some of them don't and one of my larger payers just came to us recently and suggested they are

putting a real focus on stars for next year and there is a number of things with stars that are not done by Minnesota Community Measurement and they came with a list of additional data that they will be wanting from us and such, which we are trying to figure out, how much does it cost us? It is a very legitimate burden and in some ways the variation in what the definitions are, I would say in my medical group, any process measure gets sneered at by my doctors now. They are so used to real, true clinical outcomes even though they are not perfect. I actually had my orthopedic surgeons a year ago suggest a process measure for their quality work and my primary care docs laughed them out of the room. They want real outcome measure because they have been living with the reality of that. So I don't know what people in other states do that don't have a convener to try to keep some of that noise at bay. And even with a convener we are beginning to hear more of it.

ASHISH JHA: The only quick thing I was going to say is, it's a very tough issue, it is a really important issue and the more fragmented and the more payers we have in the market, the harder this gets. I mean, in some ways we face this with the hospital side and the hospital quality alliance was an effort to do this. We brought in the major payers, a whole bunch of stakeholders and got agreement on the metrics. But it's a huge challenge, I don't have any simple answers beyond that maybe as one model.

AUDIENCE MEMBER: Hi, I'm Mike Miller. I'm a physician, health policy consultant, blogger, etcetera. I wanted to follow up on something Dr. Herson just said about Minnesota having a convener. I have done a lot of work over the years and going back 20 years, writing off physician compensation, withholds, risk pools, all of that, can you talk about the culture of Fairview and how you communicated that five year plan to the physicians in the group and if there has been any spillover to the clinical community outside of your group in the Greater Minnesota/Minneapolis area, wherever you guys have a presence? And can the other panelists talk a little bit about the cultural differences and this might be a little bit treading dangerously in this room, but other states – I know Minnesota is a place where people get along pretty well and work together and other places in the country there is a little bit more contentiousness between physicians and payers and physicians and hospitals and don't want to be told anything.

PATRICK HERSON: So Fairview has employed physicians for over 50 years, but the Fairview Medical Group, the entity that I lead, is about five years old, so in 2009 we peeled away all of the doctors and providers who are working in hospital care systems and put them into one centralized employment home, if you were, with accountability for the clinical, safety and the financial performance for the group. So we are just establishing that culture. It is still five years into it. We don't have a – we are working on a culture of accountability and one of collegiality and it is daily grinded out blocking and tackling and sticking to your knitting kind of work, if I can mush a whole mess of metaphors into sort of one particular thing. I would say in some ways our original compensation plan, though designed by a group of primary care providers, didn't enhance our culture very much. It didn't destroy it either but we were so technically focused on

getting the measurements right and the deciles right and all of that, that we – this last go around we were a much more mature group and that primary care compensation committee is much more mature in really being able to wrestle with the more difficult and challenging questions. One of the things that we wrestled with and it gets to incentives in a sense, was we would have people say to us, I have a doctor doing X. Put some remedy for X behavior in the comp plan. And the committee got to the point of saying, this is to reward providers, it is not to shape behaviors. It may help shape some global behaviors toward quality or patient experience, etcetera but it is not to deal with every little X, Y or Z that pops up among 580 different providers. So there is a – it has fostered a culture of accountability that we have local physician leaders in every practice and their job is to manage the X, the Y and the Z's and not depend on some big global compensation plan to be able to do that and have any degree of simplicity which Anne-Marie told us was really critically important at the beginning of this. I'm not sure about spill over. I know that my competitors who are also collaborators frequently, when we rolled this out four years ago, we were like, good luck man. Let's see what happens. They kind of thought we were off the beam in some ways and we overcorrected and over reached and now we are back in the neutral zone again, gearing up to run at them. So I'm not sure that it has had a tremendous spill over, because many of them have kept their old models, which is great. We can say, if you are not happy working for us with this comp arrangement, you can go across town and there is somebody else who will pay you X way and to create that distinction. Is that helping you?

ANNE-MARIE AUDET: I have one follow-up question on that because we all hear that healthcare is a team based sport and I know you have tried to incentivize your teams and actually if you look at your data, I think there was some issues there. So I wonder if what I'm hearing is that there – the way you incentivize or you cultivate accountability is not only the financial part of it, so you may have other ways of facilitating the team aspect of it, which is not necessarily linked to the dollars.

PATRICK HERSON: I think we were hoping that the comp model would create more teamness. Create more of that culture in a sense and that accountability with one another – that happened in some small, little pockets, but it did have one good benefit. Prior to starting this, there were always accusations that the best performing clinics, one of their mechanisms to do really well was to get rid of their lousy non-adherent patients. They would dump them. That is the term that people would use and you would often hear – well, X clinic gets those results because they are just better at dumping their patients onto other people. There was concern expressed, if it was all individual four years ago, that that would just lead to dumping within practices. So I would just say to my non-adherent diabetics, you know, Dr. Mehrotra is really good with diabetics like you. I think you would be really well served by him. And then my denominator would get smaller, but my numerator would improve. Part of the work that Jessica Green helped us with, showed that that sort of dumping and then that sense of dumping was eliminated, now that we have a mix of team and individual with this quality bonus, it's going to be curious to see if those allegations rise up again.

AUDIENCE MEMBER: Hi, my name is Frank and I'm with the Brookings Institution. One of the things that we are doing right now is we are looking at providers, talking about performance and one of the things that is important to understand, I think, is that much of the pay for performance was done with an underlying system of fee for service. One of the things that providers has said to us is that, regardless of what system or what performance measure you put on them, they are still not able to provide the high value unique care that they really need to get the performance. So paying for non-traditional services for example. What I would like for you all to comment on is – in addition to – is pay for performance enough? What combinations of payment models might we see in the future where they can be incented to provide high value care and still get paid to ensure that they meet certain quality metrics?

ATTEV MEHROTRA: It's an interesting idea. What I hear about frequently is this phenomenon of; we just need to generate a CPT code and an RVU value for all the stuff that we would argue as high value care. I think there is a lot of ways and I think it was the stuff at Fairview that was really interesting to hear, where providers were providing higher value care, taking care of patients over the telephone when it could be managed by the telephone. That makes a lot of sense, there is a lot of stuff we do and healthcare clinics don't do that. Let's do a telemedicine visit, let's do an evisit, let's message via their personal health record. And I do think that there is this general theme that I hear about is that, all we need to do is put the CPT code, the relative RVUs, the RVU's associated with that and then nirvana will be reached and we will have the right high value care. While I am fully supportive of the idea that that kind of high value care needs to be provided, I'm a little bit unclear about and I don't know, I might be misinterpreting the thrust of what the providers that you spoke with were talking about, but also in that particular case I'm also a little bit nervous because as soon as you start adding a code and adding a service, you are going to add high value care or experience in the healthcare system, you are going to add a lot of low value care, a lot of unnecessary phone calls, unnecessary things just by rewarding that. So while I think that we need to reward it, I am much more enthusiastic about rewarding the – using things such as global payment versus that. But I just wanted to make that point because I do hear a lot in the policy world, let's just produce. If we just cover that service, it will happen and it will happen in a high value way.

ASHISH JHA: I want to echo what ATEEV said. There is this element of, oh, you know, if we just paid for social services, if we just paid for housing for some people, we could save a lot of money. Well, I would love it if the health plan paid for my housing. But you know, the bottom line is – that was meant as a joke, people. Nobody thought that was funny. But the point is that that's what happens is that you need to – there are a few patients for whom paying for housing probably would save money on healthcare, but that is not a broad strategy that says healthcare should start paying for housing, right? So how do you get one without the other? You do it through a much more global payment approach then you ever say, okay, now we are going to pay for these social services

through healthcare because that will mean a whole bunch of people who could pay for those social services on their own, would start getting them. We don't want to go down that – it's not useful to go down that road. We are not going to save money.

PATRICK HERSON: So on an individual level, part of that 45% productivity in our original model was clinical activity, so managing someone by an econ [inaudible] to message back through epic, a phone visit, things like that, interacting with a team that was doing work. Those all sort of counted in a sense and we had some doctors say, are you telling that a phone call – my time in the exam room is worth the same credit as a phone call? So we had people making these equations that were never intended by any means. In fact, we are trying to add, because those phone calls are care that we have been giving away for decades since there has been phones. For free. And then a very wise but far too honest doctor came to me and said, I'm converting all of my patients' chronic meds to only 30 day amounts, because every refill will give me an account [unintelligible] I will count because my nurse will manage that refill. I was like, I don't want my nurses spending a lot of time managing 12 Lipitor refills when they could be managing one, right? So no matter what you do, there will be people who will figure out ways to manipulate some of these incentives to personal gain and not in the way that they are intended. That is one of the things that I have learned working with human beings.

ED HOWARD: We have just a couple minutes left, which I would ask you to use in part by pulling out the blue evaluation forms and filling them out as we get a question or two in. Anne-Marie, did you have one that you wanted to squeeze in before we finish?

ANNE-MARIE AUDET: Yeah, I'm just afraid because the ones I want may open up a Pandora's box. I'm just also curious about the balance between the rewards and the penalties. And in the context of uncertainty and so for all the panelists and starting with Patrick because I sense from you that there was some good that came out of the uncertainty or maybe I misinterpreted, but you used that in a positive way. I'm not sure.

PATRICK HERSON: Oh, thanks for letting me correct that. We found the uncertainty very disruptive and very harmful in many ways. Believe it or not I had a doctor say to me, I'm not sure if I can order sod for my yard this year until I get my envelope telling me what my compensation will be. Personally I think he needs a better financial planner if he is incapable of reserving sufficient money in the winter to pay for sod in the spring. But that was the level of discourse that some of that ratcheting down with that cap on the gap created. It was not positive.

ED HOWARD: He actually needed the new sod seller is what he needed.

ANNE-MARIE AUDET: So what are some examples of uncertainty? I heard moving threshold. So what are some examples that we could start to look at>?

ATEEV MEHROTRA: Just to review a couple of them, I think the first is that we – Patrick, I thought it was nice how you said this, where you have a choice, a very simple choice. You are a doctor in a busy clinic and you can see – you are behind in your schedule and you can devote some time and resources to try and convince Ms. Jones that she needs a mammogram or improve her diabetes care or you can catch up on your schedule and see more patients. The problem that I think right now that we face is the uncertainty on the first part, which is well, I could improve Ms. Jones' mammogram, that might increase my mammogram rate for that particular pair, but I don't know what my threshold is going to be. What is the team? Well, based on the practice. So – then this will all pay out it 15 months and by that time, my sod is dead and so you have this issue that it is so far ahead that its not surprising in that complex decision that you are going to choose the certain thing, which is seeing another patient that day. I think its striking that your providers wanted more of that certainty but a lot of people call it being on the hamster wheel, seeing so many patients. But I think it is that certainty. So how can one fix that? We can start to think about how does one – and I don't think we have time, but to explore and try to address that problem.

ED HOWARD: Well, we are just at the appointed hour. I would ask you if you haven't filled out the evaluation form – I don't know about Anne-Marie and the rest of the panelists, but I have – well, I know you folks haven't learned a lot, I have learned a lot, but secondly, I'm struck by how many more aspects of this we really didn't have time to get into that were raised in your respective presentations. So I know this is a topic that will recur in various guises over the next year or two and I want to thank our friends at the Commonwealth Fund for their work in this area, to highlight some of the issue that we have been talking about and obviously for helping us recruit a panel that is really high quality, even if there are a lot of Harvard people around here. Thank you for some terrific questions, many of which I apologize for not having been able to reach and ask you to join me in thanking our panel to a great start to the discussion of this issue.

[applause]